



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.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,500 individual/\$6,000 family network , \$6,000 individual/\$12,000 family non-network , medical and pharmacy combined.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$6,000 individual/\$12,000 family network , \$12,000 individual/\$12,000 family non-network , medical and pharmacy combined.	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 preauthorization , 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 provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	30% coinsurance after deductible	50% coinsurance after deductible	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. Telemedicine is covered at no charge deductible waived. See the plan document for further details.
	Specialist (SCP) visit	30% coinsurance after deductible	50% coinsurance after deductible	
	Preventive care/screening/immunization	No charge deductible waived	Not covered	You may have to pay for services that are not 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)	30% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for CAT scans, MRI, MRA, PET scans and CT guided procedures. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com CCPS Customer Care call 1-855-673-6504.	Tier 1 generic drugs	30% coinsurance after deductible retail and mail order		Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Coverage is limited to a 90 day supply for retail and mail order. Deductible and coinsurance may not apply to preventive care prescription drugs as outlined in the Affordable Care Act (PPACA). Certain prescription drugs require preauthorization before the prescription drug can be dispensed or before obtaining a second fill.
	Tier 2 preferred brand drugs	30% coinsurance after deductible retail and mail order		
	Tier 3 non-preferred brand drugs	30% coinsurance after deductible retail and mail order		
	Specialty drugs	See as listed above for Tier 1, Tier 2 and Tier 3		Specialty drugs may be obtained from a specialty pharmacy. Supply limited to 30 days. Please see "Important Questions" regarding the plan's out-of-pocket limit.



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	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for certain surgeries. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Hospital Services Outpatient Facility	30% coinsurance after deductible	50% coinsurance after deductible	
	Hospital Services Outpatient Professional Provider	30% coinsurance after deductible	50% 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	30% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to Urgent Care Facility, Urgent Care Center or Convenience Walk-in-clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all inpatient admissions. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Physician/surgeon fees	30% coinsurance after deductible	50% 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 Facility & Professional Provider services including office visit services	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all inpatient admissions. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Inpatient Facility and Professional Provider Services	30% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive care services. Depending on the type of services, deductible and coinsurance 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. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for care in excess of 5 visits for home health care services.. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Rehabilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for services in excess of 24 visits per discipline for physical, occupational or speech therapy. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	None
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all inpatient admissions for skilled nursing care services. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.



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	50% coinsurance after deductible	Preauthorization required for charges exceeding \$500 for rental or purchase. Failure to obtain preauthorization will result in a 50% reduction of eligible expenses.
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	Includes bereavement counseling. Preauthorization recommended for all inpatient admissions and hospice services . Failure to obtain preauthorization 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.)

- | | | |
|---------------------|---|------------------------|
| • 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 the U.S. Department of Health and Human Services at <https://www.cms.gov/marketplace/about/oversight> or call 1-888-393-2789. 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, visit www.askallegiance.com or call 1-800-877-1122. Additionally, a consumer assistance program can help file your [appeal](#). Contact information for a consumer assistance program is located at <https://www.cms.gov/ccio/resources/consumer-assistance-grants>.

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.

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	\$3,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,750
Copayments	\$0
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,560

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,300
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
---------------------------	----------------

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