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CYNET HEALTH

MEDICAL INSURANCE

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At Cynet, we believe that you are our most valueble asset.
Helping you and your families achieve and maintain good health-physical, emotional and financial- is the reason Cynet offers this benefits program. We are providing this overview to help you understand the benefits that are available and how to best use them. If you have any questions please email **benefits@cynethealth.com** or text us / call us: **844-442-5627**

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. 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 network providers $3,000 person / $6,000 family; no coverage available for out- of-network providers	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 exam charges (including specialists), in-network urgent care visits, second surgical opinions, in-network physical/occupational/speech therapy, in-network chiropractic care, in-network cardiac rehabilitation, in-network respiratory/pulmonary therapy, in-network acupuncture, in-network nutritional counseling, other in-network physician services, in-network outpatient/office/independent laboratory diagnostic labs & x-rays, 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?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; no coverage available for out- of-network providers	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.

Important Questions	Answers	Why This Matters:
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 **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 an injury or illness	$30 copay/office visit, deductible does not apply, and 50% 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, nurse practitioners, physician assistants, and mental health providers. Chiropractic coverage is limited to 30 visits per person per plan year. See Plan Document for other services.
	Specialist visit	$60 copay/visit, deductible does not apply	Not covered	Copay applies to exam charge only. Does not include office surgery. See Plan Document for other services.
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed 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	Not covered	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Generic drugs (Tier 1)	$15 copay/prescription (retail) $37.50 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). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the plan year. Prescription drug charges for obesity medications will be limited to a maximum payment of $5,000 per lifetime. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs (Tier 2)	$50 copay/prescription (retail) $125 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	$100 copay/prescription (retail) $250 copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	$350 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	Preauthorization is required for certain procedures. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	50% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$300 copay/visit, then 50% coinsurance (deductible does not apply)		Copay waived if admitted to the hospital directly from emergency room.
	Emergency medical transportation	50% coinsurance	Paid same as In-Network	Preauthorization is required for elective (non-emergent) transportation via ambulance or medical van and all transfers via air ambulance. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Urgent care	$100 copay/visit, deductible does not apply	Not covered	Includes all services done during the urgent care visit.

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 have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	50% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit, deductible does not apply, and 50% coinsurance for other outpatient services	Not covered	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Inpatient services	50% coinsurance	Not covered	
If you are pregnant	Office visits	$30 copay/office visit, deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a 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 a 50% reduction in benefits penalty.
	Childbirth/delivery professional services	50% coinsurance	Not covered	
	Childbirth/delivery facility services	50% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	Not covered	Limited to 30 visits per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Rehabilitation services	$30 copay/visit, deductible does not apply	Not covered	Physical, occupational, and speech therapy: limited to separate maximums of 30 visits of office and outpatient facility services per person per plan year for each therapy type.
	Habilitation services	$30 copay/visit, deductible does not apply	Not covered	

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)	
	Skilled nursing care	50% coinsurance	Not covered	Limited to 60 days per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Durable medical equipment	50% coinsurance	Not covered	Preauthorization is required for certain durable medical equipment. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Hospice services	50% coinsurance	Not covered	Preauthorization is required for inpatient hospice (except Medicare). Services must be pre-certified in order to avoid a 50% reduction in benefits 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.
	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 policy or 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)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care (limited to 30 visits per person per plan year)	• Hearing Aids (limited to maximum payment of $5,000 per person every 3 plan years; limit does not apply for ages 18 and younger) • Infertility treatment (except promotion of conception)	• Private-duty nursing (limited to 60 visits (one per day) per person per plan year) • Weight Loss Programs (non-surgical obesity treatment is limited to maximum payment of $5,000 per lifetime)

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 on how 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 (703) 349-5930 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 the 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	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$3,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$800
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$1,200
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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?	For network providers $1,500 person / $3,000 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 exam charges (including specialists), in-network urgent care visits, second surgical opinions, in-network physical/occupational/speech therapy, in-network chiropractic care, in-network cardiac rehabilitation, in-network respiratory/pulmonary therapy, in-network outpatient/office/independent laboratory diagnostic labs & x-rays, 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?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $8,000 family; for out- of-network providers $8,000 individual / $16,000 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.

Important Questions	Answers	Why This Matters:
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 **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 an injury or illness	$30 copay/office visit, deductible does not apply, and 0% coinsurance for other physician services	50% coinsurance	Copay applies to exam charge only. Does not include office surgery. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic coverage is limited to 30 visits per person per plan year. See Plan Document for other services.
	Specialist visit	$30 copay/visit, deductible does not apply	50% coinsurance	Copay applies to exam charge only. Does not include office surgery. See Plan Document for other services.
	Preventive care/screening/ immunization	No charge, deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed 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	50% coinsurance	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	$500 copay per day, deductible does not apply	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Generic drugs (Tier 1)	$15 copay/prescription (retail) $37.50 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). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the plan year. Prescription drug charges for obesity medications will be limited to a maximum payment of $5,000 per lifetime. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail) $87.50 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail) $187.50 copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	$250 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Preauthorization is required for certain procedures. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit, deductible does not apply		Copay waived if admitted to the hospital directly from emergency room.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Preauthorization is required for elective (non-emergent) transportation via ambulance or medical van and all transfers via air ambulance. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Urgent care	$100 copay/visit, deductible does not apply	50% coinsurance	Includes all services done during the urgent care visit.

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 have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit, deductible does not apply, and 0% coinsurance for other outpatient services	50% coinsurance	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Inpatient services	0% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$30 copay/office visit, deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a 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 a 50% reduction in benefits penalty.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Limited to 30 visits per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Rehabilitation services	$30 copay/visit, deductible does not apply	50% coinsurance	Physical, occupational, and speech therapy: limited to separate maximums of 30 visits of office and outpatient facility services per person per plan year for each therapy type.
	Habilitation services	$30 copay/visit, deductible does not apply	50% coinsurance	

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)	
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 60 days per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Durable medical equipment	0% coinsurance	50% coinsurance	Preauthorization is required for certain durable medical equipment. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Hospice services	0% coinsurance	50% coinsurance	Preauthorization is required for inpatient hospice (except Medicare). Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	50% coinsurance	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 policy or 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)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care

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

- Acupuncture
- Chiropractic Care (limited to 30 visits per person per plan year)
- Hearing Aids (limited to maximum payment of $5,000 per person every 3 plan years; limit does not apply for ages 18 and younger)
- Infertility treatment (except promotion of conception)
- Private-duty nursing (limited to 60 visits (one per day) per person per plan year)
- Weight Loss Programs (non-surgical obesity treatment is limited to maximum payment of $5,000 per lifetime)

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 on how 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 (703) 349-5930 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 the 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	$1,500
Specialist copayment	$30
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

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

The plan's overall deductible	$1,500
Specialist copayment	$30
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1,500
Specialist copayment	$30
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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. 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 network providers $6,000 person / $12,000 family; no coverage available for out- of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6,400 individual / $12,800 family; no coverage available for out- of-network providers	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?	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 **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 an injury or illness	0% coinsurance	Not covered	Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic coverage is limited to 30 visits per person per plan year. See Plan Document for other services.
	Specialist visit	0% coinsurance	Not covered	See Plan Document for other services.
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed 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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Generic drugs (Tier 1)	$15 copay/prescription (retail) $37.50 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). Deductible applies. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the plan year. Prescription drug charges for obesity medications will be limited to a maximum payment of $5,000 per lifetime. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail) $87.50 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail) $187.50 copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	$250 copay/prescription		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Preauthorization is required for certain procedures. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	0% coinsurance		None
	Emergency medical transportation	0% coinsurance	Paid same as In-Network	Preauthorization is required for elective (non-emergent) transportation via ambulance or medical van and all transfers via air ambulance. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Urgent care	0% coinsurance	Not covered	Includes all services done during the urgent care visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not covered	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Inpatient services	0% coinsurance	Not covered	
If you are pregnant	Office visits	0% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a 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
	Childbirth/delivery professional services	0% coinsurance	Not covered	

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)	
	Childbirth/delivery facility services	0% coinsurance	Not covered	and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a 50% reduction in benefits penalty.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Limited to 30 visits per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Rehabilitation services	0% coinsurance	Not covered	Physical, occupational, and speech therapy: limited to separate maximums of 30 visits of office and outpatient facility services per person per plan year for each therapy type.
	Habilitation services	0% coinsurance	Not covered	
	Skilled nursing care	0% coinsurance	Not covered	Limited to 60 days per person per plan year. Preauthorization is required. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Durable medical equipment	0% coinsurance	Not covered	Preauthorization is required for certain durable medical equipment. Services must be pre-certified in order to avoid a 50% reduction in benefits penalty per occurrence.
	Hospice services	0% coinsurance	Not covered	Preauthorization is required for inpatient hospice (except Medicare). Services must be pre-certified in order to avoid a 50% reduction in benefits 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.
	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 policy or 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)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care

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

- Acupuncture
- Chiropractic Care (limited to 30 visits per person per plan year)
- Hearing Aids (limited to maximum payment of $5,000 per person every 3 plan years; limit does not apply for ages 18 and younger)
- Infertility treatment (except promotion of conception)
- Private-duty nursing (limited to 60 visits (one per day) per person per plan year)
- Weight Loss Programs (non-surgical obesity treatment is limited to maximum payment of $5,000 per lifetime)

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 on how 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 (703) 349-5930 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 the 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	$6,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	$6,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

The plan's overall deductible	$6,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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, all services performed in a physician's office, outpatient physical/occupational/speech therapy, anesthesia and its interpretation, and emergency room physician care 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?	No.	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% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount. Chiropractor covered up to 20 visits per year.
	Specialist visit	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
	Preventive care/screening/ immunization	No charge (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance if done in office (deductible does not apply); 10% coinsurance if done Outpatient or Independent laboratory		The Plan pays using the Maximum Allowable Amount.
	Imaging (CT/PET scans, MRIs)	0% coinsurance if done in office (deductible does not apply); 10% coinsurance if done Outpatient or Independent laboratory		The Plan pays using the Maximum Allowable Amount.
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% coinsurance		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% coinsurance		
	Non-preferred brand drugs	10% coinsurance		
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year deductible and coinsurance. Please contact Allied Benefit Systems, LLC at 1-855-442-3477		The Plan pays using the Maximum Allowable Amount. *See Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Physician/surgeon fees	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
If you need immediate medical attention	Emergency room care	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Emergency medical transportation	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Urgent care	10% coinsurance		The Plan pays using the Maximum Allowable Amount.

*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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance		The Plan pays using the Maximum Allowable Amount. 50% reduction penalty up to $500 if not pre-certified
	Physician/surgeon fees	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance for office visits (deductible does not apply); 10% coinsurance for outpatient services		The Plan pays using the Maximum Allowable Amount.
	Inpatient services	10% coinsurance		The Plan pays using the Maximum Allowable Amount. 50% reduction penalty up to $500 if not pre-certified
If you are pregnant	Office visits	0% coinsurance (deductible does not apply).		The Plan pays using the Maximum Allowable Amount. 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% coinsurance		
	Childbirth/delivery facility services	10% coinsurance		
If you need help recovering or have other special health needs	Home health care	10% coinsurance		Covered up to 60 visits per calendar year. The Plan pays using the Maximum Allowable Amount.
	Rehabilitation services	0% coinsurance (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 Maximum Allowable Amount.
	Habilitation services	0% coinsurance (deductible does not apply).		
	Skilled nursing care	10% coinsurance		Covered up to 60 days per calendar year. The Plan pays using the Maximum Allowable Amount.

*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)	
	Durable medical equipment	10% coinsurance		The Plan pays using the Maximum Allowable Amount.
	Hospice services	10% coinsurance		Patient's life expectancy is 6 months or less. The Plan pays using the Maximum Allowable Amount.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply).		Applied from birth through age 5. The Plan pays using the Maximum Allowable Amount.
	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.

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

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 (703) 349-5930 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	$2,000
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	**$12,700**

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	$2,000
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
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

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	$2,000
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	**$2,800**

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 Maximum Allowable Amount. Otherwise, costs would have been higher.

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

Humana Dental Preventive Plus

Cynet Systems

VIRGINIA

	If you use an IN-NETWORK dentist Network: PPO/Traditional Preferred		If you use an OUT-OF-NETWORK dentist U&C 90	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,000			
Preventive services • Routine oral examinations (3 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (3 per year) • Periodontal cleanings (4 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth)	50% after deductible		50% after deductible	

More Value

Basic services

- Stainless steel crowns
- Harmful habit appliances for children

Major services

- Crowns
- Inlays and onlays
- Bridges
- Dentures
- Denture relines/rebases
- Denture repair and adjustments
- Implants
- Periodontics (gums)
- Endodontics (root canals)

Orthodontia services

- Adult and child orthodontia

These services are not covered under this plan. Members may receive a discount on non-covered services and may contact their participating provider to determine if any discounts are available on non-covered services.

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Voluntary funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	Not available	Not available
Late applicant [1]	No	12 months	Not available	Not available

1. Late applicants not allowed with open enrollment option.

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a Humana Dental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your Humana Dental Preventive Plus plan focuses on prevention and early diagnosis, providing three routine cleanings, or four periodontal cleanings, along with three routine periodic exams per calendar year.
* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth:

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* Humana Dental helps you feel good about your dental health so you can smile confidently.
* American Academy of Cosmetic Dentistry

Use your Humana Dental benefits

Find a dentist

With Humana Dental's Preventive Plus plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the Humana Dental Preventive Plus Network. To find a dentist in Humana Dental's Preventive Plus Network, log on to **Humana.com** or call 1-800-233-4013.

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Humana®

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Humana Dental Traditional Preferred

Cynet Systems

VIRGINIA

	If you use an IN-NETWORK dentist Network: PPO/Traditional Preferred		If you use an OUT-OF-NETWORK dentist U&C 90	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,500 + extended annual maximum (see section below)			
Preventive services • Routine oral examinations (3 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (3 per year) • Periodontal cleanings (4 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	80% after deductible		80% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth every 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use)	50% after deductible		50% after deductible	
Extended Annual Max Additional coverage for preventive, basic, and major services after the calendar-year maximum is met (excludes orthodontia)	30%		30%	

Orthodontia services

Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Voluntary funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	Not available
Late applicant [1, 2]	No	12 months	12 months	Not available

[1] Late applicants not allowed with open enrollment option.
[2] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

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Humana Vision 150
Cynet Systems

VIRGINIA

Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging [1]	Up to $39	Not covered
Contact lens exam options [2]		
• Standard contact lens fit and follow-up	Up to $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames [3]	$150 allowance 20% off balance over $150	$80 allowance
Standard plastic lenses [4]		
• Single vision	$10	Up to $25
• Bifocal	$10	Up to $40
• Trifocal	$10	Up to $60
• Lenticular	$10	Up to $100
Lens options [4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$0	Not covered
• Standard anti-reflective coating	$25	Up to $25
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
– Tier 1	$37	Up to $25
– Tier 2	$48	Up to $25
– Tier 3	80% of charge less $20 allowance	Up to $25
• Standard progressive (add-on to bifocal)	$10	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
– Tier 1	$75	Up to $40
– Tier 2	$85	Up to $40
– Tier 3	$100	Up to $40
– Tier 4	$55 copay, 80% of charge less $120 allowance	Up to $40
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	80% of charge	Not covered
Contact lenses [5] (applies to materials only)		
• Conventional	$150 allowance, 15% off balance over $150	$128 allowance
• Disposable	$150 allowance	$128 allowance
• Medically necessary	$0	$210 allowance

Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 12 months	Once every 12 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

• 12-month Frame Benefit	Benefit replaces the 24-month frequency of the base plan.
• Polycarbonate Lenses for Children <19	Provides for standard polycarbonate lens with $0 copay. Not available in AK, CT, ID, & OH.

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or lenses for frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members may receive 20% off the retail price.

- Members may also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Questions?

Check out **Humana.com**
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.

Humana®

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

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This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

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