



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:
<p>What is the overall deductible?</p>	<p>For in-network providers \$5,000.00 person / \$10,000.00 family; for out-of-network providers \$10,000.00 person / \$20,000.00 family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes, in-network preventive care services are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>There are no other specific deductibles.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers \$5,000.00 person / \$10,000.00 family; for out-of-network providers \$12,000.00 person / \$24,000.00 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>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.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.</p>	<p>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.</p>

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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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 provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	Includes all services other than labs, x-rays, imaging, surgery, and allergy injections. 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.
	Specialist visit	0% coinsurance	50% coinsurance	
	Preventive care/screening/immunization	No charge (deductible does not apply).	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rxbenefits.com	Generic drugs	0% coinsurance		Covers up to a 30-day supply (retail prescription); 90-days supply (extended retail and mail order prescription). Deductible applies. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	0% coinsurance		
	Non-preferred brand drugs	0% coinsurance		
	Specialty drugs	Contact RxBenefits, your prescription drug vendor, for applicable cost		*Please see Prescription Drug Benefit section within your Plan Document for details.

*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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Preauthorization is required for certain services in order to avoid a 50% up to a maximum of \$1,000.00 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	0% coinsurance		None.
	Emergency medical transportation	0% coinsurance	Paid same as in-network	Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily injury or disease.
	Urgent care	0% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Preauthorization is required in order to avoid 50% up to a maximum of \$1,000.00 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None.
	Inpatient services	0% coinsurance	50% coinsurance	Preauthorization is required in order to avoid 50% up to a maximum of \$1,000.00 penalty per occurrence.
If you are pregnant	Office visits	0% coinsurance	50% 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).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	Preauthorization is required 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% up to a maximum of \$1,000.00 penalty.
	Childbirth/delivery facility services	0% coinsurance	50% 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	25% coinsurance	Limited to a maximum of 100 visits per Plan Year. Preauthorization is required in order to avoid 50% up to a maximum of \$1,000.00 penalty per occurrence.
	Rehabilitation services	0% coinsurance	50% coinsurance	Physical and occupational therapy: limited to a maximum of 60 visits, per therapy type, of office and outpatient facility services per Plan Year. Speech therapy: limited to 60 visit maximum per Plan Year
	Habilitation services	0% coinsurance	50% coinsurance	
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 90 days per Plan Year. Preauthorization is required in order to avoid 50% up to a maximum of \$1,000.00 penalty per occurrence.
	Durable medical equipment	0% coinsurance	50% coinsurance	Preauthorization is required in order to avoid 50% up to a maximum of \$1,000.00 penalty per occurrence, see Plan Document
	Hospice services	0% coinsurance	50% 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).	50% 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.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Services Your [Plan](#) Generally Does NOT Cover (Check your [plan](#) document for more information and a list of any other [excluded services](#).)

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|---|---|--|
| <ul style="list-style-type: none">• Bariatric Surgery• Cosmetic Surgery• Dental Care (Adult)• Dental check-ups (Child) | <ul style="list-style-type: none">• Glasses (Child)• Long Term Care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult)• Routine Foot Care• Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none">• Chiropractic Care (limited to 60 visits per Plan Year)• Acupuncture (limited to 20 visits per Plan Year) | <ul style="list-style-type: none">• Hearing Aids (limited to one hearing aid per hearing impaired ear, limited to a maximum of \$4,000 per ear, every 2 Plan Year(s).) | <ul style="list-style-type: none">• Infertility treatment (limited to a maximum of \$20,000 per person per Lifetime) |
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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 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 (203) 367-3661 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	\$5,000
■ Specialist coinsurance	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.