



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, contact us at www.alliednational.com or by calling 1-800-825-7531. 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.cciio.cms.gov or call 1-800-825-7531 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$500 person in-network / \$1000 family in-network Separate out-of-network <u>deductible</u> is two times in-network per individual. | Generally, you must pay all the costs from providers up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$3500 person in-network / \$7000 family in-network Separate out-of-network limit is \$7000 person/\$14000 family. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover do not apply to this out-of-pocket limit. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.alliednational.com or call 1-800-825-7531 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 <u>specialist</u> ? | No. You don't need a referral to see a specialist. | You can see the <u>specialist</u> you choose without permission from this plan. |

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Sample Group: Platinum 120 PPO

Coverage Period: 1/1/2023 - 12/31/2023
Coverage for: Individuals and Families
Plan Type: PPO



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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat injury or illness | \$20 copay/visit | 50% coinsurance | \$500 max benefit per occurrence then ded/coins |
| | Specialist visit | \$20 copay/visit | 50% coinsurance | \$500 max benefit per occurrence then ded/coins |
| | Preventive care/screening/immunization | No charge | 50% coinsurance | -----none----- |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 50% coinsurance | Use of HealthChoices services can waive out of pocket cost |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.alliednational.com | Generic drugs | \$0 Copay | | -----none----- |
| | Preferred brand drugs | \$35 Copay | | -----none----- |
| | Non-preferred brand drugs | \$75 Copay | | -----none----- |
| | Specialty Drugs | See Limitation | | 10% coinsurance to \$150 |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center.) | 20% coinsurance | 50% coinsurance | -----none----- |
| | Physician/Surgeon Fees | 20% coinsurance | 50% coinsurance | -----none----- |

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| 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) | |
| If you need immediate medical attention | Emergency Room Services | 20% coinsurance | 20% coinsurance | You may have a separate ER or Urgent Care copay. See your plan documents for details. If not an emergency, out-of-network deductible & coinsurance will apply. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent Care | Copay | 50% coinsurance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | -----none----- |
| | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | -----none----- |
| If you have mental health, behavioral health, substance abuse needs | Mental/Behavioral Health outpatient services | \$20 copay/visit | 50% coinsurance | Benefit limits vary according to group size and state of residence. Please consult your plan certificate or summary plan description for exact benefit details for Mental/Behavioral Health and Substance Use disorders. |
| | Mental/Behavioral Health inpatient services | 20% coinsurance | 50% coinsurance | |
| | Substance use disorder outpatient services | \$20 copay/visit | 50% coinsurance | |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | |
| If you are pregnant | Office Visits | \$20 copay/visit | 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. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | Limited to 40 visits per calendar year |
| | Rehabilitation Services | 20% coinsurance | 50% coinsurance | -----none----- |
| | Habilitation Services | 20% coinsurance | 50% coinsurance | Limited to 40 visits per calendar year |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | -----none----- |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Lifetime Maximum Benefit of \$5000 |
| | Hospice service | 20% coinsurance | 50% coinsurance | One benefit period up to 6 months |
| If your child needs dental or eye care | Children's Eye Exam | No Charge | same coinsurance | -----none----- |
| | Children's Glasses | Not Covered | | Not Covered |
| | Children's dental Check up | Not Covered | | Not Covered |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|---|---|---|
| <ul style="list-style-type: none">Bariatric SurgeryCosmetic SurgeryDental Care (Adult)Infertility TreatmentLong-Term CareNon-emergency care when traveling outside the U.S.Private-duty nursing | <ul style="list-style-type: none">Routine eye care (Adult)Weight Loss Programs | <ul style="list-style-type: none"> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
| <ul style="list-style-type: none">AcupunctureChiropractic CareHearing Aids | | |

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 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, 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: Allied National at 1-800-825-7531 or the Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

You may also contact your State Department of Insurance. A list of contact information for all states is available through the National Association of Insurance Commissioners at http://www.naic.org/state_web_map.htm.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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.
Calculated value is 85.5%.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

Important notice:

If there is any inconsistency between this Summary of Benefits and Coverage and your health plan's Summary Plan Description, the terms in the Summary Plan Description apply.

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 copayment \$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)

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 copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
 Primary Care physician visits (including disease education)
 Diagnostic tests (blood work)
 Prescription drugs
 Durable Medical Equipment (glucose meter)

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

- The plan's overall deductible \$500
- Specialist copayment \$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 \$12,731

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|---------------|
| Deductibles | \$698 |
| Co-pays | \$100 |
| Co-insurance | \$2178 |
| What isn't covered | |
| Limits or Exclusions | \$60 |
| The total Peg would pay is | \$3036 |

Total Example Cost \$7,389

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|---------------|
| Deductibles | \$500 |
| Co-pays | \$100 |
| Co-insurance | \$1096 |
| What isn't covered | |
| Limits or Exclusions | \$55 |
| The total Joe would pay is | \$1751 |

Total Example Cost \$1,925

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$500 |
| Co-pays | \$60 |
| Co-insurance | \$199 |
| What isn't covered | |
| Limits or Exclusions | \$0 |
| The total Mia would pay is | \$759 |

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