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?	For in-network providers $1,000 person / $2,000 family; for out-of-network providers $3,000 person / $6,000 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. Prescription drugs, in-network preventive care, in-network physician services, in-network urgent care services (excluding facility fees), in-network minor medical services provided at retail clinics, in-network hearing exam charges, outpatient/office/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, imaging services through USIN, and emergency room 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: For in-network providers $4,000 person / $8,000 family; for out-of-network providers $6,000 person / $12,000 family Prescription Drugs: $3,150 person / $6,300 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?	Out-of-network hospice and home health care, penalties for failure to obtain precertification/preauthorization, 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	$25 copay/office visit (deductible does not apply); 20% coinsurance for chiropractic care and other physician services	40% coinsurance	Copay applies to exam charge only. Does not include office surgery. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians and mental health providers. Chiropractic coverage is limited to 20 visits.
	Specialist visit	$50 copay/office visit (deductible does not apply).	40% coinsurance	Copay applies to exam charge only. Does not include office surgery.
	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).	*Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Imaging services through US Imaging are covered at no charge.

*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	$4 copay/prescription (retail) $10 copay/prescription (mail-order)		Covers up to a 34-day supply (retail prescription); 91-day supply (extended retail and mail order prescription). Deductible does not apply. 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. After the third refill from a participating pharmacy, all maintenance medications must be filled through the Mail Order Drug Benefit.
	Preferred brand drugs	$30 copay/prescription (retail) $90 copay/prescription (mail-order)		
	Non-preferred brand drugs	$60 copay/prescription (retail) $180 copay/prescription (mail-order)		
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year Deductible and Co-Insurance Please contact Allied Benefit Systems Inc. at 1-800-288- 2078		*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	Select services must be pre-certified in order to avoid $500 penalty per occurrence.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/then 20% coinsurance (deductible does not apply)		Copay waived if admitted to hospital directly from emergency room.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Air Ambulance services must be pre-certified in order to avoid $500 penalty per occurrence.
	Urgent care	$50 copay/office visit (deductible does not apply); 20% coinsurance facility fees.	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 $500 penalty per occurrence.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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	$25 copay/office visit (deductible does not apply); 20% coinsurance for other outpatient services.	40% coinsurance	None.
	Inpatient services	20% coinsurance	40% coinsurance	Services must be pre-authorized through Allied Care Solutions in order to avoid $500 penalty per occurrence.
If you are pregnant	Office visits	$25 copay/office visit (deductible does not apply)	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 $500 penalty.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Services must be pre-certified in order to avoid $500 penalty per occurrence.
	Rehabilitation services	20% coinsurance	40% coinsurance	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 visit maximum per calendar year. Cardiac Rehabilitation is limited to 24 visits.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 100 days. Inpatient services must be pre-certified in order to avoid $500 penalty per occurrence.
	Durable medical equipment	20% coinsurance	40% coinsurance	A pre-certification penalty of $500 may apply, see Plan Document.
	Hospice services	20% coinsurance	50% coinsurance	Patient's life expectancy is 6 months or less. Inpatient services must be pre-certified in order to avoid $500 penalty per occurrence.
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.

*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)	
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care (limited to 20 visits per calendar year)
- Hearing Aids (limited to $500 per calendar year)
- Hearing exams
- Infertility treatment (except promotion of conception)
- Private-duty nursing

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 (419) 243-5848 ext. 1310 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.
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 $1000
- Specialist copayment $50
- 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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

- The plan's overall deductible $1000
- Specialist copayment $50
- 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
Prescription drug supplies *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$960**

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

- The plan's overall deductible $1000
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

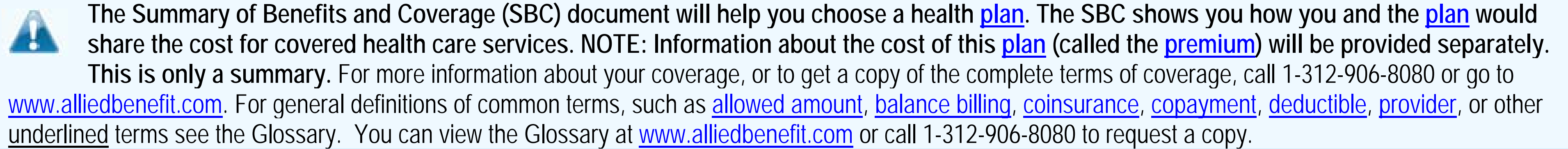
This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$400
Coinsurance	$300
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.



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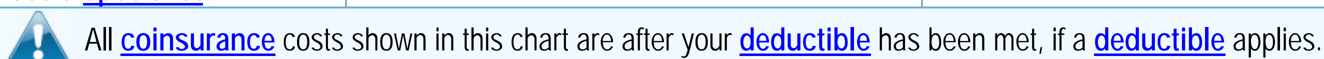
Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 person / $4,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their 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. Preventive care and services provided in a Physician's office 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,450 person / $12,900 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?	Penalties for failure to obtain precertification/preauthorization, 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?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate. Chiropractor covered up to 20 visits per year.
	Specialist visit	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
	Preventive care/screening/ immunization	No Charge (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance if done in office (deductible does not apply); 10% co-insurance if done Outpatient or Independent laboratory		*The Plan pays using the Medicare reimbursement rate.
	Imaging (CT/PET scans, MRIs)	0% co-insurance if done in office (deductible does not apply); 10% co-insurance if done Outpatient or Independent laboratory		The Plan pays using the Medicare reimbursement rate.
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% co-insurance		Covers up to a 34-day supply (retail prescription); 91-day supply (mail order prescription). *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	10% co-insurance		
	Non-preferred brand drugs	10% co-insurance		
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year Deductible and coinsurance. Please contact Allied Benefit Systems Inc. at 1-855-442-3477		*See Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Physician/surgeon fees	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you need immediate medical attention	Emergency room care	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Emergency medical transportation	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Urgent care	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
If you have a hospital	Facility fee (e.g., hospital room)	10% co-insurance		The Plan pays using the Medicare

*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)	
stay				reimbursement rate. 50% reduction penalty up to $500 if not pre-certified
	Physician/surgeon fees	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% co-insurance for office visits (deductible does not apply); 10% coinsurance for outpatient services		The Plan pays using the Medicare reimbursement rate.
	Inpatient services	10% co-insurance		The Plan pays using the Medicare reimbursement rate. 50% reduction penalty up to $500 if not pre-certified
If you are pregnant	Office visits	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate. 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 50% reduction penalty up to $500.
	Childbirth/delivery professional services	10% co-insurance		
	Childbirth/delivery facility services	10% co-insurance		
If you need help recovering or have other special health needs	Home health care	10% co-insurance		Covered up to 60 visits per calendar year. The Plan pays using the Medicare reimbursement rate.
	Rehabilitation services	0% co-insurance (deductible does not apply).		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 visit maximum per calendar year. The Plan pays using the Medicare reimbursement rate.
	Habilitation services	0% co-insurance (deductible does not apply).		
	Skilled nursing care	10% co-insurance		Covered up to 60 days per calendar year. The Plan pays using the Medicare reimbursement rate.
	Durable medical equipment	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Hospice services	10% co-insurance		Covered up to 6 months. The Plan pays using the Medicare reimbursement rate.
If your child needs	Children's eye exam	No charge (deductible does not apply).		Applied from birth through age 5. The Plan

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
dental or eye care				pays using the Medicare reimbursement rate.
	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 plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture, when used in lieu of an anesthetic in conjunction with a surgery
- Chiropractic care (limited to 20 visits 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 (419) 243-5848 ext. 1310 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.
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.*––––––––––––––––––––

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 $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$2,000
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

- The plan's overall deductible $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$2,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,660**

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

- The plan's overall deductible $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

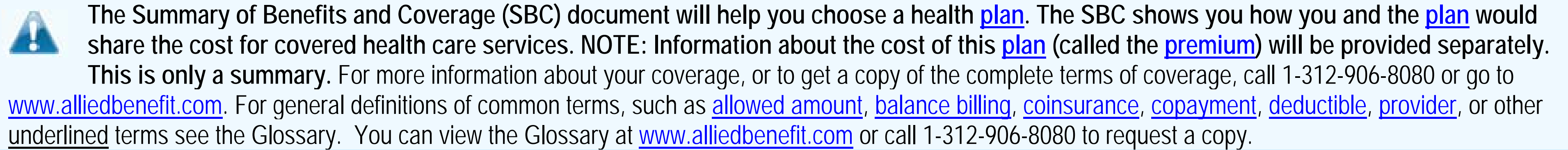
Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: The Coverage Examples above assume the patient received all care from providers accepting reimbursement in full based on the Medicare Fee Schedules. Otherwise, costs would have been higher.

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



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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% co-insurance		Limited to a combined maximum (Primary care visits and other practitioner visits) of 3 visits per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.
	Specialist visit	0% co-insurance		
	Preventive care/screening/ immunization	0% co-insurance		The Plan pays using the Medicare reimbursement rate.
If you have a test	Diagnostic test (x-ray, blood	0% co-insurance		Maximum of 2 visits per person per Calendar

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
	work)			Year. The Plan pays using the Medicare reimbursement rate.
	Imaging (CT/PET scans, MRIs)	Not covered		None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$5 co-pay (drug card); $10 co-pay (extended retail & mail-order)		Covers up to a 34-day supply (drug card prescription); 90-day supply (extended retail prescription); 91-day supply (mail-order prescription). Limited to a maximum of 12 prescriptions for retail, or a maximum of 4 prescriptions for mail order drugs, per person per Calendar Year.
	Preferred brand drugs	100% co-insurance - Discount Card only		
	Non-preferred brand drugs	100% co-insurance - Discount Card only		
	Specialty drugs	Not covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered		None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	0% co-insurance		Maximum of 2 visits (combined with Urgent Care visit maximum) per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.
	Emergency medical transportation	Not covered		None.
	Urgent care	0% co-insurance		Maximum of 2 visits (combined with Emergency room services visit maximum) per person per Calendar Year. The Plan pays using the Medicare reimbursement rate
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered		None.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered		None.
	Inpatient services			
If you are pregnant	Office visits	0% co-insurance		Limited to a combined maximum (Primary care visits and other practitioner visits) of 3 visits per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.

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)	
	Childbirth/delivery professional services	Not covered		None.
	Childbirth/delivery facility services	Not covered		None.
If you need help recovering or have other special health needs	Home health care	Not covered		None.
	Rehabilitation services	Not covered		None.
	Habilitation services			
	Skilled nursing care	Not covered		None.
	Durable medical equipment	Not covered		None.
	Hospice services	Not covered		None.
If your child needs dental or eye care	Children's eye exam	0% co-insurance		Applied from birth through age 5. The Plan pays using the Medicare reimbursement rate.
	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 plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Diagnostic imaging (CT/PET scans, MRIs)
- Durable medical equipment
- Emergency medical transportation
- Facility fees (e.g. ambulatory surgery center)
- Facility fees (e.g. hospital room)
- Glasses (Child)
- Habilitative services
- Hearing aids
- Home health care
- Hospice services
- Infertility treatment
- Long-term care
- Mental/Behavioral health outpatient services
- Mental/Behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Preferred and non-preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Substance use disorder outpatient services
- Substance use disorder inpatient services
- Weight loss programs

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

None

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 (419) 243-5848 ext. 1310 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.
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? No.
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.*––––––––––––––––––––––

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 $0
- Specialist coinsurance 0%
- Hospital (facility) coinsurance not covered
- 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,640
The total Peg would pay is	**$11,640**

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

- The plan's overall deductible $0
- Specialist coinsurance 0%
- Hospital (facility) coinsurance not covered
- 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	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,100
The total Joe would pay is	**$6,200**

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

- The plan's overall deductible $0
- Specialist coinsurance 0%
- Hospital (facility) coinsurance not covered
- Other coinsurance 0%

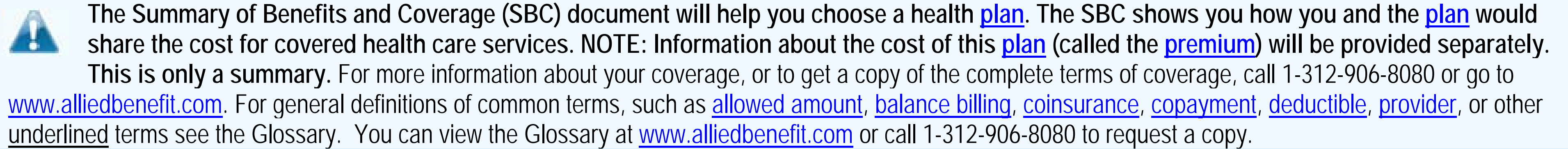
This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

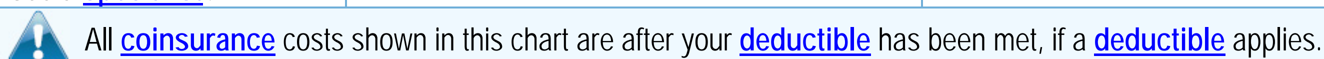
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,040
The total Mia would pay is	**$1,040**

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



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?	$2,000 person / $4,000 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. Preventive care and services provided in a Physician's office 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,450 person / $12,900 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?	Penalties for failure to obtain precertification/preauthorization, 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?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate. Chiropractor covered up to 20 visits per year.
	Specialist visit	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
	Preventive care/screening/ immunization	No Charge (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance if done in office (deductible does not apply); 10% co-insurance if done Outpatient or Independent laboratory		*The Plan pays using the Medicare reimbursement rate.
	Imaging (CT/PET scans, MRIs)	0% co-insurance if done in office (deductible does not apply); 10% co-insurance if done Outpatient or Independent laboratory		The Plan pays using the Medicare reimbursement rate.
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% co-insurance		Covers up to a 34-day supply (retail prescription); 91-day supply (mail order prescription). *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	10% co-insurance		
	Non-preferred brand drugs	10% co-insurance		
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year Deductible and coinsurance. Please contact Allied Benefit Systems Inc. at 1-855-442-3477		*See Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Physician/surgeon fees	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you need immediate medical attention	Emergency room care	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Emergency medical transportation	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Urgent care	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
If you have a hospital	Facility fee (e.g., hospital room)	10% co-insurance		The Plan pays using the Medicare

*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)	
stay				reimbursement rate. 50% reduction penalty up to $500 if not pre-certified
	Physician/surgeon fees	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% co-insurance for office visits (deductible does not apply); 10% coinsurance for outpatient services		The Plan pays using the Medicare reimbursement rate.
	Inpatient services	10% co-insurance		The Plan pays using the Medicare reimbursement rate. 50% reduction penalty up to $500 if not pre-certified
If you are pregnant	Office visits	0% co-insurance (deductible does not apply).		The Plan pays using the Medicare reimbursement rate. 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 50% reduction penalty up to $500.
	Childbirth/delivery professional services	10% co-insurance		
	Childbirth/delivery facility services	10% co-insurance		
If you need help recovering or have other special health needs	Home health care	10% co-insurance		Covered up to 60 visits per calendar year. The Plan pays using the Medicare reimbursement rate.
	Rehabilitation services	0% co-insurance (deductible does not apply).		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 visit maximum per calendar year. The Plan pays using the Medicare reimbursement rate.
	Habilitation services	0% co-insurance (deductible does not apply).		
	Skilled nursing care	10% co-insurance		Covered up to 60 days per calendar year. The Plan pays using the Medicare reimbursement rate.
	Durable medical equipment	10% co-insurance		The Plan pays using the Medicare reimbursement rate.
	Hospice services	10% co-insurance		Covered up to 6 months. The Plan pays using the Medicare reimbursement rate.
If your child needs	Children's eye exam	No charge (deductible does not apply).		Applied from birth through age 5. The Plan

*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)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
dental or eye care				pays using the Medicare reimbursement rate.
	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 plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture, when used in lieu of an anesthetic in conjunction with a surgery
- Chiropractic care (limited to 20 visits 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.

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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 $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$2,000
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

- The plan's overall deductible $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$2,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,660**

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

- The plan's overall deductible $2000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$1,800
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: The Coverage Examples above assume the patient received all care from providers accepting reimbursement in full based on the Medicare Fee Schedules. Otherwise, costs would have been higher.

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

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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% co-insurance		Limited to a combined maximum (Primary care visits and other practitioner visits) of 3 visits per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.
	Specialist visit	0% co-insurance		
	Preventive care/screening/ immunization	0% co-insurance		The Plan pays using the Medicare reimbursement rate.
If you have a test	Diagnostic test (x-ray, blood	0% co-insurance		Maximum of 2 visits per person per Calendar

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)	
	work)			Year. The Plan pays using the Medicare reimbursement rate.
	Imaging (CT/PET scans, MRIs)	Not covered		None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$5 co-pay (drug card); $10 co-pay (extended retail & mail-order)		Covers up to a 34-day supply (drug card prescription); 90-day supply (extended retail prescription); 91-day supply (mail-order prescription). Limited to a maximum of 12 prescriptions for retail, and a maximum of 4 prescriptions for mail order drugs, per person per Calendar Year.
	Preferred brand drugs	100% co-insurance - Discount Card only		
	Non-preferred brand drugs	100% co-insurance - Discount Card only		
	Specialty drugs	Not covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered		None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	0% co-insurance		Maximum of 2 visits (combined with Urgent Care visit maximum) per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.
	Emergency medical transportation	Not covered		None.
	Urgent care	0% co-insurance		Maximum of 2 visits (combined with Emergency room services visit maximum) per person per Calendar Year. The Plan pays using the Medicare reimbursement rate
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered		None.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered		None.
	Inpatient services			
If you are pregnant	Office visits	0% co-insurance		Limited to a combined maximum (Primary care visits and other practitioner visits) of 3 visits per person per Calendar Year. The Plan pays using the Medicare reimbursement rate.

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)	
	Childbirth/delivery professional services	Not covered		None.
	Childbirth/delivery facility services	Not covered		None.
If you need help recovering or have other special health needs	Home health care	Not covered		None.
	Rehabilitation services	Not covered		None.
	Habilitation services			
	Skilled nursing care	Not covered		None.
	Durable medical equipment	Not covered		None.
	Hospice services	Not covered		None.
If your child needs dental or eye care	Children's eye exam	0% co-insurance		Applied from birth through age 5. The Plan pays using the Medicare reimbursement rate.
	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 plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Diagnostic imaging (CT/PET scans, MRIs)
- Durable medical equipment
- Emergency medical transportation
- Facility fees (e.g. ambulatory surgery center)
- Facility fees (e.g. hospital room)
- Glasses (Child)
- Habilitative services
- Hearing aids
- Home health care
- Hospice services
- Infertility treatment
- Long-term care
- Mental/Behavioral health outpatient services
- Mental/Behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Preferred and non-preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Substance use disorder outpatient services
- Substance use disorder inpatient services
- Weight loss programs

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

None

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 (419) 243-5848 ext. 1310 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.
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? No.
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.*––––––––––––––––––––––

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 — $0
- Specialist coinsurance — 0%
- Hospital (facility) coinsurance — not covered
- 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,640
The total Peg would pay is	**$11,640**

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

- The plan's overall deductible — $0
- Specialist coinsurance — 0%
- Hospital (facility) coinsurance — not covered
- 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	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,100
The total Joe would pay is	**$6,200**

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

- The plan's overall deductible — $0
- Specialist coinsurance — 0%
- Hospital (facility) coinsurance — not covered
- 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,040
The total Mia would pay is	**$1,040**

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