This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.abadmin.com** or by calling **888-244-5096**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	NETWORK: $3,000 single / $6,000 family maximum for in-network and out-of-network providers	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Your deductible starts over every January 1st.
Are there other deductibles for specific services?	No	Because you don't have to meet deductibles for specific services, this plan starts to cover costs sooner.
Is there an out–of–pocket limit on my expenses?	NETWORK: $5,000 single / $10,000 family maximum for in-network providers and $7,000 single / $14,000 family maximum for out-of-network providers	The out-of-pocket limit is the most you could pay during a coverage period (one calendar 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?	Penalties, Copayments, 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.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of physician and ancillary **preferred providers** please refer to the phone number or to the website on the back of you ID card.	If you use an in-network doctor or other **provider**, this plan will pay some or all of the costs of covered services. Your in-network doctor may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See page 2 for how this plan pays different **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Cost share** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **cost share** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network physician charges $1,500 for a covered service and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use EPO or PPO **providers** by charging you lower **deductibles**, **copayments** and **cost share** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% cost share	40% cost share	---None---
	Specialist visit	20% cost share	40% cost share	---None---
	Other practitioner office visit	20% cost share Spinal manipulation 20% cost share	40% cost share	12 visits per calendar year for spinal manipulation
	Preventive care/screening/immunization	No Charge for Well Adult and Well Child	Not covered	---None---
If you have a test	Diagnostic test (x-ray, blood work)	20% cost share	40% cost share	---None---
	Imaging (CT/PET scans, MRIs)	20% cost share	40% cost share	---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	20% cost share	Not covered	3 months supply (90 days) 20% co-insurance; in-network only.
	Preferred brand drugs	20% cost share	Not covered	3 months supply (90 days) 20% co-insurance; in-network only.
	Non-preferred brand drugs	20% cost share	Not covered	3 months supply (90 days) 20% co-insurance; in-network only.
	Specialty drugs	Per script 20% cost share	Not covered	---None---

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% cost share	40% cost share	The Plan calculates benefits from the Maximum Allowable Charge
	Physician/surgeon fees	20% cost share	40% cost share	---None---
If you need immediate medical attention	Emergency room services	20% cost share		The Plan calculates benefits from the Maximum Allowable Charge
	Emergency medical transportation	20% cost share		---None---
	Urgent care	20% cost share	40% cost share	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% cost share	40% cost share	Subject to post-service notification penalty (50% up to $1,000 max)
	Physician/surgeon fee	20% cost share	40% cost share	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% cost share	40% cost share	---None---
	Mental/Behavioral health inpatient services		40% cost share	Subject to post-service notification penalty (50% up to $1,000 max)
	Substance use disorder outpatient services	20% cost share	40% cost share	---None---
	Substance use disorder inpatient services	20% cost share	40% cost share	Subject to post-service notification penalty (50% up to $1,000 max)
If you are pregnant	Prenatal and postnatal care	20% cost share	40% cost share	---None---
	Delivery and all inpatient services	20% cost share	40% cost share	You must convert to a Family Plan in order to have your newborn baby's claims covered. Subject to post-service notification penalty (50% up to $1,000 max

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% cost share	40% cost share	Subject to post-service notification penalty (50% up to $1,000 max)
	Rehabilitation services	20% cost share	40% cost share	See Facility fee (e.g. hospital room) for inpatient rehabilitation services.
	Habilitation services	20% cost share	40% cost share	See Facility fee (e.g. hospital room) for inpatient habilitation services.
	Skilled nursing care	20% cost share	40% cost share	60 visits per calendar year. Subject to post-service notification penalty (50% up to $1,000 max)
	Durable medical equipment	50% cost share	40% cost share	Subject to post-service notification penalty (50% up to $1,000 max)
	Hospice service	20% cost share	40% cost share	---None---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---None---
	Glasses	Not Covered	Not Covered	---None---
	Dental check-up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Complications of a Non-covered Treatment
- Cosmetic Services and Treatment
- Dental Care
- Foreign Travel
- Family, group, marital and religious counseling
- Infertility
- Exercise programs
- TMJ Syndrome
- Surgical Sterilization Reversal

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Emergency Ambulance Service
- Prosthetics and Orthotics
- Pregnancy of Dependent Child

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-244-5096. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to file a **grievance**. A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-595-6053 or visit www.insurance.ky.gov.

For questions about your rights or assistance, you can contact:

Assured Benefits Administrators
3817 NW Expressway Suite 810
Oklahoma City, OK 73112
1-888-244-5096

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,240
- **Patient pays** $ 6,300

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,000
Copays	$0
Cost share	$300
Limits or exclusions	0
Total	**$6,300**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $908
- **Patient pays** $3, 192

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$3,000
Copays	$0
Cost share	$192
Limits or exclusions	$0
Total	**$3,192**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **cost share** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **cost share**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.