



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:
<u>What is the overall deductible?</u>	Tier 1: \$2,000 individual/\$4,000 family <u>network</u> , Tier 2: \$2,500 individual/\$5,000 family <u>network</u> , Tier 3: \$6,000 individual/\$12,000 family non- <u>network</u> , medical and pharmacy combined.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> (non-embedded) must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. Preventive care is not subject to <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care-benefits .
<u>Are there other deductibles for specific services?</u>	No	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Tier 1: \$6,000 individual/\$12,000 family <u>network</u> , Tier 2: \$6,750 individual/\$13,500 family <u>network</u> , Tier 3: \$12,500 individual/\$25,000 family non- <u>network</u> , medical and pharmacy combined.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limits</u> (non-embedded) must be met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance billing</u> charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.askallegiance.com/ECUHealth or call 1-800-258-5794 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay the least if you use a <u>provider</u> in Tier 1. You pay more if you use a <u>provider</u> in Tier 2. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No	You can see the <u>specialist</u> 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	5% <u>coinsurance</u> after <u>deductible</u>	5% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
	<u>Specialist</u> (SCP) visit	10% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>		
	<u>Preventive care/screening/immunization</u>	No charge <u>deductible</u> waived	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) – Outpatient/Independent facility	No charge after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Includes interpretation by separate provider.	
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>		
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.cap-rx.com/ or call 1-833-554-4733.	Generic drugs	ECU Health Employee Pharmacy: 10% <u>coinsurance</u> up to 90 day supply PBM Network: 20% <u>coinsurance</u> up to 90 day supply			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 <u>copayment</u> amount. 15% <u>coinsurance</u> will apply if the cost of the prescription exceeds \$300 at the ECU Health Employee Pharmacy. 25% <u>coinsurance</u> will apply if the cost of the prescription exceeds \$300 at all other pharmacies. <u>Copayments</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 or before obtaining a second fill.	
	Preferred brand drugs	ECU Health Employee Pharmacy: 20% <u>coinsurance</u> up to 90 day supply PBM Network: 30% <u>coinsurance</u> up to 90 day supply				
	Non-preferred brand drugs	ECU Health Employee Pharmacy: 30% <u>coinsurance</u> up to 90 day supply PBM Network: 40% <u>coinsurance</u> up to 90 day supply				
	Specialty drugs	Generic: 20% <u>coinsurance</u> up to 30 day supply Preferred Brand: 30% <u>coinsurance</u> up to 30 day supply Non-Preferred Brand: 40% <u>coinsurance</u> up to 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% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u> after <u>deductible</u>	25% <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>	15% <u>coinsurance</u> after Tier 1 <u>deductible</u>			None
	<u>Emergency medical transportation</u>	Air & Ground: 15% <u>coinsurance</u> after Tier 1 <u>deductible</u>			None.
	<u>Urgent care</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-certification strongly recommended for all inpatient admissions. Pre-treatment review strongly recommended for certain surgeries.
	Physician/surgeon fees	15% <u>coinsurance</u> after <u>deductible</u>	25% <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 visits	5% <u>coinsurance</u> after <u>deductible</u>	5% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Outpatient services	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Inpatient services	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-certification strongly recommended for all inpatient admissions.
If you are pregnant	Office visits	5% <u>coinsurance</u> PCP 10% <u>coinsurance</u> SCP after <u>deductible</u>	5% <u>coinsurance</u> PCP 25% <u>coinsurance</u> SCP after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	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, <u>deductible</u> and <u>coinsurance</u> or <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review strongly recommended for home health services.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Habilitation services</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after Tier 2 <u>deductible</u>		Pre-certification strongly recommended for all inpatient admissions.

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
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Pre-treatment review strongly recommended for charges exceeding \$2,500.
	<u>Hospice services</u>	15% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after Tier 2 <u>deductible</u>		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 <u>deductible</u> 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	10% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>		
	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	• Long-term care	• Weight loss programs
• Cosmetic surgery		
• Dental care (Adult)		

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

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

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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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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.