



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](http://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](http://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- <u>network providers</u> \$4,000.00 person / \$8,000.00 family; for <u>out-of-network providers</u> \$8,000.00 person / \$16,000.00 family  | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.<br><br>If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In-network <u>preventive care</u> services are covered before you meet your <u>deductible</u> .  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <u>deductibles</u> for specific services?           | There are no other specific <u>deductibles</u> .  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | For in- <u>network providers</u> \$8,000.00 person / \$16,000.00 family; for <u>out-of-network providers</u> \$15,000.00 person / \$30,000.00 family  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| What is not included in the <u>out-of-pocket limit</u> ?            | Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.alliedbenefit.com">www.alliedbenefit.com</a> or call 1-312-906-8080 for a list of <u>network providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

|  |     |  |
|--|-----|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No. | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |
|--|-----|--|



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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | 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. |
|  | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | See Plan Document for other services.   |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge ( <a href="#">deductible</a> does not apply).  | 50% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.      |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | Does not include emergency room or urgent care diagnostic services.   |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | Does not include emergency room or urgent care imaging services.  |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.welldyne.com">www.welldyne.com</a> | Generic drugs  | \$10.00 <a href="#">copay</a> /prescription (retail)<br>\$20.00 <a href="#">copay</a> /prescription (extended retail and mail-order) |  | Covers up to a 31-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). <a href="#">Deductible</a> applies.  |
|  | Preferred brand drugs                                  | \$25.00 <a href="#">copay</a> /prescription (retail)<br>\$50.00 <a href="#">copay</a> /prescription (extended retail and mail-order) |  | Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.  |
|  | Non-preferred brand drugs                              | \$40.00 <a href="#">copay</a> /prescription (retail)<br>\$80.00 <a href="#">copay</a> /prescription (extended retail and mail-order) |  | *See Plan Document for non-use of generic drug penalty.   |
|  | <a href="#">Specialty drugs</a>                        | 20% <a href="#">copay</a> /prescription, up to maximum <a href="#">copay</a> of \$250  |  | *Please see Prescription Drug Benefit section within your Plan Document for details.  |

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | In-Network Provider<br>(You will pay the least)                             | Out-of-Network Provider<br>(You will pay the most) |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for certain out-of-network services in order to avoid 50% reduction in benefits penalty per occurrence.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | None.  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150.00 <a href="#">copay</a> /visit ( <a href="#">deductible</a> applies) |  | None.  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>   | Paid same as in-network                            | 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. <a href="#">Preauthorization</a> is required for out-of-network air ambulance services in order to avoid 50% reduction in benefits penalty per occurrence.                   |
|   | <a href="#">Urgent care</a>                      | \$50.00 <a href="#">copay</a> /visit ( <a href="#">deductible</a> applies)  | 50% <a href="#">coinsurance</a>                    | <a href="#">Copay</a> includes all services done during the urgent care visit.   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for out-of-network services in order to avoid 50% reduction in benefits penalty per occurrence.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | None.  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | None.  |
|   | Inpatient services                               | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for out-of-network services in order to avoid 50% reduction in benefits penalty per occurrence.   |
| If you are pregnant   | Office visits                                    | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> .<br>Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).<br><a href="#">Preauthorization</a> is required for out-of-network vaginal deliveries requiring more than a 48 hour |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    |  |

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

| Common Medical Event   | Services You May Need                     | What You Will Pay                                       |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|--|---|
|  |   | In-Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |   |
|  | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid 50% reduction in benefits penalty per occurrence.   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | Limited to a maximum of 100 visits per Calendar Year  |
|  | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | Includes physical, speech, occupational, hearing, and respiratory therapy as well as cardiac/pulmonary rehabilitation. No visit limits apply.   |
|  | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    |   |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | Limited to 100 days per Calendar Year.  |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for certain out-of-network services in order to avoid 50% reduction in benefits penalty per occurrence.  |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>                         | 50% <a href="#">coinsurance</a>                    | Patient's life expectancy is 6 months or less. <a href="#">Preauthorization</a> is required for out-of-network services in order to avoid 50% reduction in benefits penalty per occurrence. |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge ( <a href="#">deductible</a> does not apply). | 50% <a href="#">coinsurance</a>                    | Applies 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.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care

\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://www.alliedbenefit.com).

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

- Acupuncture (limited to 20 visits per Calendar Year)
- Bariatric Surgery (limited to 1 procedure per Lifetime.)
- Chiropractic Care
- Hearing Aids (limited to one hearing aid and maximum plan payment of \$2,500 per hearing impaired ear every 36 months)
- Infertility treatment (assisted reproduction excluded, but cryopreservation for iatrogenic infertility covered & limited to maximum plan payment of \$20,000 per lifetime)

**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](http://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](http://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 (323) 319-1900 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](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 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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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\*For more information about limitations and exceptions, see plan document at [www.alliedbenefit.com](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ <a href="#">Hospital (facility) coinsurance</a>               | 20%     |
| ■ <a href="#">Other coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,700        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,770</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ <a href="#">Hospital (facility) coinsurance</a>               | 20%     |
| ■ <a href="#">Other coinsurance</a>                             | 20%     |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$70           |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$4,290</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ <a href="#">Hospital (facility) coinsurance</a>               | 20%     |
| ■ <a href="#">Other coinsurance</a>                             | 20%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.