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 1-312-906-8080.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** per person Does not include prescription drug benefit, co-pays and co-insurance.	See the chart starting on page 2 for your costs for services this plan covers.
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?	No	There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Prescription drug copays, 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	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 4. 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**.

Questions: Call 1-312-906-8080 or go to www.alliedbenefit.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

- 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	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	0% co-insurance	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 4 visits per person per Calendar Year.
	Specialist visit	0% co-insurance	Not covered	
	Other practitioner office visit	0% co-insurance	Not covered	
	Preventive care/screening/immunization	0% co-insurance	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance		Maximum of 3 visits per person per Calendar Year.
	Imaging (CT/PET scans, MRIs)	Not covered		None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 co-pay (drug card); $12.50 co-pay (mail-order)		Covers up to a 34-day supply (drug card prescription); 91-day supply (mail-order prescription). Limited to a combined maximum of 12 prescriptions for retail and for mail order drugs, per person per Calendar Year.
	Preferred brand drugs	$40 co-pay (drug card); $100 co-pay (mail-order)		
	Non-preferred brand drugs	Not covered		
	Specialty drugs	Not covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered		None.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	0% co-insurance		Maximum of 3 visits (combined with Urgent Care visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
	Emergency medical transportation	Not covered		None.
	Urgent care	0% co-insurance		Maximum of 3 visits (combined with Emergency room services visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered		None.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered		None.
	Mental/Behavioral health inpatient services	Not Covered		None.
	Substance use disorder outpatient services	Not Covered		None.
	Substance use disorder inpatient services	Not Covered		None.
If you are pregnant	Prenatal and postnatal care	Not covered		None.
	Delivery and all inpatient services	Not covered		None.
If you need help recovering or have other special health needs	Home health care	Not covered		None.
	Rehabilitation services	Not covered		None.
	Habilitative services	Not covered		
	Skilled nursing care	Not covered		None.
	Durable medical equipment	Not covered		None.
	Hospice service	Not covered		None.
If your child needs dental or eye care	Eye exam	0% co-insurance	Not covered	Applies from birth through age 5.
	Glasses	Not covered		None.
	Dental check-up	Not covered		None.

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Diagnostic imaging (CT/PET scans, MRIs)
- Durable medical equipment
- Emergency medical transportation
- Facility fees (e.g. ambulatory surgery center)
- Facility fees (e.g. hospital room)
- Glasses (Child)
- Habilitative services
- Hearing aids
- Home health care
- Hospice services
- Infertility treatment
- Long-term care
- Mental/Behavioral health outpatient services
- Mental/Behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Substance use disorder outpatient services
- Substance use disorder inpatient services
- Weight loss programs

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

None.

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 not 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** $840
- **Patient pays** $6,700

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	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$6,700
Total	**$6,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,550
- **Patient pays** $850

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	$0
Coinsurance	$0
Limits or exclusions	$850
Total	**$850**

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.