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/ARUP or call 1-855-999-2279. 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/ or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual/$3,000 family network and 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family network and 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?	Specialty drug copayment access programs, 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/ARUP or call 1-855-999-2279 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)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	45% coinsurance	None
	Specialist visit	25% coinsurance	45% coinsurance	None
	Preventive care/screening/ immunization	No charge deductible waived	45% coinsurance	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)	25% coinsurance	45% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com/ARUP or 1-855-999-2279, or visit www.navitus.com or 1-855-847-1025.	Tier 1 drugs	$5 copayment 1-30 day supply retail and mail order $10 copayment 31-60 day supply retail and mail order $15 copayment 61-90 day supply retail and mail order		Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician prescribes a brand name drug and communicates on the prescription "Dispense as Written" (DAW), covered person will pay brand name copayment only. 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. Deductible does not apply. Certain maintenance medications are available at a 90 day supply at select pharmacies. Copayments 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.
	Tier 2 drugs	$45 copayment 1-30 day supply retail and mail order $90 copayment 31-60 day supply retail and mail order $135 copayment 61-90 day supply retail and mail order		
	Tier 3 drugs	$175 copayment 1-30 day supply retail and mail order $350 copayment 31-60 day supply retail and mail order $525 copayment 90 day supply retail and mail order		
	Specialty drugs	$175 copayment 1-30 day supply		Specialty drugs may 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	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copayment then 25% coinsurance		Copayment waived if admitted.
	Emergency medical transportation	25% coinsurance		None
	Urgent care	25% coinsurance	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	None
	Inpatient services	25% coinsurance	45% coinsurance	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	25% coinsurance	45% coinsurance	Pre-certification recommended 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).
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	45% coinsurance	Pre-treatment review recommended for home health care services.
	Rehabilitation services	25% coinsurance	45% coinsurance	Pre-treatment review recommended for rehabilitation services.
	Habilitation services	25% coinsurance	45% coinsurance	None
	Skilled nursing care	25% coinsurance	45% coinsurance	Pre-certification recommended for all inpatient admissions.

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)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
	Durable medical equipment	25% coinsurance	45% coinsurance	Pre-treatment review recommended for durable medical equipment charges exceeding $5,000. Option to purchase CPAP machine following 3 months rental. Durable medical equipment otherwise limited to rental up to purchase price.
	Hospice services	25% coinsurance	45% coinsurance	Coverage includes 14 days respite care per covered person per hospice benefit period (hospice incident). Bereavement counseling is not covered under the medical plan. Bereavement counseling services are covered under the employee assistance program. Pre-certification recommended for hospice services.
If your child needs dental or eye care	Children's eye exam	No charge deductible waived		Coverage limited to 1 exam, including refraction and retinal screening per benefit period. Non-routine eye exam subject to deductible and coinsurance. This benefit can be waived, though waiver does not change the required contribution.
	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 • Dental care (Adult)	• Long-term care	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (12 visits max per benefit period) • Bariatric surgery (1 surgery max lifetime benefit) • Chiropractic care (12 visits max per benefit period)	• Hearing aids ($2,500 max benefit every 3 benefit periods) • Infertility treatment ($20,000 max lifetime benefit) • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing • Routine eye care (Adult) (1 eye exam for refractory and retinal screening per benefit period)

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/cciio/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 $1,500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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	$1,500
Copayments	$10
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$4,410**

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

- The plan's overall deductible $1,500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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	$1,500
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,500**

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

- The plan's overall deductible $1,500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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