



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/sph or call 1-855-999-4293. For 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?	Allegiance PPO: \$3,000 individual/\$6,000 family network , \$9,100 individual/\$18,200 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?	No. There are no other specific deductibles .	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 , Unlimited 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?	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 .
Will you pay less if you use a network provider?	Yes. See www.askallegiance.com/sph or call 1-855-999-4293 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	Allegiance PPO	Non-Network	Limitations & Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge <u>deductible</u> waived	50% <u>coinsurance</u> after <u>deductible</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> after <u>deductible</u>	50% <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.optumrx.com or call 1-800-334-8134.	Generic drugs	Optum Rx and Mail Order: No charge 1–90-day supply	Not covered	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 <u>copayment</u> amount. <u>Coinsurance</u> may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Certain prescriptions require prior authorization before the drug can be dispensed.
	Preferred brand drugs	Optum Rx and Mail Order: 20% <u>coinsurance</u> (\$100 max) 1- 30-day supply 20% <u>coinsurance</u> (\$200 max) 31- 60-day supply 20% <u>coinsurance</u> (\$300 max) 61- 90-day supply	Not covered	
	Non-preferred brand drugs	Optum Rx and Mail Order: 20% <u>coinsurance</u> (\$100 max) 1- 30-day supply 20% <u>coinsurance</u> (\$200 max) 31- 60-day supply 20% <u>coinsurance</u> (\$300 max) 61- 90-day supply	Not covered	
	<u>Specialty drugs</u>	30% <u>coinsurance</u> (\$300 max) 1–30-day supply.	Not covered	
				Specialty prescriptions must be obtained from a specialty pharmacy.



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	Allegiance PPO	Non-Network	Limitations & Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copayment</u> then 10% <u>coinsurance</u> after <u>network deductible</u>		<u>Copayment</u> waived if admitted, and inpatient hospital benefits will apply.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>network deductible</u>		None
	<u>Urgent care</u>	\$75 <u>copayment deductible</u> waived	50% <u>coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Office Visit Services & Psychiatric Collaborative Care Management	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Outpatient Facility Services & Outpatient Professional Provider Services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Inpatient Facility Services & Inpatient Professional Provider Services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services. Depending on the type of services, <u>deductible</u> and <u>coinsurance</u> may apply.
	Ultrasounds (if not part of a global fee)	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Outpatient facility services other than ultrasounds or sonograms	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery professional services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).



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	Allegiance PPO	Non-Network	Limitations & Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review recommended for home health care services..
	Rehabilitation services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review recommended for rehabilitation services
	Habilitation services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Skilled nursing care	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review recommended for skilled nursing care services.
	Durable medical equipment	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review recommended for durable medical equipment charges exceeding \$5,000.
	Hospice services	10% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Includes bereavement counseling. Pre-certification recommended for hospice services .
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.)

<ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside of the U.S.	<ul style="list-style-type: none">• Routine eye care (Adult)• Weight loss programs
--	--	---

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

<ul style="list-style-type: none">• Acupuncture• Chiropractic care	<ul style="list-style-type: none">• Hearing aids	<ul style="list-style-type: none">• Private-duty nursing• Routine foot care (Medically Necessary)
---	--	--

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/sph or call 1-855-999-4293. 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$3,000
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$3,000
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$1,900
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$2,400
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIO/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.