**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: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers $1,000.00 person / $3,000.00 family; for out-of-network providers $2,000.00 person/ $6,000.00 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br>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 Prescription drugs, in-network physician charges, in-network urgent care charges, second surgical opinions, outpatient/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, and renal dialysis services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical:<br>For in-network providers $4,000.00 person / $12,000.00 family; for out-of-network providers $10,000.00 person/ $25,000.00 family<br>Prescription Drugs:$1,200.00 person / $2,600.00 family | The out-of-pocket limit is the most you could pay in a year for covered services.<br>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?** | Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| | | |
|---|---|---|
| | charges, and health care this plan doesn't cover. | |
| **Will you pay less if you use a network provider?** | Yes. See www.alliedbenefit.com or call 1-312-906-8080 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?** | No. | You can see the specialist you choose without a referral**.** |

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 |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Primary care visit to treat an injury or illness | $10.00 copay/office visit, then 0% coinsurance (deductible does not apply) | 50% coinsurance | Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants and mental health providers. See Plan Document for other services. |
| | Specialist visit | $15.00 copay/office visit, then 0% coinsurance (deductible does not apply) | 50% coinsurance | See Plan Document for other services. |
| | Preventive care/screening/ immunization | No charge (deductible does not apply). | 50% 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) | 0% coinsurance (deductible does not apply) | 0% coinsurance (deductible does not apply) | Does not include emergency room or urgent care diagnostic services. |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% 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 |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs | $0 copay/prescription (retail)<br>$0 copay/prescription (extended retail)<br>$0 copay/prescription (mail-order) | | Covers up to a 30-day supply (retail prescription); 90-days supply (extended retail and mail order prescription Deductible does not apply. Once the prescription drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.<br>*See Plan Document for non-use of generic drug penalty. |
| | Preferred brand drugs | $10.00 copay/prescription (retail)<br>$20.00 copay/prescription (extended retail)<br>$20.00 copay/prescription (mail-order) | | |
| | Non-preferred brand drugs | $20.00 copay/prescription (retail)<br>$40.00 copay/prescription (extended retail)<br>$40.00 copay/prescription (mail-order) | | |
| | Specialty drugs | $100.00 copay/prescription | | *Please see Prescription Drug Benefit section within your Plan Document for details. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | 50% coinsurance | Preauthorization is recommended |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | None. |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | | $350.00 copay will apply for non-emergent care received in an Emergency Room. |
| | Emergency medical transportation | 40% coinsurance | Paid same as in-network | Preauthorization is recommended |
| | Urgent care | $10.00 copay/visit, then 0% coinsurance (deductible does not apply); | 50% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | Preauthorization is recommended |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | None. |
| | Outpatient services | $10.00 copay/office visit, then 0% coinsurance (deductible does not apply) and 40% coinsurance for outpatient services | 50% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Inpatient services | 40% coinsurance | 50% coinsurance | Preauthorization is recommended |

*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 |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $10.00 copay/office visit, then 0% coinsurance (deductible does not apply) | 50% coinsurance | Cost sharing does not apply to certain preventive services.<br><br>Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. |
| | Childbirth/delivery professional services | 40% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 40% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | 50% coinsurance | Limited to a maximum of 40 visits per Calendar Year |
| | Rehabilitation services | 40% coinsurance | 50% coinsurance | Physical and occupational per therapy type: limited to a maximum of 20 visits of office and outpatient facility services per Calendar Year. Speech therapy: limited to 20 visit maximum per Calendar Year |
| | Habilitation services | 40% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 40% coinsurance | 50% coinsurance | Limited to 60 days per Calendar Year. Preauthorization is recommended |
| | Durable medical equipment | 40% coinsurance | 50% coinsurance | Preauthorization is recommended for certain services, see Plan Document. |
| | Hospice services | 40% coinsurance | 50% coinsurance | Patient's life expectancy is 6 months or less. |
| **If your child needs dental or eye care** | Children's eye exam | No charge (deductible does not apply). | Not covered | Limited to one exam per Calendar Year, limit does not apply from birth through age 5. |
| | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

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

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care

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

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic Care (limited to 20 visits per Calendar Year)<br>• Acupuncture (limited to 20 visits per Calendar Year)<br>• Bariatric Surgery (limited to 1 procedure per Lifetime.) | • Hearing Aids (limited to $2,000 per person per Calendar Year)<br>• Infertility treatment (except promotion of conception) | • Private-duty nursing (limited to 60 visits (one per day) per Calendar Year.)<br>• Routine eye care (Adult) Limited to one exam per year and limited to $300 combined with glasses/contacts) |

**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, contact: the Plan Administrator at (888) 766-3001 or the 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 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 | $15 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $1,000 |
| Copayments | $0 |
| Coinsurance | $3,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,060** |

### 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 | $15 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $800 |
| Copayments | $200 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,070** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $15 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $1,000 |
| Copayments | $200 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

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