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/nisd or call 1-855-333-1008. 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.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-855-333-1008 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual/$4,000 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 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?	Yes. $250 individual for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,000 individual/$16,000 family network medical and pharmacy combined. No limit non-network expenses.	The network 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 until the overall family out-of-pocket limits has been met. This plan does not have a non-network out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-certification, 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/nisd or call 1-855-333-1008 for a list of network providers.	This plan uses a provider network. You will 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 you 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	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge deductible waived	50% coinsurance deductible waived	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No charge for routine immunizations network or non-network for covered persons less than age 18. First diagnostic colonoscopy per benefit period payable same as preventive care. Subsequent diagnostic colonoscopy subject to regular cost share.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com /nisd or 1-855-333-1008.	Generic drugs	greater of a $10 or 30% copayment retail $25 copayment mail order		Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If the Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative for the prescription drug, and the covered person chooses a brand name instead, the covered person must pay the difference in cost between the generic and brand name medication plus the applicable brand copayment amount. Coverage is limited to 90 day supply for retail or mail order. Deductible and copayments may not apply to certain PPACA preventive care prescriptions. Prior authorization required for certain prescriptions.
	Preferred brand drugs	greater of a $45 or 30% copayment $75 copayment mail order		
	Non-preferred brand drugs			
	Specialty drugs	50% copayment, $1,500 maximum per prescription		First fill may be obtained at retail. All subsequent fills must be obtained from a specialty pharmacy. Coverage is limited to 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Pre-treatment review required for certain surgeries. Failure to obtain pre-treatment review will result in a $500 penalty.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/nisd or call 1-855-333-1008.

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 need immediate medical attention	Emergency room care	$250 copayment then 30% coinsurance for facility 30% coinsurance provider		Copayment waived if admitted as inpatient from the emergency room. Hospital and physician services related to non-emergency are not covered.
	Emergency medical transportation	30% coinsurance		None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance inpatient services 30% coinsurance outpatient services	50% coinsurance	Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a $500 penalty.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a $500 penalty.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance inpatient services 30% coinsurance outpatient services	50% coinsurance	Pre-certification required for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Failure to pre-certify will result in a $500 penalty.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Coverage limited to 60 visits per benefit period. Pre-treatment review required. Failure to obtain pre-treatment review will result in a $500 penalty.
	Rehabilitation services	30% coinsurance	50% coinsurance	Coverage limited to 100 days per benefit period. Maximum days does not apply to therapy related to Acquired Brain Injury. Pre-treatment review required. Failure to obtain pre-treatment review will result in a $500 penalty.
	Habilitation services	30% coinsurance	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Coverage limited to 60 days per benefit period. Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a $500 penalty.
	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-treatment review required for charges exceeding $1,000. Failure to obtain pre-treatment review will result in a $500 penalty.

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/nisd or call 1-855-333-1008.

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
	Hospice services	No charge	50% coinsurance	Pre-certification required for all inpatient admissions. Failure to pre-certify will result in a $500 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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.)

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

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 1-855-333-1008 or www.askallegaince.com/nisd. 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/nisd or call 1-855-333-1008.

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 coinsurance	**30%**
Hospital (facility) coinsurance	**20%**
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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 coinsurance	**30%**
Hospital (facility) coinsurance	**20%**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,920**

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

The plan's overall deductible	**$2,000**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**20%**
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	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
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.**

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