

 **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 1-312-906-8080 or go to www.alliedbenefit.com. 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.alliedbenefit.com or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For Level 1 providers \$1,000 person / \$2,000 family; for Level 2 providers \$1,000 person / \$2,000 family; For Level 3 providers \$3,000 person / \$6,000 family; For Level 4 providers \$5,000 person / \$10,000 family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Prescription drugs, Level 1, 2 & 3 preventive care, services provided at Moore County Family Health Clinic, Level 1, 2 & 3 physician/specialist exam charges, in-network urgent care exam charges, second surgical opinions, Level 1 outpatient/office/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, Level 1 emergency room services, and wigs/hairpieces are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Medical: For Tier 1 providers \$3,000 person / \$6,000 family; for Tier 2 providers \$3,000 person / \$6,000 family; For Tier 3 providers \$6,550 person / \$13,100 family; For Tier 4 providers unlimited</p>	<p>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 until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for failure to obtain precertification, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



All [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
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$10 copay/Moore County Family Health Clinic; \$20 copay/other Physician office visit (deductible does not apply); 10% coinsurance for chiropractic care and other physician services</p>	<p>\$20 copay/other Physician office visit (deductible does not apply); 10% coinsurance for chiropractic care and other physician services</p>	<p>\$30 copay/other Physician office visit (deductible does not apply); 30% coinsurance for chiropractic care and other physician services</p>	<p>60% coinsurance</p>	<p>\$10 Copay at Moore County Family Health Clinic Providers includes all services performed during the office visit; \$20 Copay Physician's Office visit applies to exam charge only. Does not include office surgery. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, physician assistants, nurse practitioners and mental health providers. Chiropractic coverage is limited to 20 visits.</p>
	<p>Specialist visit</p>	<p>\$40 copay/office visit (deductible does not apply).</p>	<p>\$40 copay/office visit (deductible does not apply).</p>	<p>\$50 copay/office visit (deductible does not apply).</p>	<p>60% coinsurance</p>	<p>Copay applies to exam charge only. Does not include office surgery.</p>

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
	Preventive care/screening/immunization	No charge (deductible does not apply).	No charge (deductible does not apply).	No charge (deductible does not apply).	60% coinsurance	Routine labs and x-rays are covered for out-of-network providers at no charge. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Blood work: No charge (deductible does not apply). X-rays: 10% coinsurance (deductible does not apply).	30% coinsurance	30% coinsurance	60% coinsurance	*Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	30% coinsurance	60% coinsurance	None.

Common Medical Event	Services You May Need	Dumas Texas: Roger's Pharmacy; Stratford, Texas: Elk Pharmacy, Amarillo, Texas: Kings Compounding Pharmacy and Martin Tipton Pharmacy.	Caremark For prescription drug questions please call 1-877-860-6415 or visit www.caremark.com	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Generic drugs	\$20 copay /prescription (retail) \$40 copay /prescription (extended retail and mail-order)	\$40 copay /prescription (retail) \$80 copay /prescription (extended retail and mail-order)	Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	\$40 copay /prescription (retail) \$80 copay /prescription (extended retail and mail-order)	\$120 copay /prescription (retail) \$240 copay /prescription (extended retail and mail-order)	
	Non-preferred brand drugs	\$60 copay /prescription (retail) \$120 copay /prescription (extended retail and mail-order)	\$240 copay /prescription (retail) \$480 copay /prescription (extended retail and mail-order)	

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	Dumas Texas: Roger's Pharmacy; Stratford, Texas: Elk Pharmacy, Amarillo, Texas: Kings Compounding Pharmacy and Martin Tipton Pharmacy.	Caremark For prescription drug questions please call 1-877-860-6415 or visit www.caremark.com	Limitations, Exceptions, & Other Important Information
	Specialty drugs	Not Covered through participating pharmacies or Caremark; Subject to Level 3 Calendar Year Deductible and coinsurance Please contact Allied Benefit Systems, LLC at 1-800-288-2078		*Please see Prescription Drug Benefit section within your Plan Document for details.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	30% coinsurance	60% coinsurance	Certain services must be pre-certified in order to avoid \$500 penalty per occurrence.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	30% coinsurance	60% coinsurance	None.
If you need immediate medical attention	Emergency room care	\$150 copay /visit then 10% coinsurance (deductible does not apply)	N/A	\$150 copay /visit then 30% coinsurance	Paid Same as Level 3	Copay waived if admitted to hospital directly from emergency room.
	Emergency medical transportation	10% coinsurance	30% coinsurance	30% coinsurance	Paid Same as Level 3	Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
	Urgent care	N/A	\$30 copay /office visit then 30% coinsurance (deductible does not apply); 30% coinsurance facility fees.	\$30 copay /office visit then 30% coinsurance (deductible does not apply); 30% coinsurance facility fees.	60% coinsurance	*Does not include labs and x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	N/A	30% coinsurance	60% coinsurance	\$1,500 penalty per admission for Tier 3 and 4 if the service could have been provided at Moore County Hospital. Services must be pre-certified in order to avoid \$500 penalty per occurrence.
	Physician/surgeon fees	10% coinsurance	N/A	30% coinsurance	60% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered				None.
	Inpatient services	Not Covered				None.
If you are pregnant	Office visits	\$20 copay /office visit (deductible does not apply)	\$20 copay /office visit (deductible does not apply)	\$30 copay /office visit (deductible does not apply)	60% coinsurance	None.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
If you are pregnant	Childbirth/delivery facility services	10% coinsurance	N/A	30% coinsurance	60% coinsurance	\$1,500 penalty per admission for Tier 3 and 4 if the service could have been provided at Moore County Hospital. Cost sharing does not apply to certain 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). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid \$500 penalty.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	Limited to a maximum of 40 visits.
	Rehabilitation services	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	Physical, Speech and occupational therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year.
	Habilitation services	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	An admission to a Skilled Nursing Facility must be within 14 days of a 3-day inpatient admission. Services must be pre-certified in order to avoid \$500 penalty per occurrence.
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	None.
	Hospice services	10% coinsurance	10% coinsurance	30% coinsurance	60% coinsurance	Patient's life expectancy is 6 months or less. Services must be pre-certified in order to avoid \$500 penalty per occurrence.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Level 1: Moore County Hospital/ Providers only*	Level 2: Moore County affiliated Physicians	Level 3: In-Network*	Level 4: Out-of-Network	
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply).			60% coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered				Not covered.
	Children's dental check-up	Not covered				Not covered.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your [plan](#) document for more information and a list of any other [excluded services](#).)

<ul style="list-style-type: none"> Bariatric Surgery Cosmetic Surgery Dental Care (Adult) Dental check-ups (Child) 	<ul style="list-style-type: none"> Glasses (Child) Hearing Aids Long Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult) Routine Foot Care Weight Loss Programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> Acupuncture 	<ul style="list-style-type: none"> Chiropractic Care (limited to 20 visits per calendar year) 	<ul style="list-style-type: none"> Infertility treatment (except promotion of conception)
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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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: the Plan Administrator at 1-806-935-7171 or the Texas Department of Insurance at 1-800-252-3439.

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 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 plan document at www.alliedbenefit.com.

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	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,270

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	
Deductibles	\$900
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400