




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](http://www.abadmin.com) or call 1-800-247-7114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<a href="#">Preventive care</a> services are covered.	This <a href="#">plan</a> only covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	Not applicable.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	Not applicable.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	Not applicable.
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> For a list of PHCS providers, visit <a href="http://www.phcs.com">www.phcs.com</a> or call 1-800-922-4362.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	Not covered.

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Specialist</a> visit	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Preventive care/screening/immunization</a>	\$0	Not covered	You have coverage for preventive care / screening / immunizations only. For an updated list, see <a href="http://www.healthcare.gov/what-are-my-preventive-care-benefits">www.healthcare.gov/what-are-my-preventive-care-benefits</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 (preventive laboratory test)	Not covered	You have coverage for preventive care / screening / immunizations only. For an updated list, see <a href="http://www.healthcare.gov/what-are-my-preventive-care-benefits">www.healthcare.gov/what-are-my-preventive-care-benefits</a> .
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	Not covered under this medical plan.
<b>If you need drugs to treat your illness or condition</b> For more information about <a href="#">prescription drug coverage</a> , 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.
	<a href="#">Specialty drugs</a>	Not covered	Not covered	Not covered under this medical plan, but discount card available.
<b>If you have outpatient surgery</b>	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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Urgent care</a>	Not covered	Not covered	Not covered under this medical plan.
<b>If you have a hospital stay</b>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not covered	Not covered	Not covered under this medical plan.
	Inpatient services	Not covered	Not covered	Not covered under this medical plan.
<b>If you are pregnant</b>	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	Not covered under this medical plan.
	<a href="#">Hospice services</a>	Not covered	Not covered	Not covered under this medical plan.
<b>If your child needs dental or eye care</b>	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 My 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 <a href="http://www.mytelemedicine.com">www.mytelemedicine.com</a> .				

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

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

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

**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](http://www.dol.gov/ebsa). To contact the U.S. Department of Health and Human Services, call 1-877-267-2323 x61565 or visit [www.cciio.cms.gov](http://www.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](http://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, kwijijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
---------------------------	-----------------

#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
---------------------------	----------------

#### In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
---------------------------	----------------

#### In this example, Mia would pay:

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