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 1-800-288-2078 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 1-800-288-2078 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $250 person / $500 family; no coverage available for out-of-network providers unless specifically provided.	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. Generic prescription drugs and Specialty prescription drugs, in-network preventive care, in-network physician exam charges (including specialists),in-network urgent care services, in-network Physical/Speech/Occupational therapy and chiropractic care, emergency room services, in-network Inpatient Hospital Services, in-network ambulatory surgical facility charges, in-network Outpatient Hospital facility charges, in-network home health care, in-network nutritional counseling, in-network organ and tissue transplant procedures, in-network professional ambulance service, and in-network skilled nursing facility 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?	Yes. $150 person for prescription drug brand coverage. 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?	For in-network providers $3,000 person / $6,000 family; no coverage available for out-of-network providers unless specifically provided.	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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.alliedbenefit.com or call 1-800-288-2078 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	$30 copay/office visit (deductible does not apply); $20 copay/visit for chiropractic care (deductible does not apply); 0% coinsurance for other physician services.	Not Covered	Copay applies to exam charge only. Does not include office surgery. Limited to General Practice, Family Practice, OB/GYN, Internal Medicine, Osteopaths, Pediatricians, Physician Assistants, Nurse Practitioners, and Mental Health Providers. Chiropractic coverage is limited to 20 visits.
	Specialist visit	$30 copay/office visit (deductible does not apply).	Not Covered	Copay applies to exam charge only. Does not include office surgery.
	Preventive care/screening/ immunization	No charge	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)	0% coinsurance	Not Covered	*Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$15 copay/prescription (retail) $30 copay/prescription (extended retail and mail-order)		Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Separate $150 Deductible applies to brand drugs, Deductible does not apply to generic drugs. 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	$30 copay/prescription (retail) $60 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs	$45 copay/prescription (retail) $90 copay/prescription (extended retail and mail-order)		
	Specialty drugs	20% copay (up to a maximum copay of $200) per prescription (deductible does not apply)		*Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 copay per provider per day (deductible does not apply)	Not Covered	*Select surgeries must be pre-certified in order to avoid a $250 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay (deductible does not apply).		Copay waived if admitted to Hospital directly from Emergency Room
	Emergency medical transportation	$100 copay, then 0% coinsurance per transport (deductible does not apply)	$100 copay, then 0% coinsurance per transport (deductible does not apply)	None
	Urgent care	$40 copay/visit, then 0% coinsurance (deductible does not apply).	Not Covered	*Does not include labs and x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission, then 0% coinsurance (deductible does not apply)	Not Covered	Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	Not Covered	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	$30 copay/office visit (deductible does not apply); $250 copay per provider per day (deductible does not apply), then 0% coinsurance for other outpatient services.	Not Covered	None
	Inpatient services	$500 copay per admission, then 0% coinsurance (deductible does not apply)	Not Covered	Services must be pre-authorized through Allied Care Solutions in order to avoid a $250 penalty per occurrence.
If you are pregnant	Office visits	$30 copay/office visit (deductible does not apply).	Not Covered	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	0% coinsurance	Not Covered	
	Childbirth/delivery facility services	$500 copay per admission, then 0% coinsurance (deductible does not apply)	Not Covered	
If you need help recovering or have other special health needs	Home health care	$20 copay per visit, then 0% coinsurance (deductible does not apply)	Not covered	Limited to a maximum of 100 visits per calendar year.
	Rehabilitation services	$20 copay/visit (deductible does not apply)	Not Covered	Physical and occupational therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 20 visits maximum per calendar year.
	Habilitation services	$20 copay/visit (deductible does not apply)	Not Covered	

*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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	$100 copay per day, then 0% coinsurance (deductible does not apply)	Not Covered	Limited to 100 days.
	Durable medical equipment	50% coinsurance	Not Covered	Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	0% coinsurance	Not covered	Patient's life expectancy is 6 months or less.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply).	Not Covered	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 plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing Aids
- 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 (limited to 20 visits per calendar year)
- Bariatric Surgery (limited to 1 surgical procedure per Lifetime)
- Chiropractic Care (limited to 20 visits per calendar year)
- Infertility treatment (Limited to Covered Services necessary to diagnose this condition only)
- Weight Loss Programs (limited to $5,000 maximum paid per Lifetime)

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

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 1-707-469-1973 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**	**$250**
■ **Specialist copayment**	**$30**
■ **Hospital (facility) copayment**	**$500**
■ **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$810**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist copayment**	**$30**
■ **Hospital (facility) copayment**	**$500**
■ **Other coinsurance**	**0%**

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	$250
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,410**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist copayment**	**$30**
■ **Hospital (facility) copayment**	**$500**
■ **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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