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?	$6,650 person/ $13,300 family In-Network; No non-emergency Out-of-Network coverage available (unless specifically stated in the Schedule of Covered Services).	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 is 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,650 person/ $13,300 family In-Network; No non-emergency Out-of-Network coverage available (unless specifically stated in the Schedule of Covered Services).	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	0% coinsurance	No coverage	None.
	Specialist visit	0% coinsurance	No coverage	None.
	Preventive care/screening/ immunization	No charge (deductible does not apply).	No coverage	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)	0% coinsurance	No coverage	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	No coverage	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs	Prescription Drugs purchased at a participating pharmacy (or through the Mail Order Program) will be dispensed at a discounted rate provided You show Your member ID card at the time of purchase. Charges incurred for prescription drugs apply toward Your Deductible. After Your Deductible is met, the Plan will pay 100% of Your prescription costs		Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	Contact 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)	0% coinsurance	No coverage	None.
	Physician/surgeon fees	0% coinsurance	No coverage	None.
If you need immediate medical attention	Emergency room care	0% coinsurance		None.
	Emergency medical transportation	0% coinsurance	No coverage	None.
	Urgent care	0% coinsurance	No coverage	Exam charge only.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	No coverage	Services must be pre-certified in order to avoid $200 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	No coverage	None.

*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 mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	No coverage	None.
	Inpatient services	0% coinsurance	No coverage	Services must be pre-certified in order to avoid $200 penalty per occurrence.
If you are pregnant	Office visits	0% coinsurance	No coverage	Cost sharing does not apply to certain preventive services. 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 $200 penalty.
	Childbirth/delivery professional services	0% coinsurance	No coverage	
	Childbirth/delivery facility services	0% coinsurance	No coverage	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	No coverage	None.
	Rehabilitation services	0% coinsurance	No coverage	Physical, Occupational, Speech therapy and all care rendered by a Chiropractor are limited to a combined maximum of 62 Visits for office and Outpatient facility services, per Covered Person per Calendar Year. Does not include labs or x-rays. Outpatient Physical Therapy Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of $200 per occurrence.
	Habilitation services	0% coinsurance	No coverage	
	Skilled nursing care	0% coinsurance	No coverage	Limited to a Maximum of 60 visits per Calendar Year
	Durable medical equipment	0% coinsurance	No coverage	Select services must be pre-certified in order to avoid $200 penalty per occurrence.
	Hospice services	0% coinsurance	No coverage	Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	No coverage	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.

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)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care (limited to 62 visits combined with other therapies)
- Home Health Care
- Infertility treatment (except promotion of conception)
- Private duty nursing
- Weight loss programs

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 (419) 267-2806 or the Ohio Superintendent of Insurance at 800-686-1526 or https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$6,650
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,710**

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

The plan's overall deductible	$6,650
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
Prescription drug supplies (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,710**

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

The plan's overall deductible	$6,650
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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