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, go to abadmin.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.healthcare.gov/sbc-glossary. You can also request a copy by calling 1-877-275-9787.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000** Individual Plan Year Deductible **$6,000** Family Plan Year Deductible. **Out-of-Network :** **$6,000** Individual Plan Year Deductible **$12,000** Family Plan Year Deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.**	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?	**$7,500 Individual** **$15,000 Family** **Out-of-Network:** **$15,000 Individual** **$30,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 abadmin.com or call 1-866-366-3124, for a list of network providers.	This uses a provider network. You will pay less is 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 permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay (deductible waived)	40% coinsurance after deductible	
	Specialist visit	$70 Copay (deductible waived)	40% coinsurance after deductible	
	Preventive care/screening/ Immunization Outpatient Hospital Free Standing Facility Services	$0 Copay (deductible waived) $0 Copay (deductible waived)	40% coinsurance after deductible $0 Copay (deductible waived)	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. Prior authorization is required.
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay (deductible waived)	$30 Copay (deductible waived)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance (deductible waived)	20% coinsurance (deductible waived)	Prior authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic	$10 Copay Mail Order: $25 Copay	Not Covered	Covers up to a 30-day supply. Mail order 90-day supply.
	Preferred Brand	$35 Copay Mail Order: $87.50 Copay	Not Covered	Covers up to a 30-day supply. Mail order 90-day supply.
	Non-Preferred Brand	30% up to $125 Max Mail Order 30% up to $125 Max	Not Covered	Covers up to a 30-day supply. Mail order 90-day supply.
	Specialty drugs Amwins Patient Assurance Program	50% Copay up to a $500 Max $0 Copay	Not Covered Not Covered	Covers up to a 30-day supply. Mail order 90-day supply.

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)	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Non-emergency care in an emergency room setting will not be covered.
	Non-Emergent Care rendered in an Emergency Room	Not Covered	Not Covered	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$50 Copay (deductible waived)	40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required for inpatient and outpatient treatment.
	Physician/surgeon fees	20% coinsurance after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient Office Visit	$30 Copay (deductible waived)	40% coinsurance after deductible	Prior authorization is required for outpatient facility services.
	Outpatient Facility	$30 Copay (deductible waived)	$30 Copay (deductible waived)	
	Inpatient services	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required for inpatient treatment.
If you are pregnant	Office visits	$30 Copay (deductible waived)	40% coinsurance after deductible	
	Childbirth/delivery professional services	20% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	20% coinsurance after deductible	

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 help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 30 Visits Per Plan Year. Prior authorization required.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 Days Per Plan Year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Bereavement Counseling will be covered up to 6 visits, and must be utilized within 6 months of death
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (30 visits per plan 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: the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or

Texas Capitalization Resource Group, Inc. at (972) 699-9141. 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 Assured Benefits Administrators at 1-866-366-3124 or abadmin.com or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Texas Capitalization Resource Group, Inc. at (972) 699-9141.

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Consumer Health Assistance Program, Texas Department of Insurance at (800) 252-3439.

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 1-866-3124.

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	$70
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	$3,000
Copayments	$500
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,160**

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	$70
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	$800
Copayments	$600
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	$3,000
Specialist copayment	$70
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	$2,300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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