



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-877-1122. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary/> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,400 / individual or \$6,800 / family, for out-of-network providers \$6,800 / individual or \$13,600 / family	You must pay all costs up to the deductible amount before this plan pays for covered services. Because the deductible is embedded, once one member meets the individual deductible , that member moves to coinsurance even if the family deductible is not yet met.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . Generic drugs classified as preventive under ACA guidelines are covered at no cost to you when obtained from an in-network pharmacy. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers \$3,400 individual / \$6,800 family, for out-of-network providers \$6,800 / individual or \$13,600 / family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See https://www.askallegiance.com/ProviderSearch for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance , subject to deductible	50% coinsurance	None
	Specialist visit	0% coinsurance , subject to deductible	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance , subject to deductible	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance , subject to deductible	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	0% coinsurance , subject to deductible	50% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	0% coinsurance , subject to deductible	50% coinsurance	
	Non-preferred brand drugs (Tier 3)	0% coinsurance , subject to deductible	50% coinsurance	
	Specialty drugs (Tier 4)	0% coinsurance , subject to deductible	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance , subject to deductible	50% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	0% coinsurance , subject to deductible	50% coinsurance	50% coinsurance for anesthesia.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance , subject to deductible	100% coinsurance , subject to deductible	None
	Emergency medical transportation	0% coinsurance , subject to deductible	100% coinsurance , subject to deductible	
	Urgent care	0% coinsurance , subject to deductible	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance , subject to deductible	50% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	0% coinsurance , subject to deductible	50% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance , subject to deductible	50% coinsurance	None
	Inpatient services	0% coinsurance , subject to deductible	50% coinsurance	
If you are pregnant	Office visits	0% coinsurance , subject to deductible	50% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance , subject to deductible	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance , subject to deductible	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance , subject to deductible	50% coinsurance	60 visits/year
	Rehabilitation services	0% coinsurance , subject to deductible	50% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	0% coinsurance , subject to deductible	50% coinsurance	
	Skilled nursing care	0% coinsurance , subject to deductible	50% coinsurance	60 visits/calendar year
	Durable medical equipment	0% coinsurance , subject to deductible	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	0% coinsurance , subject to deductible	50% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	0% coinsurance , subject to deductible	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Hearing aids • Bariatric surgery
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture- limited to 30 visits/plan year.	• Chiropractic care - limited to 30 visits/plan year.	• Weight loss programs • Naturopathic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

[* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.insert.com].]

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$3400
■ Specialist coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

This EXAMPLE event includes services like:

[Specialist](#) office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (ultrasounds and blood work)
[Specialist](#) visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3400
■ Specialist coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)
[Diagnostic tests](#) (blood work)
[Prescription drugs](#)
[Durable medical equipment](#) (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles *	\$3,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,455

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3400
■ Specialist coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)
[Diagnostic test](#) (x-ray)
[Durable medical equipment](#) (crutches)
[Rehabilitation services](#) (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles *	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.