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:
What is the overall deductible?	$500 person / $1,000 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. In-network preventive care, routine vision care, lenses and frames, spectacle lenses, disposable contact lenses, eyeglass frames, Lasik eye surgery, all outpatient/independent laboratory/ office diagnostic and routine radiology and pathology administration and interpretation services, Imaging services done through USIN, second surgical opinions, and prescription drugs 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?	Yes. $50 person for prescription retail program	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $3,500 person / $7,000 family; for out-of-network providers $7,000 person / $14,000 family Prescription Drugs: $2,950 person / $5,900 family combined for In and Out-of-Network	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, 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.

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 **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	20% coinsurance	40% coinsurance	Does not include lab and x-rays. *See Plan Document for other services.
	Specialist visit	20% coinsurance	40% coinsurance	*See Plan Document for other services.
	Preventive care/screening/ immunization	No charge (deductible does not apply).	Not covered	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 you need 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).	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Imaging services through USIN are covered at no charge (*See Plan Document for details).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 copay (retail); $25 copay (mail-order)		Covers up to a 34-day supply (retail prescription); 91-day supply (mail order prescription). Once the prescription drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. Retirees and their spouses over age 65 are not eligible for Rx coverage. Separate Prescription Retail Deductible Applies. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$25 copay (retail); $62.50 copay (mail-order)		
	Non-preferred brand drugs	$40 copay (retail); $100 copay (mail-order)		

*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)	
	Specialty drugs	Contact Caremark, your prescription drug vendor, for applicable cost		*Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$500 co-pay/visit, then 20% coinsurance		If admitted to hospital directly from emergency room, benefit will be covered at the in-network inpatient hospital benefit.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Air ambulance services must be pre-certified in order to avoid $250 penalty per occurrence.
	Urgent care	20% coinsurance	40% coinsurance	*Does not include labs and x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None.
	Inpatient services	Not covered	Not covered	None.
If you are pregnant	Office visits	20% coinsurance	40% 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). 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 $250 penalty.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Services must be pre-certified in order to avoid a $250 penalty.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy, and all Chiropractic care: Limited to a combined maximum of 60 visits per Covered Person per Calendar Year.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to a maximum of 60 days due to the same or related causes. Services must be pre-certified in order to avoid a $250 penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Selected durable medical equipment must be pre-certified in order to avoid a $250 penalty.
	Hospice services	20% coinsurance	40% coinsurance	Inpatient services must be pre-certified to avoid a $250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply).	No charge (deductible does not apply).	Limited to a maximum payment of $300 per calendar year. This limit does not apply to physician office vision exams for children from birth to age 5. Benefit does not apply to sunglasses, tinting or Progressive lenses.
	Children's glasses	No charge (deductible does not apply).	No charge (deductible does not apply).	
	Children's dental check-up	Not covered	Not covered	Not covered under this Plan. See separate Dental Summary Plan Description for coverage.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids
- Long-term care
- Mental/Behavioral health services
- Substance use disorder services
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (However, treatment for obesity is covered.)

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

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

- Acupuncture (if performed by a M.D. as an alternative form of medically necessary anesthesia)
- Bariatric surgery
- Chiropractic care (limited to 60 visits combined with other therapies)
- Infertility treatment ($25,000 lifetime maximum)
- Private Duty Nursing
- Routine eye care (Adult) (limited to active employees and under age 65 retirees and their under age 65 dependents. Limited to a maximum payment of $400 per calendar year.)

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 (219) 942-7224 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	$500
Specialist coinsurance	20%
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	$500
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	$500
Specialist coinsurance	20%
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	$550
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,370**

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

The plan's overall deductible	$500
Specialist coinsurance	20%
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	$500
Copayments	$500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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