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 $1,500 person / $3,000 family; for out-of-network providers $3,000 person / $6,000 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, the overall family deductible must be met before the plan beings to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care charges 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?	Medical: For in-network providers $2,500 person / $5,000 family; for out-of-network providers $5,000 person / $10,000 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, the overall family out-of-pocket limit must be met.
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.
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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% 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. Certain office surgeries must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
	Specialist visit	0% coinsurance	20% coinsurance	See Plan Document for other services.
	Preventive care/screening/ immunization	No charge (deductible does not apply).	20% coinsurance	Age restrictions may apply, see Plan Document. 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	20% coinsurance	Does not include urgent care services, emergency room services, MRI, PET or CT scans.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
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 copay/prescription (retail) $25 copay/prescription (mail-order)		Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). Deductible applies. For both retail and mail order drugs, if a Covered Person purchases a brand name medication when a generic is available, then, in addition to the brand co-pay, he must also pay the difference in price between the generic and brand medication.
	Preferred brand drugs	$30 copay/prescription (retail) $87.50 copay/prescription (mail-order)		
	Non-preferred brand drugs	$60 copay/prescription (retail) $150 copay/prescription (mail-order)		

*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)	
	Specialty drugs	Contact Express Scripts, your prescription drug vendor, for applicable cost		Contact Express Scripts, your prescription drug vendor.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	Certain Surgeries must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None.
If you need immediate medical attention	Emergency room care	0% coinsurance		None.
	Emergency medical transportation	0% coinsurance	0% coinsurance	None.
	Urgent care	0% coinsurance	20% coinsurance	Includes all services done during Urgent care visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	None.
	Inpatient services	0% coinsurance	20% coinsurance	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. 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 a 50% penalty up to a maximum penalty of $500 per occurrence. Co-pay applies to the first prenatal visit per pregnancy.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% 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	0% coinsurance	20% coinsurance	Home Health Aide services are payable at 50% co-insurance.
	Rehabilitation services	0% coinsurance	20% coinsurance	Physical, Occupational, Speech therapy and all care rendered by a Chiropractor are limited to a combined maximum of 62 Visits for office and Outpatient facility services, per Covered Person per Calendar Year. Does not include labs or x-rays. Outpatient Physical Therapy Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $500 per occurrence.
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	Limited to 60 days per calendar year, and includes extended care facility.
	Durable medical equipment	0% coinsurance	20% coinsurance	None.
	Hospice services	0% coinsurance	20% 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).	20% coinsurance	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.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental check-ups (child)
- Glasses (child)
- Hearing aids
- Long-term care
- Acupuncture
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (however treatment for obesity is covered)

*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.)		
• Bariatric surgery • Chiropractic care (limited to 62 visits combined with other therapies)	• Infertility treatment (except promotion of conception)	• Private-duty nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 (614) 445-3750 or the Ohio Superintendent of Insurance at 800-686-1526 or https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

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	$1,500
Specialist copayment	0%
Hospital (facility) coinsurance	0%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$1,500
Specialist copayment	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	$1,500
Specialist copayment	0%
Hospital (facility) coinsurance	0%
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	**$2,800**

In this example, Mia would pay:

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

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