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, call 1-888-472-4352. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-888-472-4352 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?	Alliance Network $100/individual $200/family	In-Network/Out-of-Area (OOA) $750/individual $1,500/family	Non-Network $3,900/individual $7,800/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 until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Network and non-network deductibles are separate.			
Are there services covered before you meet your deductible?	Yes, network preventive services, services paid with a copayment, services paid at no charge, and prescription drugs.			This plan covers some items and services even if you haven't yet 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 https://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?	Alliance Network $2,500/individual $5,000/family	In-Network/Out-of-Area (OOA) $3,500/individual $7,000/family	Non-network $10,000/individual $20,000/family	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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Network and Non-Network out-of-pocket limits are separate.			
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balance billing is prohibited), prescription drug brand-name drug penalty, specialty drugs covered under SaveOnSP (whether enrolled or not), 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.HCHealthbenefits.com or call 1-888-472-4352 for a list of network providers.			You pay the least if you use a provider in the Alliance Network. You pay more if you use a provider In-Network. You will pay the most if you use an non-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.

* For more information about limitations and exceptions, see the plan or policy document at www.HCHealthbenefits.com.

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	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Alliance Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-network Provider* (You will pay the most)	**If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit, deductible does not apply; No charge for other outpatient services	10% coinsurance	30% coinsurance	Copay is per provider and applies to office visit, supplies, minor office surgery, and injections (including B-12 injections). Native Traditional Practitioner: 0% co-insurance after In-Network deductible, $500 max per family per calendar year. MDLIVE services paid with $22 copay/consultation, deductible does not apply. Call 877-953-4955, visit www.HCHealthbenefits.com, or use the MDLIVE mobile app.
	Specialist visit	$25 copay/visit, deductible does not apply; No charge for other outpatient services	10% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay: Alliance Network Provider (You will pay the least)	What You Will Pay: In-Network Provider (You will pay more)	Non-network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information *If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.*
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.HCHealthbenefits.com	Generic drugs (Tier 1)	**Retail** (30-day supply) $10/prescription		Retail: You are responsible for the amount payable in excess of the amounts shown for In-Network prescription drugs, which may include the ingredient cost and dispensing fee. Mail Order: Not Covered	*Retail pharmacy 90-day supply is available only at Walgreens and select pharmacies in remote locations. Maintenance medications must be filled for 90-day supply at Walgreens, select pharmacies in remote locations, or Mail Order after the first (2) 30-day fills. All In-Network preventive medication and contraceptives are covered at no charge as required by law. Preventive medication and contraceptives not required by law are covered subject to applicable copayment. Weight loss drugs: 50% of the cost of the drug. Excludes fertility and infertility drugs. Prescription specialty drug third-party & manufacturer coupons or rebates: Your costs for certain specialty drugs could be lower when using the third-party copayment assistance program (SaveOnSP). Specialty drugs not covered under the SaveOnSP program must be filled through Accredo Specialty Pharmacy or they are not covered. Brand-name drug penalty: If you or your physician chooses a brand name drug when a generic equivalent is available, you must pay the cost difference between the brand and generic in addition to the brand name copay. Step therapy requirements may apply to certain drugs. Deductible does not apply to prescription drugs.
		Retail* & Mail Order (90-day supply) $20/prescription			
	Preferred brand drugs (Tier 2)	**Retail** (30-day supply) 25% coinsurance ($25 min/$50 max) per prescription			
		Retail* & Mail Order (90-day supply) 25% coinsurance ($50 min/$100 max) per prescription			
	Non-preferred brand drugs (Tier 3)	**Retail** (30-day supply) 50% coinsurance ($50 min/$150 max) per prescription			
		Retail* & Mail Order (90-day supply) 50% coinsurance ($100 min/$300 max) per prescription			
	Specialty drugs (high dollar or injectable drugs)	Drugs covered under SaveOnSP: Enrolled in program: No charge Not enrolled in program: 30% coinsurance Drugs not covered under SaveOnSP: Tier 1: $10/prescription Tier 2: 25% coinsurance ($25 min/$50 max) per prescription Tier 3: 50% coinsurance ($50 min/$150 max) per prescription			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information *If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.*
		Alliance Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-network Provider* (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	No charge	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	5% coinsurance	10% coinsurance		None
	Emergency medical transportation	10% coinsurance			None
	Urgent care	$25 copay/visit, deductible does not apply	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	10% coinsurance	30% coinsurance	Precertification is required or a penalty of $250 may apply.
	Physician/surgeon fees	No charge	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	$15 copay/office visit, deductible does not apply	30% coinsurance	Copay is per provider and applies only to the office visit.
	Inpatient services	Not applicable	5% coinsurance	30% coinsurance	Precertification is required or a penalty of $250 may apply.
If you are pregnant	Office visits	$15 copay/visit, deductible does not apply	10% coinsurance	30% coinsurance	Cost sharing does not apply for Alliance Network and In-Network provider preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	5% coinsurance	10% coinsurance	30% coinsurance	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or a penalty of $250 may apply.

* For more information about limitations and exceptions, see the plan or policy document at www.HCHealthbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information *If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.*
		Alliance Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-network Provider* (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	10% coinsurance	30% coinsurance	None
	Rehabilitation services	**Inpatient**: 5% coinsurance **Outpatient**: $15 copay/visit, deductible does not apply	10% coinsurance	30% coinsurance	No coverage for occupational and speech therapy for developmental delay unless associated with autism diagnosis. Cardiac rehab, occupational, physical, & speech therapy limited to 60 outpatient visits/year combined, & 60 inpatient days per illness/injury combined.
	Habilitation services	Not covered	Not covered	Not covered	No coverage for habilitation services, except occupational and speech therapy for autism, limited to coverage described above.
	Skilled nursing care	5% coinsurance	10% coinsurance	30% coinsurance	Limited to 365 days lifetime maximum for same or related injury/illness. Precertification is required or a penalty of $250 may apply.
	Durable medical equipment	No charge	10% coinsurance	30% coinsurance	Durable medical equipment & prosthetics require precertification if over $5,000 or services/supplies will not be covered. Replacement of equipment limited to every 3 years unless it cannot be repaired or due to growth of child. Sleep apnea mouth guard only if patient has used a CPAP/BIPAP machine for 3 or more months.
	Hospice services	No charge	10% coinsurance	30% coinsurance	Limited to 365 days lifetime maximum.

Common Medical Event	Services You May Need	What You Will Pay: Alliance Network Provider (You will pay the least)	What You Will Pay: In-Network Provider (You will pay more)	What You Will Pay: Non-network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information **If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.*
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for children's eye exam.
	Children's glasses	Not covered	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

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) / (Child)
- Habilitation services (except as indicated above)
- Long-term care
- Non-emergency care when traveling outside the U.S., except for an unexpected medical condition as determined by the Plan Administrator
- Private-duty nursing
- Routine eye care (Adult) / (Child)

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

- Acupuncture, up to $1,250/calendar year
- Bariatric surgery, up to 1 surgery lifetime max, limited to Alliance Approved Facilities (for members residing inside AZ) or Cigna Centers of Excellence (for members residing outside AZ)
- Chiropractic care (limited to 26 visits/calendar year)
- Hearing aids (retirees + dependents are ineligible)
- Infertility: eligible treatment up to $2,000/calendar year. Prescription drugs are not covered
- Routine foot care if medically necessary due to diabetes or neuro/vascular insufficiency affecting the feet, and administered by a podiatrist
- Weight loss programs up to $500 lifetime max

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-472-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-472-4352.

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 and use of Alliance providers.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **5%**
- **Other (Tests) copayment** **$0**

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	$100
Copayments	$30
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$490**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **5%**
- **Other (Brand drug) copayment** **$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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **5%**
- **Other (Physical Therapy) copayment** **$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	$100
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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