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, go to www.thealliance.health or call the plan at 1-800-700-3874. 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 1-800-700-3874 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	There is no deductible for this plan.
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?	**$** 3,000	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, failure to obtain preauthorization for services when required 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. Go to https://thealliance.health/for-members/get-started/find-a-doctor/ or call 1-800-700-3874 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 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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/visit.	$10 copayment/visit	A referral is required to see a doctor that is not your primary care provider. Preauthorization is required in order to see an out-of-network provider or a provider out of the plan's service area. If you don't get a referral or preauthorization when required, you may be responsible for some or all of the cost.
	Specialist visit	$10 copayment/visit	$10 copayment/visit	A referral is required to see a network provider. Preauthorization is required in order to see an out-of-network provider or a provider out of the plan's service area. If you don't get preauthorization, you may be responsible for some or all of the cost.
	Preventive care/screening/ immunization	No charge	No charge	A referral is required to see a provider that is not your primary care provider. Preauthorization is required in order to see an out-of-network provider or a provider out of the plan's service area. If you don't get preauthorization, you may be responsible for some or all of the cost. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Physician order or referral required. Preauthorization is required in order to see an out-of-network provider or a provider out of the plan's service area. If you don't get preauthorization, you may be responsible for some or all of the cost.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Physician order or referral required. Preauthorization is required for some services and to see an out-of-network

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				provider or a provider out of the plan's service area. If you don't get preauthorization, you may be responsible for some or all of the cost.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://thealliance.health/for-members/get-care/prescription-drugs-and-pharmacy-benefits/	Generic drugs	Up to $5 copayment/prescription	Up to $5 copayment/prescription Not covered without preauthorization.	No copayment is required for prescription drugs that you get in an inpatient setting or that you get in a doctor's office or outpatient facility.
	Preferred brand drugs	Up to $15 copayment/prescription	Up to $15 copayment/prescription Not covered without preauthorization.	No copayment is required for prescription drugs that you get in an inpatient setting or that you get in a doctor's office or outpatient facility.
	Non-preferred brand drugs	Up to $15 copayment/prescription	Up to $15 copayment/prescription	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost. No copayment required for prescription drugs you get in an inpatient setting or that you get in a doctor's office or outpatient facility.
	Specialty drugs	Up to $15 copayment/prescription	Up to $15 copayment/prescription.	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost. No copayment required for prescription drugs you get in an inpatient setting or that you get in a doctor's office or outpatient facility.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
	Physician/surgeon fees	No charge	No charge	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
If you need immediate	Emergency room care	$25 copayment/visit	$25 copayment/visit	Your copayment is waived if you are

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention				admitted to the hospital.
	Emergency medical transportation	No charge	No charge	N/A
	Urgent care	$10 copayment/visit	$10 copayment/visit.	A referral is required to see a network provider that is not your primary care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
	Physician/surgeon fees	No charge	No charge	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/visit	$10 copayment/visit	Preauthorization is required for some services and to see an out-of-network provider. If you don't get preauthorization you may be responsible for some or all of the cost.
	Inpatient services	No charge	No charge	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
If you are pregnant	Office visits	No charge	No charge	Preauthorization is required in order to see an out-of-network provider or a provider out of the plan's service area. If you don't get preauthorization you may be responsible for some or all of the cost.
	Childbirth/delivery professional services	No charge	No charge	Preauthorization is required to see an out-of-network provider or a provider out of the plan's service area. If you don't get preauthorization you may be responsible for some or all of the cost.
	Childbirth/delivery facility services	No charge	No charge	Preauthorization is required for services received at an out-of-network or out-of-area facility. If you don't get preauthorization you may be responsible for some or all of the cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge except for $10 copayment/visit for physical, occupational and speech therapy	No charge except for $10 copayment/visit for physical, occupational and speech therapy	Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost.
	Rehabilitation services	No charge for inpatient services. $10 copayment/visit for outpatient services.	No charge for inpatient services. $10 copayment/visit for outpatient services	Preauthorization is required. The plan may require periodic evaluations. If you don't get preauthorization you may be responsible for some or all of the cost
	Habilitation services	No charge for inpatient services. $10 copay/visit for outpatient services.	No charge for inpatient services. $10 copay/visit for outpatient services.	Preauthorization is required. The plan may require periodic evaluations. If you don't get preauthorization you may be responsible for some or all of the cost
	Skilled nursing care	No charge	No charge	Limited to 100 days per benefit year. Preauthorization is required. If you don't get preauthorization you may be responsible for some or all of the cost
	Durable medical equipment	No charge	No charge	Preauthorization is required for some items. If you don't get preauthorization you may be responsible for some or all of the cost
	Hospice services	No charge	No charge	Covered for members diagnosed with a terminal illness with a life expectancy of 12 months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded
	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

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
- Experimental medical and DME services
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs
- Services and treatments which are not medically-necessary

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery	• Chiropractic care	• Hearing aids

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 Department of Managed Health Care at www.dmhc.ca.gov, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext.61565, 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 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 the Plan at 1-800-700-3874. You may also contact the Department of Managed Health Care Help Center at 1-888-466-2219, www.healthhelp.ca.gov.

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 1-800-700-3874.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **Prescription Drug copayment (generic)** **$5**

Prescription Drug copayment (brand) **$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	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Prescription Drug copayment (generic)** **$5**

Prescription Drug copayment (brand) **$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	$0
Copayments	$570
Coinsurance	$
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$620**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Prescription Drug copayment (generic)** **$5**

Prescription Drug copayment (brand) **$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	$0
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$110**

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