



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, visit www.askallegiance.com/dsbcc or call 1-855-333-1012. 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 www.healthcare.gov/sbc-glossary/ and www.cciio.cms.gov or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,250 individual/\$2,500 family network , \$2,600 individual/\$5,200 family non-network .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible (embedded) until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care is not subject to deductible .	This plan covers some items and services even if you haven't 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 . See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	Yes. \$250 individual for prescription drug coverage . There are no other specific deductibles .	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 ?	\$5,000 individual/\$10,000 family network , \$12,500 individual/\$17,000 family non-network , medical, \$2,150/\$4,300 pharmacy.	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 (embedded) until the overall family out-of-pocket-limit has been met.
What is not included in the out-of-pocket limit ?	Penalties for failure to obtain pre-certification, premiums , balance billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . Certain specialty drugs are considered non-essential health benefits and fall outside of the out-of-pocket limit . The cost of these drugs (though reimbursed by the manufacturer at no cost) will not be applied towards satisfying the out-of-pocket maximum.
Will you pay less if you use a network provider ?	Yes. See www.askallegiance.com/dsbcc or call 1-855-333-1012 for a list of network providers ..	This plan uses a provider network . You 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.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral.



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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care (PCP) visit to treat an injury or illness	\$50 <u>copayment</u> for services up to \$500 then 30% <u>coinsurance</u>	45% <u>coinsurance</u> after <u>deductible</u>	<u>Copayment</u> applies to all services performed associated with the office visit, not to exceed \$500 per visit. Charges exceeding \$500 subject to <u>deductible</u> and benefit percentage. If more than one physician is seen in the same clinic on the same day, only one <u>copayment</u> will apply. Office visit includes telemedicine services through Brightside Health Telemedicine Consultations at www.brightside.com/allegiance or visit www.recurohealth.com (855) 6RECURO for Recuro Consultations
	<u>Specialist</u> (SPC) visit	\$75 <u>copayment</u> for services up to \$500 then 30% <u>coinsurance</u>	45% <u>coinsurance</u> after <u>deductible</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>deductible</u> waived	Not covered	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	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u> after <u>deductible</u>	45% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> after <u>deductible</u>	45% <u>coinsurance</u> after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.askallegiance.com/dsbcc or call 1-855-333-1012.	Tier 1 generic drugs	30% <u>coinsurance</u> (\$10 minimum) retail and mail order	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If the Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative for the prescription drug, and the covered person chooses a brand name instead, the covered person must pay the difference in cost between the generic and brand name medication plus the applicable brand <u>copayment</u> amount. Coverage is limited to 90 day supply for retail and mail order. <u>Deductible</u> and <u>coinsurance</u> may not apply to certain PPACA preventive care prescriptions. Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill.	
	Tier 2 preferred brand drugs	30% <u>coinsurance</u> (\$25 minimum) retail and mail order		
	Tier 3 non-preferred brand drugs	50% <u>coinsurance</u> (\$50 minimum) retail and mail order		
	<u>Specialty drugs</u>	See as listed above for Tier 1, Tier 2 and Tier 3	Specialty prescriptions must be obtained from a preferred specialty pharmacy. Supply limited to 30 days. Please see "Important Questions" regarding the plan's out-of-pocket limit.	

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/dsbcc or call 1-855-333-1012.



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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations & Exceptions
If you have outpatient surgery	Ambulatory Surgical Center	No charge after deductible	45% coinsurance after deductible	Pre-notification required for certain surgeries. Failure to pre-notify will result in a 50% reduction of eligible expenses.
	Hospital Services Outpatient Facility	\$400 copayment then, no charge after deductible	45% coinsurance after deductible	
	Hospital Services Outpatient Professional Provider	30% coinsurance after deductible	45% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	30% coinsurance after network deductible		Non-emergency use of the emergency room including the facility and professional fees are not covered.
	Emergency medical transportation	30% coinsurance after network deductible		None
	Urgent care	\$50 copayment PCP \$75 copayment SPC for services up to \$500 then 30% coinsurance	45% coinsurance after deductible	Coverage limited to Urgent Care Facility, Urgent Care Center or Convenience Walk-in-clinic. Copayment applies to all services performed associated with the urgent care visit, not to exceed \$500 per visit. Charges exceeding \$500 subject to deductible and benefit percentage. If more than one physician is seen in the same clinic on the same day, only one copayment will apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	45% coinsurance after deductible	Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a 50% reduction of eligible expenses.
	Physician/surgeon fees	30% coinsurance after deductible	45% coinsurance after deductible	



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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations & Exceptions
If you need mental health, behavioral health, or substance abuse services	Outpatient Professional Provider and Office Visit Services	\$50 copayment for services up to \$500 then 30% coinsurance	45% coinsurance after deductible	None
	Outpatient Facility Services	30% coinsurance after deductible	45% coinsurance after deductible	Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a 50% reduction of eligible expenses.
	Inpatient Professional Provider and Facility Services	30% coinsurance after deductible	45% coinsurance after deductible	
If you are pregnant	Office visits	\$50 copayment PCP \$75 copayment SPC for services up to \$500 then 30% coinsurance if billed per office visit	45% coinsurance after deductible	Pre-certification required for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Failure to pre-certify will result in a 50% reduction of eligible expenses. Cost sharing does not apply for preventive services. Depending on the type of services, deductible and coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Labor and delivery are covered only for the participant and spouse. Charges for dependent children on the plan are excluded except for prenatal well-women care under the preventive care benefit.
	Childbirth/delivery professional services	30% coinsurance if billed as global fee	45% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	45% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	45% coinsurance after deductible	Pre-notification required for care in excess of 5 visits for skilled nursing visits or for home physical, occupational and speech therapy. Failure to pre-notify will result in a 50% reduction of eligible expenses.
	Rehabilitation services	30% coinsurance after deductible	45% coinsurance after deductible	Pre-notification required for services in excess of 12 visits per discipline for physical, occupational or speech therapy. Failure to pre-notify will result in a 50% reduction of eligible expenses.
	Habilitation services	30% coinsurance after deductible	45% coinsurance after deductible	None
	Skilled nursing care	30% coinsurance after deductible	45% coinsurance after deductible	Pre-certification required for all inpatient admissions. Failure to pre-notify will result in a 50% reduction of eligible expenses.

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/dsbcc or call 1-855-333-1012.



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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations & Exceptions
	Durable medical equipment	30% coinsurance after deductible	45% coinsurance after deductible	Charges for rental of DME limited up to purchase price. Pre-notification required for charges exceeding \$500 for rental or purchase. Failure to pre-notify will result in a 50% reduction of eligible expenses.
	Hospice services	No charge deductible waived	No charge deductible waived	Includes bereavement counseling. Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a 50% reduction of eligible expenses.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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 | • Infertility treatment | • Routine eye care (Adult) |
| • Dental care (Adult) | • Long-term care | • Routine foot care |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---------------------|---|------------------------|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric surgery | • Non-emergency care when traveling outside of the U.S. | • Weight loss programs |
| • Chiropractic 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.cciio.cms.gov, www.askallegiance.com/dsbcc or call 1-855-333-1012. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.cciio.cms.gov/programs/consumer/capgrants/index.html.

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](#).

————— *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	\$1,250
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$1,300
Copayments	\$0
Coinsurance	\$3,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,760

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,250
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$1,200
Copayments	\$500
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,250
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$1,300
Copayments	\$200
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.