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?	**Tier 1 St. Peter's Family Providers:** $2,000 individual/$4,000 family, **Tier 2 Friendly Providers:** $3,000 individual/$6,000 family, **Tier 3 Allegiance Network:** $7,500 individual/$15,000 family, **Tier 4 Non-Network:** $9,100 individual/$18,200 family.	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?	**Tier 1 St. Peter's Family Providers:** $4,000 individual/$8,000 family, **Tier 2 Friendly Providers:** $6,000 individual/$12,000 family, **Tier 3 Allegiance Network:** $9,000 individual/$18,000 family, **Tier 4 Non-Network:** Unlimited, 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 pay the least if you use a provider in Tier 1, St. Peter's Family Health. You pay more if you use a provider in Tier 2 Friendly Provider and Tier 3 Allegiance 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 plan 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	Tier 1 St. Peter's Family Providers	Tier 2 Friendly Providers	Tier 3 Allegiance Network	Tier 4 Non-Network	Limitations & Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$35 copayment deductible waived	$45 copayment deductible waived	30% coinsurance after deductible	50% coinsurance after deductible	Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other outpatient setting). Additional charges for services that are performed at the time of the visit, together with any additional charges that are incurred in conjunction with the office visit, e.g., diagnostic lab, office surgery, diagnostic miscellaneous testing, allergy injections, are subject to the applicable deductible and coinsurance or copayment.
	Specialist (SCP) visit	$45 copayment deductible waived	$55 copayment deductible waived	30% coinsurance after deductible	50% coinsurance after deductible	
	Gynecological Services (non-routine)	$25 copayment deductible waived		30% coinsurance after deductible	50% coinsurance after deductible	
	Dermatology Office Visit & Surgeries	$75 copayment deductible waived		30% coinsurance after deductible	50% coinsurance after deductible	
	Dermatology Diagnostic Tests	10% coinsurance after deductible	30% coinsurance after Tier 3 deductible		50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge deductible waived	No charge deductible waived	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)	No charge deductible waived	30% coinsurance after Tier 3 deductible		50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$150 copayment deductible waived	30% coinsurance after Tier 3 deductible		50% coinsurance after deductible	None

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	Tier 1 St. Peter's Family Providers	Tier 2 Friendly Providers	Tier 3 Allegiance Network	Tier 4 Non-Network	Limitations & Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-800-334-8134.	Generic drugs	**St. Peter's Pharmacy:** No charge 90-day supply retail **Retail PBM:** 20% coinsurance ($150 max) 30-day supply **Mail Order:** 20% coinsurance ($150 max) 1-30-day supply 20% coinsurance ($300 max) 31-60-day supply 20% coinsurance ($450 max) 61-90-day supply				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. Coinsurance 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	**St. Peter's Pharmacy:** 20% coinsurance ($150 max) 1-30-day supply 20% coinsurance ($300 max) 31-60-day supply 20% coinsurance ($450 max) 61-90-day supply **Retail PBM:** 20% coinsurance ($400 max) 1-30-day supply **Mail Order:** 20% coinsurance ($400 max) 1-30-day supply 20% coinsurance ($800 max) 31-60-day supply 20% coinsurance ($1,200 max) 61-90-day supply				
	Non-Preferred brand drugs	**St. Peter's Pharmacy:** 20% coinsurance ($150 max) 1-30-day supply 20% coinsurance ($300 max) 31-60-day supply 20% coinsurance ($450 max) 61-90-day supply **Retail PBM:** 20% coinsurance ($400 max) 1-30-day supply **Mail Order:** 20% coinsurance ($400 max) 1-30-day supply 20% coinsurance ($800 max) 31-60-day supply 20% coinsurance ($1,200 max) 61-90-day supply				
	Specialty drugs	**St. Peter's Pharmacy:** 30% coinsurance ($350 max) 30-day supply **Retail PBM:** 50% coinsurance ($1,000 max) 30-day supply **Mail Order:** 50% coinsurance ($1,000 max) 30-day supply				Specialty drugs 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	Tier 1 St. Peter's Family Providers	Tier 2 Friendly Providers	Tier 3 Allegiance Network	Tier 4 Non-Network	Limitations & Exceptions & Other Important Information
If you have outpatient surgery	Gynecological Surgical Procedures – Facility & Professional Provider Services at St. Peter's Hospital	$250 copayment deductible waived		30% coinsurance after deductible	50% coinsurance after deductible	None
	Gynecological Surgical Procedures – Facility & Professional Provider Services not performed at St. Peter's Hospital	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	None
	All other Surgical Procedures Professional Provider & Facility Services	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$150 copayment, then 10% coinsurance after Tier 1 deductible				Copayment waived if admitted, and inpatient hospital benefits will apply. Non-Emergency room services are not covered.
	Emergency medical transportation	10% coinsurance after Tier 1 deductible				None
	Urgent care within 100-mile radius	$40 copayment deductible waived		30% coinsurance after deductible	50% coinsurance after deductible	Within 100 miles radius from St. Peter's Health, Helena, MT.
	Urgent care more than 100-mile radius	$40 copayment deductible waived	$75 copayment deductible waived	$70 copayment deductible waived	50% coinsurance after deductible	More than 100 miles radius from St. Peter's Health, Helena, MT.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	None

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	Tier 1 St. Peter's Family Providers	Tier 2 Friendly Providers	Tier 3 Allegiance Network	Tier 4 Non-Network	Limitations & Exceptions & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Office Visit Services & Psychiatric Collaborative Care Management	$35 copayment deductible waived	$45 copayment deductible waived	30% coinsurance after deductible	50% coinsurance after deductible	None
	Outpatient Facility Services & Outpatient Professional Provider Services	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	None
	Inpatient Facility Services & Inpatient Professional Provider Services	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	$35 copayment PCP $45 copayment SCP if billed per office visit	$45 copayment PCP $55 copayment SCP if billed per office visit	30% coinsurance after deductible	50% coinsurance after deductible	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, deductible and coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Ultrasounds (if not part of a global fee)	No charge deductible waived	30% coinsurance after Tier 3 deductible		50% coinsurance after deductible	
	Outpatient facility services other than ultrasounds or sonograms	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	
	If Provider is Tier 1 or Tier 2 and performs Pregnancy/Maternity Services at St. Peter's Hospital (if billed as a global fee)	*$500 copayment deductible waived if billed as a global fee *Total copayment will be $500 for Facility and Professional Provider Services		30% coinsurance after deductible	50% coinsurance after deductible	
	If Tier 2 Provider performs Pregnancy/Maternity Services at facility other than St. Peter's Hospital (includes facility and professional provider and if billed as a global fee)	10% coinsurance after deductible if billed as a global fee	10% coinsurance after deductible if billed as a global fee	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	Tier 1 St. Peter's Family Providers	Tier 2 Friendly Providers	Tier 3 Allegiance Network	Tier 4 Non-Network	Limitations & Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-treatment review recommended for home health care services.
	Rehabilitation services	$75 copayment deductible waived	$75 copayment deductible waived	30% coinsurance after deductible	50% coinsurance after deductible	Pre-treatment review recommended for rehabilitation services.
	Habilitation services	$75 copayment deductible waived	$75 copayment deductible waived	30% coinsurance after deductible	50% coinsurance after deductible	See mental health/substance abuse benefit for habilitation services for mental health or substance abuse conditions.
	Skilled nursing care	10% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Pre-treatment review recommended for skilled nursing care services.
	Durable medical equipment	10% coinsurance after Tier 1 deductible			50% coinsurance after deductible	Pre-treatment review recommended for durable medical equipment charges exceeding $5,000.
	Hospice services	No charge deductible waived	30% coinsurance after deductible	No charge deductible waived	No charge deductible waived	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	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- 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.)

- Acupuncture
- Chiropractic care
- Hearing aids
- 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.

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	$2,000
Specialist copayment	$45
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	$2,000
Copayments	$300
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$45
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	$2,000
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$45
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	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.