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.CoalBenefits.com** or call **1-855-979-5192**. 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 **1-855-979-5192** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For Alliance Direct providers: **$0**; for Non-Direct providers: **$400** individual/**$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.
Are there services covered before you meet your deductible?	Yes. Alliance Direct services, preventive services, emergency room care, emergency medical transportation and prescription drugs are covered before you meet your deductible.	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 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?	The medical out-of-pocket limit for Alliance Direct: **$2,000** individual/**$4,000** family; for Non-Direct: **$4,000** individual/**$8,000** family. For Alliance Direct and Non-Direct, the combined medical/prescription out-of-pocket limit is **$9,100** individual/**$18,200** family (adjusted each year to reflect federal limits).	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.
What is not included in the out-of-pocket limit?	The medical out-of-pocket limit does not include copayments or prescription drugs. Neither the medical out-of-pocket limit nor the combined medical/prescription out-of-pocket limit includes penalties, premiums, balance-billing charges, covered services not considered essential health benefits by federal law (such as chiropractic and acupuncture), any discounts or similar reductions by providers/manufacturers, or 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?	This plan does not use a provider network. You can receive covered services from any provider. This plan has direct contracts with certain providers who are referred to as Alliance Direct providers. See **www.CoalBenefits.com** or call **1-855-979-5192** for a list of Alliance Direct providers. The allowed amount for services provided by Alliance Direct providers is based on the contract with the provider. The allowed amount for services from Non-Direct providers is based on a payment rate established by the plan, which is typically a percentage of the Medicare fee schedule.	You will pay the least if you use an Alliance Direct provider. You will pay the most if you use a Non-Direct provider, and you might receive a bill from a Non-Direct provider for the difference between the Non-Direct provider's charge and what your plan pays (balance billing). Be aware your Alliance Direct provider might use a Non-Direct 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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Alliance Direct Provider (You will pay the least)	Non-Direct 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	No charge	20% coinsurance	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.
	Specialist visit	No charge	20% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Preauthorization required or 25% benefit penalty applies.
		In-Network	**Out-of-Network**	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CoalBenefits.com	Approved Over-the-Counter (OTC)	Not covered	Not covered	Covered only at on-site clinics.
	Approved Preventive (ACA PV)	No charge	Cost minus the amount the plan would have paid to an In-Network pharmacy.	Covers up to a 30-day supply from a retail pharmacy; up to a 90-day supply from Elixir Pharmacy home delivery; up to a 30-day supply for specialty drugs. Certain preventive drugs are covered only when dispensed from an on-site clinic, when available. Certain medications require prior authorization, step therapy, or substitution with clinical alternative, or you pay 100%. For certain medications, additional restrictions apply on brand names, non-approved products, or quantities. Coverage for specialty drugs is limited to drugs provided by Elixir Specialty. Expenses do not count toward medical out-of-pocket limit.
	Generic Preferred (Tier 1)	10% coinsurance ($5 minimum); some $0 exceptions in Formulary		
	Generic Non-Preferred (Tier 2)	10% coinsurance ($10 minimum)		
	Brand-Name Preferred (Tier 3)	20% coinsurance ($10 minimum)		
	Brand-Name Non-Preferred (Tier 4)	40% coinsurance ($10 minimum)		
	Specialty Preferred (Tier 5)	10% coinsurance (min. $100, max. $300)		
	Specialty Non-Preferred (Tier 6)	20% coinsurance (min. $200, max. $600)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Alliance Direct Provider (You will pay the least)	Non-Direct Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization required or 25% benefit penalty applies. For certain cardiothoracic, spinal and cochlear implant procedures, use of Center of Excellence required or 40% benefit penalty applies unless alternate provider specifically preauthorized.
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copayment	$250 copayment	Copay applies regardless of whether admitted.
	Emergency medical transportation	Not applicable	0% coinsurance	Air ambulance limited to 200% of Medicare-approved amount. Ground ambulance limited to 150% of Medicare-approved amount.
	Urgent care	No charge	20% coinsurance	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Up to 180 days/calendar year. Preauthorization required or 25% benefit penalty applies. Items or services provided by a Non-Direct physician or other provider at an Alliance Direct facility may be eligible for Alliance Direct level of benefits. Contact Member Services to confirm your level of benefits. For certain cardiothoracic, spinal and cochlear implant procedures, use of Center of Excellence required or 40% benefit penalty applies unless alternate provider specifically preauthorized.
	Physician/surgeon fees	No charge	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	Preauthorization required for certain services, such as outpatient partial hospitalization or intensive outpatient care, or 25% benefit penalty applies.
	Inpatient services	No charge	20% coinsurance	Up to 180 days/calendar year of inpatient and residential treatment center services. Preauthorization required or 25% benefit penalty applies. Items or services provided by a Non-Direct physician or other provider at an Alliance Direct facility may be eligible for Alliance Direct level of benefits. Contact Member Services to confirm your level of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Alliance Direct Provider (You will pay the least)	Non-Direct Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Preauthorization required for extended inpatient stays or 25% benefit penalty applies. Dependent child pregnancy not covered (except for applicable preventive services).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge when coordinated through Care Coordination	20% coinsurance	Up to 120 visits/calendar year. Preauthorization required or 25% benefit penalty applies.
	Rehabilitation services	No charge	20% coinsurance	Up to 25 visits/calendar year for each type of therapy. Preauthorization required for treatment or 25% benefit penalty applies.
	Habilitation services	No charge	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	Up to 90 days/calendar year for care in a skilled-nursing facility. Preauthorization required or 25% benefit penalty applies.
	Durable medical equipment	No charge	20% coinsurance	Preauthorization required for rental or purchase of certain items (e.g., hospital beds, wheelchairs), or 25% benefit penalty applies.
	Hospice services	No charge when coordinated through Care Coordination	20% coinsurance	Preauthorization required or 25% benefit penalty applies.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered under Alliance Coal Dental Plan and Vision Plan.
	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 policy or plan document for more information and a list of any other excluded services.)

- Any service or supply that is not medically necessary (some services require preauthorization of medical necessity)
- Bariatric surgery
- Complications resulting from excluded care (e.g., bariatric surgery, dependent child's maternity)
- Cosmetic surgery (unless medically necessary within a reasonable period of time to repair conditions resulting from an accidental injury, or for the improvement of the physiological functioning of a malformed body member)
- Dental care (Adult) [covered separately under the Alliance Coal Dental Plan]
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) [covered separately under the Alliance Coal Vision Plan]
- Weight loss programs

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

- Acupuncture (limited to 25 treatments per calendar year)
- Chiropractic care
- Routine foot care

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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact Member Services at 1-855-979-5192. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://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.

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.

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **$0**
- **Other: Rx coinsurance** **$20**

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	$0
Coinsurance	$20
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 Alliance Direct care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **$0**
- **Other: Rx coinsurance** **$880**

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	$0
Coinsurance	$880
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

Mia's Simple Fracture
(Alliance Direct emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) ER copayments** **$250**
- **Other coinsurance** **$0**

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	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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