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?	**$0**	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?	Preventive care and primary care services are covered.	This plan only covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	Not applicable.
What is the out-of-pocket limit for this plan?	Not applicable.	Not applicable.
What is not included in the out-of-pocket limit?	Not applicable.	Not applicable.
Will you pay less if you use a network provider?	**Yes.** For a list of PHCS providers, visit www.phcs.com or call 1-800-922-4362.	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.**	Not covered.

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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	$10 copay	Not covered	Four visits per plan year. Copay covers ONLY the office visit.
	Specialist visit	Not covered	Not covered	Not covered under this medical plan.
	Preventive care/screening/ immunization	$0	Not covered	You have coverage for preventive care / screening / immunizations only. For an updated list, see www.healthcare.gov/what-are-my-preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	$0 (preventive laboratory test)	Not covered	You have coverage for preventive care / screening / immunizations only. For an updated list, see www.healthcare.gov/what-are-my-preventive-care-benefits.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	Not covered under this medical plan.
If you need drugs to treat your illness or condition For more information about **prescription drug coverage**, check the pharmacy plan section of your ID card.	Generic drugs	Not covered	Not covered	Not covered under this medical plan, but discount card available.
	Preferred brand drugs	Not covered	Not covered	Not covered under this medical plan, but discount card available.
	Non-preferred brand drugs	Not covered	Not covered	Not covered under this medical plan, but discount card available.
	Specialty drugs	Not covered	Not covered	Not covered under this medical plan, but discount card available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered under this medical plan.
	Physician/surgeon fees	Not covered	Not covered	Not covered under this medical plan.
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Not covered under this medical plan.
	Emergency medical transportation	Not covered	Not covered	Not covered under this medical plan.
	Urgent care	Not covered	Not covered	Not covered under this medical plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered under this medical plan.
	Physician/surgeon fees	Not covered	Not covered	Not covered under this medical plan.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Not covered under this medical plan.
	Inpatient services	Not covered	Not covered	Not covered under this medical plan.
If you are pregnant	Office visits	Not covered	Not covered	Not covered under this medical plan.
	Childbirth/delivery professional services	Not covered	Not covered	Not covered under this medical plan.
	Childbirth/delivery facility services	Not covered	Not covered	Not covered under this medical plan.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Not covered under this medical plan.
	Rehabilitation services	Not covered	Not covered	Not covered under this medical plan.
	Habilitation services	Not covered	Not covered	Not covered under this medical plan.
	Skilled nursing care	Not covered	Not covered	Not covered under this medical plan.
	Durable medical equipment	Not covered	Not covered	Not covered under this medical plan.
	Hospice services	Not covered	Not covered	Not covered under this medical plan.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	The USPSTF recommends vision screening for all children at least once between 3 to 5 years of age to detect the presence of amblyopia or its risk factors.
	Children's glasses	Not covered	Not covered	Not covered under this medical plan.
	Children's dental check-up	0% coinsurance	Not covered	Children from birth to 5 years old. The USPSTF recommends that PCPs apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
This plan includes 24/7 TeleMedicine services at no cost to you. Licensed doctors and nurses are available for you and your family 24/7. To speak with a doctor, call **800-611-5601** or visit **www.mytelemedicine.com**.				

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.)

- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Weight loss programs
- Long-term care
- Private duty nursing
- Routine eye care (adult)
- Acupuncture
- Treatment for medical conditions
- Routine foot care
- Non-emergency care when traveling outside of the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Preventive exams
- Immunizations
- Mammograms
- Routine laboratory tests
- PSA

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the U.S. Department of Labor, Employee Benefits Security Administration call 1-866-444-3272 or visit www.dol.gov/ebsa. To contact the U.S. Department of Health and Human Services, call 1-877-267-2323 x61565 or visitwww.cciio.cms.gov. 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 Assured Benefits Administrators at 1-800-247-7114.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No.
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 1-800-247-7114.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-247-7114.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-247-7114.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-247-7114.

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	$0
Specialist copay	N/A
Hospital (facility) coinsurance	N/A
Other coinsurance	N/A

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,731
The total Peg would pay is	**$12,731**

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

The plan's overall deductible	$0
Specialist copay	N/A
Hospital (facility) coinsurance	N/A
Other coinsurance	N/A

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,389
The total Joe would pay is	**$7,389**

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

The plan's overall deductible	$0
Specialist copay	N/A
Hospital (facility) coinsurance	N/A
Other coinsurance	N/A

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**

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