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?	$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?	Not applicable.	This plan does not have a deductible.
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?	Unlimited.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
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.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 6 visits per person per Calendar Year.
	Specialist visit	$20 co-pay	Not covered	
	Preventive care/screening/	0% coinsurance	Not covered	None.

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)	
	immunization			
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	Maximum of 3 visits per person per Calendar Year.
	Imaging (CT/PET scans, MRIs)	Not covered		None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$5 copay (drug card); $12.50 copay (mail-order)		Covers up to a 34-day supply (drug card prescription); 91-day supply (mail-order prescription). Limited to a combined maximum of 24 prescriptions for retail and for mail order drugs, per person per Calendar Year. See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$40 copay (drug card); $100 copay (mail-order)		
	Non-preferred brand drugs	Not covered		None.
	Specialty drugs	Not covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered		None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$150 co-pay/per visit		Maximum of 2 visits (combined with Urgent Care visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
	Emergency medical transportation	Not covered		None.
	Urgent care	0% coinsurance		Maximum of 2 visits (combined with Emergency room services visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered		None.
	Physician/surgeon fees			

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 mental health, behavioral health, or substance abuse services	Outpatient services	Not covered		None.
	Inpatient services			
If you are pregnant	Office visits	$10 co-pay	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 6 visits per person per Calendar Year.
	Childbirth/delivery professional services	Not covered		None.
	Childbirth/delivery facility services	Not covered		None.
If you need help recovering or have other special health needs	Home health care	Not covered		None.
	Rehabilitation services	Not covered		None.
	Habilitation services			
	Skilled nursing care	Not covered		None.
	Durable medical equipment	Not covered		None.
	Hospice services	Not covered		None.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	Applied 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Diagnostic imaging (CT/PET scans, MRIs)
- Durable medical equipment
- Facility fees (e.g. hospital room)
- Glasses (Child)
- Habilitative services
- Hearing aids
- Home health care
- Hospice services
- Infertility treatment
- Long-term care
- Mental/Behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Substance use disorder outpatient services

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

• Emergency medical transportation • Facility fees (e.g. ambulatory surgery center)	• Mental/Behavioral health outpatient services	• Substance use disorder inpatient services • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
None

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 (312) 673-4333 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**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **No**.
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** **$0**
- **Specialist copay** **$20**
- **Hospital (facility) coinsurance** **not covered**
- **Other coinsurance** **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,430
The total Peg would pay is	**$11,430**

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 copay** **$20**
- **Hospital (facility) coinsurance** **not covered**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Prescription drug supplies *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,780
The total Joe would pay is	**$2,080**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$20**
- **Hospital (facility) coinsurance** **not covered**
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,040
The total Mia would pay is	**$1,540**

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