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/MMIA or 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 a PDF of the Glossary or online at www.healthcare.gov/sbc-glossary/ or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual/$2,000 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. Many services including DME, home healthcare, hospice services, preventive care, professional provider services are 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?	$4,000 individual/$8,000 family medical, $3,600 individual/$7,200 family 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?	Prescription drug copayments*, 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. *Prescription drug copayments don't apply to the medical deductible or out-of-pocket maximum, but do apply to the pharmacy out-of-pocket maximum.
Will you pay less if you use a network provider?	This plan uses participating providers. See www.askallegiance.com/MMIA or call 1-800-877-1122 for a list of participating providers.	If you use a participating provider, this plan will pay some or all of the costs of covered services. Be aware, your participating provider may use a non-participating provider for some services. See the chart starting on page 2 for how this plan pays different kinds of participating providers. **All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).**
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	Your Cost if you use a Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance deductible waived	All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Specialist visit	30% coinsurance deductible waived	
	Preventive care/screening/ immunization	No charge deductible waived	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	Deductible waived for outpatient provider and inpatient provider expenses. Deductible applies for outpatient and inpatient facility expenses. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com/MMIA or call 1-800-877-1122, or contact ProActPLUS at 1-888-242-9798.	Generic drugs	$4 copayment retail $8 copayment mail order	Charges payable through the Plan's Pharmacy Benefit Manager program. Coverage is limited to 30 day supply for retail; 90 day supply for mail order. Deductible and Copayments may not apply to certain PPACA preventive care prescriptions. Ancillary charge applies if brand is purchased when generic is available. Prior Authorization required for certain prescriptions.
	Preferred brand drugs	$20 copayment retail $40 copayment mail order	
	Non-preferred brand drugs	$50 copayment retail $100 copayment mail order	
	Specialty drugs	Contact ProActPlus	Specialty Drugs are a benefit only when obtained through a Specialty Care Pharmacy and with enrollment in ProActPlus. Copayment assistance may be available for certain specialty and non-specialty drugs obtained through ProActPLUS prescription drug program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Prior authorization recommended for certain surgeries. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Physician/surgeon fees	30% coinsurance deductible waived	
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible*	Emergency room care is payable as stated regardless of participating provider status. *Facility services for non-emergency room care are not covered. Deductible waived for emergency and non-emergency provider services. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Emergency medical transportation	30% coinsurance after deductible	
	Urgent care	30% 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	Your Cost if you use a Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Pre-certification recommended for inpatient services. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Physician/surgeon fees	30% coinsurance deductible waived	
If you need mental health, behavioral health, or substance abuse services	Office visits	30% coinsurance deductible waived	All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Inpatient and outpatient provider services	30% coinsurance deductible waived	Pre-certification recommended for inpatient services. Deductible waived for outpatient provider and inpatient provider expenses. Deductible applies for outpatient and inpatient facility expenses. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Inpatient and outpatient facility services	30% coinsurance after deductible	
If you are pregnant	Office visits	30% coinsurance deductible waived	All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing). Cost sharing does not apply for preventive 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).
	Inpatient and outpatient provider services	30% coinsurance deductible waived	
	Inpatient and outpatient facility services	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance deductible waived	All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Rehabilitation services	30% coinsurance after deductible	Deductible waived for provider expenses, deductible applies for facility expenses. All services are subject to the Procedure Based Maximum Expense (PBME) (Referenced Based Pricing).
	Habilitation services	30% coinsurance after deductible	
	Skilled nursing care	30% coinsurance after deductible	Pre-certification recommended for inpatient services. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
	Durable medical equipment	30% coinsurance deductible waived	All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing). Prior Authorization recommended.
	Hospice services	No charge deductible waived	Pre-certification recommended for inpatient services. All services are subject to the Procedure Based Maximum Expense (PBME) (Reference Based Pricing).
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	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	• Long-term care	• Routine foot care
• Dental care (Adult)	• 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	• Hearing aids	• Non-emergency care when traveling outside of the U.S.
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• 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, or contact 1-800-877-1122 or www.askallegaince.com/MMIA. 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	$1,000
Specialist coinsurance	30%
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$3,000
What isn't covered	
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	$1,000
Specialist coinsurance	30%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1,000
Specialist coinsurance	30%
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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.