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 1-866-231-5589.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual / $3,000 family; for out-of-network providers, $2,500 individual / $7,500 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. Preventive services 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $9,000 family; for out-of-network providers, $6,000 individual / $18,000 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?	Premiums, balance-billing charges, penalties, 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 whyuhc.com/uhss or call 1-866-231-5589 for a 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.

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	$15 copay/office visit, deductible does not apply	40% coinsurance	None
	Specialist visit	$25 copay/visit, deductible does not apply	40% coinsurance	Chiropractic care limited to 35 visits per calendar year.
	Preventive care/screening/ immunization	No charge, deductible does not apply	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 (blood work)	No charge, deductible does not apply	40% coinsurance	Office visit copay may apply.
	Diagnostic test (x-ray)	No charge, deductible does not apply	40% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.verus-rx.com	Generic drugs	30-day: $10 copay/ prescription, deductible does not apply 90-day: $20 copay/ prescription, deductible does not apply	Not Covered	Covers up to a 30-day supply (retail prescriptions and specialty drugs); 31-90 day supply (90-days at retail and mail order prescriptions).
	Preferred brand drugs	30-day: $30 copay/ prescription, deductible does not apply 90-day: $60 copay/ prescription, deductible does not apply	Not Covered	
	Non-Preferred brand drugs	30-day: $50 copay/ prescription, deductible does not apply 90-day: $100 copay/ prescription, deductible does not apply	Not Covered	
	Specialty drugs	10% specialty copay up to $100 max/ prescription; deductible does not apply	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)	20% coinsurance	40% coinsurance	Preauthorization is required for some surgeries and procedures. $250 penalty if not pre-authorized.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$500 copay/visit, then 20% coinsurance	$500 copay/visit, then 20% coinsurance	Emergency room Copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground & Air
	Urgent care	$45 copay/visit, deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient hospital admissions. $250 penalty if not pre-authorized.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services (office visit)	$15 copay/office visit, deductible does not apply	40% coinsurance	Preauthorization is required for intensive outpatient and partial hospitalization. $250 penalty if not pre-authorized.
	Outpatient services (facility)	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient hospital admissions and residential treatment centers. $250 penalty if not pre-authorized.
If you are pregnant	Office visits (Primary & OBGyn)	$15 copay/office visit deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Office visits (Specialist)	$25 copay/office visit deductible does not apply	40% coinsurance	Office visit copay applies to initial visit only.

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)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Preauthorization is required for stays over 48 hours (vaginal delivery) or 96 hours (caesarean delivery). $250 penalty if not pre-authorized.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 45 visits per calendar year Preauthorization is required. $250 penalty if not pre-authorized.
	Rehabilitation services	**Office Visit:** $15 copay (PCP) / $25 copay (Specialist) deductible does not apply **Other Services:** 20% coinsurance	40% coinsurance	None
	Habilitation services			
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 45 days per calendar year Preauthorization is required. $250 penalty if not pre-authorized.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for durable medical equipment over $1,000. $250 penalty if not pre-authorized.
	Hospice services	20% coinsurance	40% coinsurance	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	$15 copay PCP $25 copay Specialist	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	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 • Dental care (Adult)	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs • Elective abortions
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (limited to 35 visits per calendar year)	• Hearing aids (limited to 1 per ear each 36-consecutive months)	• Routine eye care (Adult)

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 . 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 1-866-231-5589 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 Call Weslaco Independent School District Human Resource – 956-969-6529.

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 1-866-231-5589.

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	$1,000
Specialist copayment	$25
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	$1,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$1,000
Specialist copayment	$25
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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$1,000
Specialist copayment	$25
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	$1,000
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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