




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. [www.alliedbenefit.com](http://www.alliedbenefit.com) or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$2,000 person / \$4,000 family; for <a href="#">out- of-network</a> providers \$4,000 person / \$8,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Prescription drugs, in-network <a href="#">preventive care</a> , breast pumps and supplies, immunizations provided at retail clinics, in-network physician exam charges (including specialists), in-network urgent care exam charges, second surgical opinions, in-network physical/occupational/speech therapy, in-network chiropractic care, outpatient/office/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, emergency room services, and renal dialysis 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> .
Are there other <a href="#">deductibles</a> for specific services?	There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$6,350 individual / \$12,700 family; for <a href="#">out- of-network</a> providers \$12,000 individual / \$24,000 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties for failure to obtain precertification/preauthorization, 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	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> .

 All [copayment](#) and [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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) <i>*Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule</i>	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$45 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply, and 30% <a href="#">coinsurance</a> for other physician services	40%* <a href="#">coinsurance</a>	<a href="#">Copay</a> applies to exam charge only. Does not include office surgery. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic coverage is limited to 20 visits per person per calendar year. See Plan Document for other services.
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	40%* <a href="#">coinsurance</a>	<a href="#">Copay</a> applies to exam charge only. Does not include office surgery. See Plan Document for other services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) <i>*Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule</i>	
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	40%* <a href="#">coinsurance</a>	Routine labs and x-rays are covered for <a href="#">out-of-network providers</a> at no charge. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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)	No charge, <a href="#">deductible</a> does not apply	No charge*, <a href="#">deductible</a> does not apply	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.maxorplus.com</a> .	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail) \$25 <a href="#">copay</a> /prescription (mail-order)		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). <a href="#">Deductible</a> does not apply. 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 (Tier 2)	\$35 <a href="#">copay</a> /prescription (retail) \$87.50 <a href="#">copay</a> /prescription (mail-order)		
	Non-preferred brand drugs (Tier 3)	\$60 <a href="#">copay</a> /prescription (retail) \$150 <a href="#">copay</a> /prescription (mail-order)		
	<a href="#">Specialty drugs</a> (Tier 4)	Please contact the Maxor+ Specialty Pharmacy at 1-800-687-0707.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.

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If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply), then 0% <a href="#">coinsurance</a>		None.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30%* <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$100 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	40%* <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$45 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply, and 30% <a href="#">coinsurance</a> for other outpatient services	40%* <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient services. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Inpatient services	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$45 <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 for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) <i>*Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule</i>	
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	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% reduction in benefits penalty per occurrence.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	Limited to 60 visits per person per calendar year.
	<a href="#">Rehabilitation services</a>	\$45 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply	40%* <a href="#">coinsurance</a>	Physical and occupational therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per person per calendar year. Speech therapy: limited to 20 visits maximum per person per calendar year.
	<a href="#">Habilitation services</a>	\$45 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply	40%* <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	Limited to 60 days per person per calendar year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	40%* <a href="#">coinsurance</a>	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) <i>*Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule</i>	
If your child needs dental or eye care	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 policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric Surgery (limited to 1 procedure per person per lifetime)
- Chiropractic Care (limited to 20 visits per person per calendar year)
- Hearing Aids (limited to 1 hearing aid per ear every 3 calendar years)
- Infertility treatment (except promotion of conception)
- Weight Loss Programs (limited to a maximum payment of \$5,000 per person per lifetime)

**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](http://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](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 on how 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 (404) 812-8270 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 the 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.*



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,700

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$4,770</b>
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### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$1,920</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$2,000</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.