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 servcies. 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 deductible?	**$3000** person in-network / **$6000** family in-network Separate out-of-network deductible is two times in-network per individual.	Generally, you must pay all 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. Preventive care services 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?	No. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$7000** person in-network / **$14000** family in-network Separate out-of-network limit is $14000 person/$28000 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?	Premiums, balance-billing charges and health care this plan doesn't cover do not apply to this out-of-pocket limit.	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.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 specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	$35 copay/visit	50% coinsurance	$500 max benefit per occurrence then ded/coins
	Specialist visit	$35 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	$50 Copay		--------none--------
	Non-preferred brand drugs	$100 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--------

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	$35 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	$35 copay/visit	50% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office Visits	$35 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Bariatric Surgery • Cosmetic Surgey • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Weight Loss Programs	• •

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

• Acupuncture • Chiropractic Care • Hearing 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 76.4%.

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

Important notice:

If their 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** **$3000**
- **Specialist copayment** **$35**
- **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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3198
Co-pays	$175
Co-insurance	$1678
What isn't covered	
Limits or Exclusions	$60
The total Peg would pay is	**$5111**

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

- **The plan's overall deductible** **$3000**
- **Specialist copayment** **$35**
- **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)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3000
Co-pays	$175
Co-insurance	$596
What isn't covered	
Limits or Exclusions	$55
The total Joe would pay is	**$3826**

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

- **The plan's overall deductible** **$3000**
- **Specialist copayment** **$35**
- **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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1496
Co-pays	$105
Co-insurance	$0
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$1601**

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