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?	$2,000 person / $4,000 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. Preventive care, all services performed in a physician's office, outpatient physical/occupational/speech therapy, anesthesia and its interpretation, and emergency room physician care 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,450 person / $12,900 family	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?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and 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?	No.	This plan does not use a provider network. You can receive covered services from any provider.
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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount. Chiropractor covered up to 20 visits per year.
	Specialist visit	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
	Preventive care/screening/ immunization	No charge (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance if done in office (deductible does not apply); 10% coinsurance if done Outpatient or Independent laboratory		The Plan pays using the Maximum Allowable Amount.
	Imaging (CT/PET scans, MRIs)	0% coinsurance if done in office (deductible does not apply); 10% coinsurance if done Outpatient or Independent laboratory		The Plan pays using the Maximum Allowable Amount.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	10% coinsurance		Covers up to a 34-day supply (retail prescription); 91-day supply (mail order prescription). *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	10% coinsurance		
	Non-preferred brand drugs	10% coinsurance		
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year deductible and coinsurance. Please contact Allied Benefit Systems, LLC at 1-855-442-3477		The Plan pays using the Maximum Allowable Amount. *See Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Physician/surgeon fees	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.

*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 immediate medical attention	Emergency room care	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Emergency medical transportation	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Urgent care	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance		The Plan pays using the Maximum Allowable Amount. 50% reduction penalty up to $500 if not pre-certified
	Physician/surgeon fees	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance for office visits (deductible does not apply); 10% coinsurance for outpatient services		The Plan pays using the Maximum Allowable Amount.
	Inpatient services	10% coinsurance		The Plan pays using the Maximum Allowable Amount. 50% reduction penalty up to $500 if not pre-certified
If you are pregnant	Office visits	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount. Cost sharing does not apply to certain preventive services. 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 50% reduction penalty up to $500.
	Childbirth/delivery professional services	10% coinsurance		
	Childbirth/delivery facility services	10% coinsurance		

*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 help recovering or have other special health needs	Home health care	10% coinsurance		Covered up to 60 visits per calendar year. The Plan pays using the Maximum Allowable Amount.
	Rehabilitation services	0% coinsurance (deductible does not apply).		Physical and Occupational therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 20 visits maximum per calendar year. The Plan pays using the Maximum Allowable Amount.
	Habilitation services	0% coinsurance (deductible does not apply).		
	Skilled nursing care	10% coinsurance		Covered up to 60 days per calendar year. The Plan pays using the Maximum Allowable Amount.
	Durable medical equipment	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Hospice services	10% coinsurance		Patient's life expectancy is 6 months or less. The Plan pays using the Maximum Allowable Amount.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply).		Applied from birth through age 5. The Plan pays using the Maximum Allowable Amount.
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

*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.)	
• Acupuncture, when used in lieu of an anesthetic in conjunction with a surgery	• Chiropractic care (limited to 20 visits per calendar year)

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 (847) 262-3800 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	$2,000
Specialist coinsurance	0%
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	0%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	$2,000
Specialist coinsurance	0%
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: The Coverage Examples above assume the patient received all care from providers accepting reimbursement in full based on the Maximum Allowable Amount. Otherwise, costs would have been higher.

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