



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 ?	<p>\$5,000 Individual Plan Year Deductible \$10,000 Family Plan Year Deductible.</p> <p>Out-of-Network : \$10,000 Individual Plan Year Deductible \$20,000 Family Plan Year Deductible</p>	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 ?	<p>\$9,100 Individual \$18,200 Family</p> <p>Out-of-Network: \$18,200 Individual \$36,400 Family</p>	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 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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 Copay (deductible waived)	50% coinsurance after deductible	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.
	<u>Specialist</u> visit	\$70 Copay (deductible waived)	50% coinsurance after deductible	
	<u>Preventive care/screening/</u> Immunization	\$0 Copay (deductible waived)	50% coinsurance after deductible	
	Outpatient Hospital Free Standing Facility Services	\$0 Copay (deductible waived)	\$0 Copay (deductible waived)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$50 Copay (deductible waived)	\$50 Copay (deductible waived)	Prior authorization required.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	30% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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	Not Covered	Not Covered	
	<u>Specialty drugs</u>	50% up to a \$500 Max	Not Covered	Covers up to a 30-day supply. Mail order 90-day supply.
	<u>Amwins Patient Assurance Program</u>	\$0 Copay	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	Prior authorization required.
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	50% coinsurance after deductible	Non-emergency care in an emergency room setting will not be covered.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	
	Urgent care	\$50 Copay (deductible waived)	50% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Prior authorization required for inpatient and outpatient treatment.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient Office Visit	\$30 Copay (deductible waived)	50% coinsurance after deductible	Prior authorization is required for outpatient facility services.
	Outpatient Facility	\$30 Copay (deductible waived)	\$30 Copay (deductible waived)	
	Inpatient services	30% coinsurance after deductible	30% coinsurance after deductible	Prior authorization required for inpatient treatment.
If you are pregnant	Office visits	\$30 Copay (deductible waived)	50% coinsurance after deductible	
	Childbirth/delivery professional services	30% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 30 Visits Per Plan Year. Prior authorization required.
	Rehabilitation services	30% coinsurance after deductible	50% coinsurance after deductible	
	Habilitation services	30% coinsurance after deductible	50% 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)	
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 Days Per Plan Year. Prior authorization required.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	
	Hospice services	30% coinsurance after deductible	50% 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 .)
<ul style="list-style-type: none"> • 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.)
<ul style="list-style-type: none"> • 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](#) \$5,000
- [Specialist](#) copayment \$70
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$600
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,460

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) copayment \$70
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,900
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,080

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) copayment \$70
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600