
 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:
<b>What is the overall <a href="#">deductible</a>?</b>	For in-network providers \$750 person / \$2,000 family; for out-of-network providers \$1,500 person / \$4,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> , In-Network Physician/Specialist office visit co-pays, urgent care, second surgical opinions, chiropractic treatment, therapy services, emergency room services and renal dialysis charges are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical: For in-network providers \$3,500 person / \$7,000 family; for out-of-network providers \$7,000 person / \$14,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain precertification, services in excess of Plan maximums or limits, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.alliedbenefit.com">www.alliedbenefit.com</a> or call 1-312-906-8080 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply); all other physician services: 20% <a href="#">coinsurance</a> ; No charge for second surgical opinions.	40% <a href="#">coinsurance</a> ; No charge for second surgical opinions	Copay applies to exam charge only. 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.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply).	40% <a href="#">coinsurance</a>	Copay applies to exam charge only. See Plan Document for other services.
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply).	40% <a href="#">coinsurance</a>	Age restrictions may apply, see Plan Document. 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>	40% <a href="#">coinsurance</a>	Does not include urgent care services, emergency room services, MRI, PET or CT scans.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of \$500 per occurrence.

\*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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	\$10 <a href="#">copay</a> /prescription (retail) \$25 <a href="#">copay</a> /prescription (mail-order)		Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). <a href="#">Deductible</a> does not apply. 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	\$35 <a href="#">copay</a> /prescription (retail) \$87.50 <a href="#">copay</a> /prescription (mail-order)		
	Non-preferred brand drugs	\$60 <a href="#">copay</a> /prescription (retail) \$150 <a href="#">copay</a> /prescription (mail-order)		
	<a href="#">Specialty drugs</a>	\$75 <a href="#">copay</a> /prescription (retail) \$150 <a href="#">copay</a> /prescription (mail-order)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> ( <a href="#">deductible</a> does not apply)		None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> ( <a href="#">deductible</a> does not apply)	40% <a href="#">coinsurance</a>	Includes all services done during Urgent care visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of \$500 per occurrence.

\*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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply); 20% <a href="#">coinsurance</a> for other physician services.	40% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of \$500 per occurrence.
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply)	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . 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). 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	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Home Health Aide services are payable at 50% co-insurance.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply); 20% <a href="#">coinsurance</a> for all outpatient services	40% <a href="#">coinsurance</a>	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

\*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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> /office visit ( <a href="#">deductible</a> does not apply); 20% <a href="#">coinsurance</a> for all outpatient services	40% <a href="#">coinsurance</a>	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.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 60 days per calendar year, and includes extended care facility.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Patient's life expectancy is 6 months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge ( <a href="#">deductible</a> does not apply).	40% <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.

### 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental check-ups (child)</li> <li>• Glasses (child)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Acupuncture</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs (however treatment for obesity is covered)</li> </ul>
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care (limited to 62 visits combined with other therapies)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (except promotion of conception)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>
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**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

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

[www.cciio.cms.gov](http://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](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 (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](#).

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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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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](#) \$750
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,210</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>