The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Assured Benefits Administrators at 1-866-231-5589. 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.abadmin.com or call 1-866-231-5589 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000/individual- OR- $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. In-Network preventive care, in-network services with a copay.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$5,000/individual- OR- $10,000/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?	Copayments for certain services, Premiums, balance-billing charges, and health care this plan doesn't cover, and non-compliance penalties	These expenses do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. United Healthcare Network. Please visit www.abadmin.com or call 866-231-5589 for a list of participating providers.	This plan does not have an out-of-network benefits. Please contact Assured Benefits Administrators at www.abadmin.com 1-866-231-5589 for help finding an in-network provider.
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, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay What You Will Pay with any Provider Benefits are paid based on the Plan's Maximum Allowable Charge, generally determined based on multiplying the Medicare allowable fee by 125%	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	$15 PCP copay/visit ($0 PCP Child<19) deductible waived	None
	Specialist visit	$50 copay/visit, deductible waived	None
	Preventive care/screening/ immunization	No charge, deductible waived	Preventive Care for adults age 18 and over is not covered out-of-network. 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)	20% coinsurance after deductible	Included if rendered during the same time as an office visit (see above).
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Includes services performed in an independent laboratory or inpatient or outpatient facility or rendered in a doctor's office. Includes CT scans, PET scans, MRI, nuclear medicine, therapeutic treatments, radiation and chemotherapy.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.verus-rx.com.	Preferred generic drugs	$0 co-pay	3 months supply (90 days) Preferred generic $0 co-pay
	Preferred brand drugs	$25 co-pay	3 months supply (90 days) $65 Co-pay
	Non-preferred brand drugs	$65 co-pay	3 months supply (90 days) $165 Co-pay
	Specialty drugs	Tier 1: $0 Co-pay Tier 2: $150 Co-pay Tier 3: $500 Co-pay	Specialty medication, as defined by the VerusRx Specialty Medication List, are not a standard covered benefit. The plan reserves the right to approve any medication outside of the plan exclusions based on their discretion. Should a medication listed on the VerusRx Specialty Medication List be approved by the plan, it shall be subject to a $0 Copay for generics, $150 for preferred brands, and $500 for non-preferred brand Specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible,	Precertification required. 800-862-3338 $500 non-compliance penalty.
	Physician/surgeon fees	20% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay What You Will Pay with any Provider Benefits are paid based on the Plan's Maximum Allowable Charge, generally determined based on multiplying the Medicare allowable fee by 125%	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$300 Co-pay + deductible + 20% coinsurance	Must be a true emergency. Otherwise, no coverage.
	Emergency medical transportation	20% coinsurance after deductible	Must be a true emergency. Otherwise, no coverage
	Urgent care	$25 copay/visit, deductible waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty.
	Physician/surgeon fees	20% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty.
If you are pregnant	Office visits	20% coinsurance after deductible	None
	Childbirth/delivery professional services	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty.
	Childbirth/delivery facility services	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30 visits maximum per calendar year. One visit equals four hours or less.
	Rehabilitation services	20% coinsurance after deductible	30 visits maximum per calendar year. **Precertification required**. 800-862-3338. $500 non-compliance penalty.
	Habilitation services	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty
	Skilled nursing care	20% coinsurance after deductible	60 days maximum per calendar year. **Precertification required**. 800-862-3338. $500 non-compliance penalty.

Common Medical Event	Services You May Need	What You Will Pay What You Will Pay with any Provider Benefits are paid based on the Plan's Maximum Allowable Charge, generally determined based on multiplying the Medicare allowable fee by 125%	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	20% coinsurance after deductible	None.
	Hospice services	20% coinsurance after deductible	**Precertification required**. 800-862-3338. $500 non-compliance penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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 (25 visits/calendar year)
- Private duty nursing (Inpatient only if medically necessary)

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: the 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 your employer 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-615-6705.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-615-6705.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-615-6705.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-615-6705.

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$250
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,710

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
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
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,820

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance*]*	20%
Other coinsurance	20%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$800
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.