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/ECUHealth or call 1-800-258-5794. 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: $1,200 individual/$2,400 family network, Tier 2: $1,500 individual/$3,000 family network, Tier 3: $4,500 individual/$9,000 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: $4,000 individual/$8,000 family network, Tier 2: $5,000 individual/$10,000 family network, Tier 3: $10,000 individual/$20,000 family non-network, $2,500 individual/$5,000 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 limits 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/ECUHealth or call 1-800-258-5794 for a list of network providers.	This plan uses a provider network. You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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	Tier 1 Network	Tier 2 Network	Tier 3 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	$10 copayment deductible waived	$10 copayment deductible waived	50% coinsurance after deductible	Copayment applies to charges billed by the provider for the office visit including, but not limited to: diagnostic lab, office surgery, second surgical opinion. See specific benefits for further details.
	Specialist (SCP) visit	$25 copayment deductible waived	$60 copayment deductible waived	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge deductible waived	No charge deductible waived	50% coinsurance after deductible	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) Outpatient/Independent facility	No charge deductible waived	No charge deductible waived	50% coinsurance after deductible	Includes interpretation by separate provider.
	Imaging (CT/PET scans, MRIs)	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.cap-rx.com/ or call 1-833-554-4733.	Generic drugs	**ECU Health Employee Pharmacy:** $10 copayment 30 day supply retail $25 copayment 90 day supply retail **PBM Network:** $25 copayment 30 day supply retail $75 copayment 90 day supply retail			Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. Regardless of whether the Physician specifically prescribes the brand name version of a drug, if 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. 15% coinsurance will apply if the cost of the prescription exceeds $300 at the ECU Health Employee Pharmacy. 25% coinsurance will apply if the cost of the prescription exceeds $300 at all other pharmacies. Copayments 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 or before obtaining a second fill.
	Preferred brand drugs	**ECU Health Employee Pharmacy:** $25 copayment 30 day supply retail $62.50 copayment 90 day supply retail **PBM Network:** $50 copayment 30 day supply retail $150 copayment 90 day supply retail			
	Non-preferred brand drugs	**ECU Health Employee Pharmacy:** $50 copayment 30 day supply retail $125 copayment 90 day supply retail **PBM Network:** $100 copayment 30 day supply retail $300 copayment 90 day supply retail			
	Specialty drugs	**Generic:** $25 copayment 30 day supply **Preferred Brand:** $100 copayment 30 day supply **Non-Preferred Brand:** $300 copayment 30 day supply			Specialty prescriptions must be obtained from a specialty pharmacy. ECU Health In-House pharmacy is the preferred specialty pharmacy.

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ECUHealth or call 1-800-258-5794.

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 Network	Tier 2 Network	Tier 3 Non-Network	Limitations & Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	None
	Physician/surgeon fees	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	Facility: $250 copayment, then 15% coinsurance after Tier 1 deductible Provider: No charge deductible waived			Copayment includes facility charge, physician charges and all services rendered during the emergency room visit. Copayment waived if admitted, and inpatient hospital benefits will apply.
	Emergency medical transportation	Air & Ground: 25% coinsurance after Tier 2 deductible			None.
	Urgent care	$50 copayment deductible waived	$60 copayment deductible waived	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	Pre-certification strongly recommended for all inpatient admissions. Pre-treatment review strongly recommended for certain surgeries.
	Physician/surgeon fees	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Office visits	$10 copayment deductible waived	$10 copayment deductible waived	50% coinsurance after deductible	None
	Outpatient services	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	None
	Inpatient services	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	Pre-certification strongly recommended for all inpatient admissions.
If you are pregnant	Office visits	$10 copayment PCP $25 copayment SCP deductible waived if billed per office visit	$10 copayment PCP $60 copayment SCP deductible waived if billed per office visit	50% coinsurance after deductible	Pre-certification strongly 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).
	Childbirth/delivery professional services	15% coinsurance after deductible if billed as global fee	25% coinsurance after deductible if billed as global fee	50% coinsurance after deductible	
	Childbirth/delivery facility services	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	Pre-treatment review strongly recommended for home health services.
	Rehabilitation services	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	None

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ECUHealth or call 1-800-258-5794.

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 Network	Tier 2 Network	Tier 3 Non-Network	Limitations & Exceptions & Other Important Information
	Habilitation services	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	None
	Skilled nursing care	15% coinsurance after deductible	25% coinsurance after Tier 2 deductible		Pre-certification strongly recommended for all inpatient admissions.
	Durable medical equipment	15% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	Pre-treatment review strongly recommended for charges exceeding $2,500.
	Hospice services	15% coinsurance after deductible	25% coinsurance after Tier 2 deductible		Includes bereavement counseling. Pre-certification strongly recommended for all inpatient admissions.
If your child needs dental or eye care	Children's eye exam Up to 19 years of age	No charge deductible waived		Not covered	One (1) exam per benefit period for refractory conditions and retinal screening. This benefit can be waived, though waiver does not change the required contribution.
	Eye exam 19 years of age or older	$25 copayment deductible waived	$60 copayment deductible waived		
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (diabetic)

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/ECUHealth or call 1-800-258-5794. 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	$1,200
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$1,200
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	$1,200
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$900
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$1,200
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$1,200
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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.