This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.alliedbenefit.com or by calling 1-800-288-2078 or 1-312-906-8080.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$650** person/ **$1,300** family In-Network combined for Tier 1 and Tier 2; **$1,500** person/ **$4,500** family Out-of-Network. Does not apply to In-Network preventative care, routine vision exams, school flu shots and health screenings, In-Network physician office visit charges, allergy injections, In-Network outpatient and Independent Laboratory radiology/pathology/interpretation, nutritional counseling, chiropractic services, urgent care facility services, emergency room services, second/third surgical opinion, smoking cessation treatment, co-payments and co-insurance.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$2,650** person/ **$5,300** family In-Network; **$6,500** person/ **$16,500** family Out-of-Network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties for failure to obtain precertification, 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See your ID card for a phone number to call, and website address to go to, to find participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how

		this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider Tier 1	Your cost if you use an In-network Provider Tier 2	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit		50% co-insurance	Co-pay applies to exam charge including diagnostics performed during the office visit limited to X-rays and laboratory services. See Plan Document for other services.
	Specialist visit	$50 co-pay/visit		50% co-insurance	
	Other practitioner office visit	$50 co-pay/visit for second surgical opinions; $30 co-pay/visit for all other providers.		50% co-insurance	Chiropractic coverage is limited to 24 visits. See Plan Document for other services.
	Preventive care/screening/immunization	No charge		50% co-insurance	Age restrictions may apply, see Plan Document for details.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider Tier 1	Your cost if you use an In-network Provider Tier 2	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Independent Labs: No charge; Outpatient Facility: 20% co-insurance		50% co-insurance	Diagnostic tests done during a Physician's office visit will be payable under the Primary care visit to treat an injury or illness benefit.
	Imaging (CT/PET scans, MRIs)	Independent Labs: 20% co-insurance; Outpatient Facility: 20% co-insurance	Independent Labs: 20% co-insurance; Outpatient Facility: 30% co-insurance	Independent Labs: 50% co-insurance; Outpatient Facility: 50% co-insurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$15 co-pay (retail), $35 co-pay (mail-order)			Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations. Patient must pay the cost difference between the brand and generic drug in addition to your co-pay or co-insurance.
	Preferred brand drugs	$35 co-pay (retail), $85 co-pay (mail-order)			
	Non-preferred brand drugs	Not Covered			
	Specialty drugs	$75 co-pay per prescription			Covers up to a 30-day supply. Patient may call the pharmacy benefit manager with questions regarding quantity limitations or prior authorizations.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	$300 co-pay, then 30% co-insurance	50% co-insurance	None.
	Physician/surgeon fees	20% co-insurance	20% co-insurance	50% co-insurance	None.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider Tier 1	Your cost if you use an In-network Provider Tier 2	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$200 co-pay/visit			Co-pay waived if patient is admitted as in inpatient. Admissions through the Emergency Room for Tier 2 providers will be payable at the Tier 1 Inpatient level.
	Emergency medical transportation	20% co-insurance			None.
	Urgent care	$40 co-pay/visit			None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	$300 co-pay, then 30% co-insurance	50% co-insurance	Services must be pre-certified in order to avoid $200 penalty per occurrence.
	Physician/surgeon fee	20% co-insurance		50% co-insurance	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/individual office visit; $15 co-pay/group office visit		50% co-insurance	None.
	Mental/Behavioral health inpatient services	20% co-insurance	$300 co-pay, then 30% co-insurance	50% co-insurance	Services must be pre-certified in order to avoid $200 penalty per occurrence.
	Substance use disorder outpatient services	$30 co-pay/individual office visit; $15 co-pay/group office visit		50% co-insurance	None.
	Substance use disorder inpatient services	20% co-insurance	$300 co-pay, then 30% co-insurance	50% co-insurance	Services must be pre-certified order to avoid $200 penalty per occurrence.
If you are pregnant	Prenatal and postnatal care	$30 co-pay/visit		50% co-insurance	Co-pay applies to the first prenatal visit per pregnancy.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider Tier 1	Your cost if you use an In-network Provider Tier 2	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% co-insurance	$300 co-pay, then 30% co-insurance	50% co-insurance	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 $200 penalty.
If you need help recovering or have other special health needs	Home health care	20% co-insurance		50% co-insurance	60 day limit per Calendar Year.
	Rehabilitation services	20% co-insurance		50% co-insurance	Physical, Speech, Occupational, Biofeedback and Inversion Therapy: Limited to 20 visits per therapy per Calendar Year.
	Habilitative services	20% co-insurance		50% co-insurance	
	Skilled nursing care	20% co-insurance		50% co-insurance	Services must be pre-certified in order to avoid $200 penalty per occurrence.
	Durable medical equipment	20% co-insurance		50% co-insurance	Durable Medical Equipment over $1,000 must be pre-certified in order to avoid $200 penalty per occurrence.
	Hospice service	20% co-insurance			Patient's life expectancy is less than 6 months.
If your child needs dental or eye care	Eye exam	Birth to age 5: No charge Age 5 and over: $30 co-pay			For age 5 and over: Limited to one exam every 24 months
	Glasses	Not covered			Not covered.
	Dental check-up	Not covered			Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult) (limited to dental related services under medical coverage)
- Dental check-ups (child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Acupuncture
- Glasses (child)
- Routine foot care
- Weight loss programs
- Bariatric Surgery

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Infertility treatment (diagnosis)
- Chiropractic care (24 visits per calendar year)
- Hearing aids (maximum payment of $500 for both ears within a 3 year replacement cycle)
- Private-duty nursing (precertification required)
- Routine eye care (Adult), limited to one exam every 24 months.
- Skilled nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-312-906-8080. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance** For questions about your rights, this notice, or assistance, you can contact: the plan at 1-312-906-8080. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,840
- **Patient pays** $1,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$650
Copays	$50
Coinsurance	$800
Limits or exclusions	$200
Total	**$1,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,300
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.