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 1-800-247-7114. 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 1-800-247-7114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual / $4,000 family for In-Network $4,000 individual / $8,000 family for Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You 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?	$4,000 individual / $8,000 family for In-Network $8,000 individual $16,000 family for Out- of-Network	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.	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 https://whyuhc.com/uhss or call 1-866-207-2260 for 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, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit, deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% 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 if billed with office visit **Independent / Outpatient lab**: 10% coinsurance	40% coinsurance	Includes simple lab tests and X-rays if ordered by the physician
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.verus-rx.com**	Generic drugs	Retail: $0 copay Mail: $0 copay	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: $35 copay Mail: $70 copay	Not covered	
	Non-preferred brand drugs	Retail: $75 copay Mail: $150 copay	Not covered	
	Specialty drugs	Contact Verus Path at 800-838-0007	Not covered	*Specialty medications as defined by VerusRx Specialty Medication List are not a standard covered benefit. As a solution, the plan has elected to offer advocacy services to members in need of specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260. $500 non-compliance penalty.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay, then deductible, then 10% coinsurance	$300 copay, then deductible, then 10% coinsurance	Must be a true emergency. Otherwise, no coverage.
	Emergency medical transportation	10% coinsurance	40% coinsurance	Must be a true emergency. Otherwise, no coverage.
	Urgent care	$75 copay/visit deductible does not apply	40% coinsurance	None

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	40% coinsurance	Preauthorization is required. Call 1-866-207-2260. $500 non-compliance penalty.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260. $500 non-compliance penalty.
If you are pregnant	Office visits	$25 copay deductible does not apply	40% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260. $500 non-compliance penalty.
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260. $500 non-compliance penalty.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty. Limited to 60 visits per year.
	Rehabilitation services	$50 copay deductible does not apply	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty.
	Habilitation services	$50 copay deductible does not apply	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty.
	Skilled nursing care	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty. Limited to 25 days per year.
	Durable medical equipment	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty. Limited to $1000 per year.
	Hospice services	10% coinsurance	40% coinsurance	Preauthorization is required. Call 1-866-207-2260 $500 non-compliance penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	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, Occupational Therapy, Physical Therapy, Speech-Language Pathology (60 visits/calendar year for all combined)
- 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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copay	$50
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:

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 copay	$50
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:

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

The plan's overall deductible	$2,000
Specialist copay	$50
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:

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

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**

Cost Sharing	
Deductibles	$900
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,310**