**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. 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 network providers $750 person / $1,500 family; for out-of-network providers $2,000 person / $4,000 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, 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. |
| **Are there services covered before you meet your deductible?** | Yes. Prescription drugs, in-network preventive care, 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 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?** | There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $5,000 individual / $10,000 family; for out- of-network providers $12,000 individual / $24,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | 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. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 **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) **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* | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/office visit, deductible does not apply, and 20% coinsurance for other physician services | 40%* coinsurance | Copay 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. |
| | Specialist visit | $60 copay/visit, deductible does not apply | 40%* coinsurance | Copay 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) *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 | |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 40%* coinsurance | Routine labs and x-rays are covered for out-of-network providers at no charge. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge, deductible does not apply | No charge*, deductible does not apply | Does not include emergency room diagnostic services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40%* coinsurance | None. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.maxorplus.com. | Generic drugs (Tier 1) | $10 copay/prescription (retail) $25 copay/prescription (mail-order) | | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Deductible 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 copay/prescription (retail) $87.50 copay/prescription (mail-order) | | |
| | Non-preferred brand drugs (Tier 3) | $60 copay/prescription (retail) $150 copay/prescription (mail-order) | | |
| | Specialty drugs (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) | 20% coinsurance | 40%* coinsurance | None. |
| | Physician/surgeon fees | 20% coinsurance | 40%* coinsurance | 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) *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 | |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit (deductible does not apply), then 0% coinsurance | | None. |
| | Emergency medical transportation | 20% coinsurance | 20%* coinsurance | |
| | Urgent care | $75 copay/visit, deductible does not apply | 40%* coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40%* coinsurance | Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40%* coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/office visit, deductible does not apply, and 20% coinsurance for other outpatient services | 40%* coinsurance | Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence. |
| | Inpatient services | 20% coinsurance | 40%* coinsurance | |
| **If you are pregnant** | Office visits | $30 copay/office visit, deductible does not apply | 40%* coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance 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) *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 | |
| | Childbirth/delivery professional services | 20% coinsurance | 40%* coinsurance | 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 | 20% coinsurance | 40%* coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40%* coinsurance | Limited to 60 visits per person per calendar year. |
| | Rehabilitation services | $30 copay/office visit, deductible does not apply | 40%* coinsurance | 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. |
| | Habilitation services | $30 copay/office visit, deductible does not apply | 40%* coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40%* coinsurance | Limited to 60 days per person per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40%* coinsurance | None. |
| | Hospice services | 20% coinsurance | 40%* coinsurance | 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) *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 | |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | 40%* 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 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. 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 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.

**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 plan's overall deductible | $750 |
| Specialist copayment | $60 |
| 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $10 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,920** |

### 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 | $60 |
| 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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $900 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,680** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copayment | $60 |
| 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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $600 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,450** |

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