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?	**None.** This plan has no deductible.	This plan has no deductibles, but it has limited plan year maximum benefits. See the "Limits, Exceptions & Other Important Information" section next to each covered medical event.
Are there services covered before you meet your deductible?	Not applicable. This plan has no deductible.	This plan covers some items and a copayment or coinsurance may apply. 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?	**None.** This plan has no out-of-pocket limit.	This plan has no out-of-pocket limit, but it does have limited plan year maximum benefits for all inpatient and outpatient services except for the covered preventive services listed at https://www.healthcare.gov/coverage/preventive-care-benefits/.
What is not included in the out-of-pocket limit?	Not applicable. This plan has no out-of-pocket limit.	Not applicable.
Is there an overall annual limit on what the plan pays?	**Yes.** The maximum benefit per plan year is **$10,000** per person, which includes the following: $1,500 for inpatient surgeon's fees, $300 for inpatient anesthesiologist's fees, $1,000 for outpatient benefits, $10,000 for inpatient hospital due to illness and $7,500 for inpatient hospital due to injury.	The chart starting on page 2 describes specific coverage limits.
Will you pay less if you use a network provider?	**Yes.** For a list of (Limited Benefit Plan) providers, visit www.multiplan.com or call 1-888-371-7427.	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 applicable.

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	$20 copay/office visit	Not covered	Includes simple lab tests and X-rays rendered during the same office visit. $1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Specialist visit	$20 copay/office visit	Not covered	Includes simple lab tests and X-rays rendered during the same office visit. $1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Preventive care/screening/ immunization	No charge	Not covered	Out-of-network immunizations are covered at 100% of allowable charge. Age and frequency schedules apply. For an updated list of covered preventive services, see www.healthcare.gov/what-are-my-preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	**In physician's office:** No charge **Independent/outpatient lab:** 30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
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	$10 copay	Not covered	$500 maximum combined benefit per plan year.
	Preferred brand drugs	$40 copay	Not covered	$500 maximum combined benefit per plan year.
	Non-preferred brand drugs	Not covered	Not covered	Not covered under this plan.
	Specialty drugs	Not covered	Not covered	Not covered under this 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Physician/surgeon fees	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Maximum benefit of $50 per visit and 3 visits per plan year for illnesses. Maximum benefit of $500 per visit and 2 visits per plan year for accidents. Must be a true emergency. Otherwise, no coverage.
	Emergency medical transportation	30% coinsurance	30% coinsurance	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Urgent care	$20 copay	30% coinsurance	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Maximum benefit of $500 per day.
	Physician/surgeon fees	30% coinsurance	Not covered	$1,500 maximum plan year benefit. All inpatient physician/surgeon fees are combined under this limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Inpatient services	30% coinsurance	Not covered	$10,000 maximum plan year benefit. All inpatient services are combined under this limit.
If you are pregnant	Office visits	**Initial visit:** $20 copay **All other office visits:** 30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Childbirth/delivery professional services	30% coinsurance	Not covered	$1,500 maximum plan year benefit. All inpatient physician/surgeon fees are combined under this limit.

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 are pregnant	Childbirth/delivery facility services	30% coinsurance	Not covered	Maximum benefit of $500 per day.
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	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Habilitation services	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	Skilled nursing care	Not covered	Not covered	Not covered under this medical plan.
	Durable medical equipment	30% coinsurance	Not covered	$1,000 maximum plan year benefit. All outpatient services are combined under this limit.
	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 Lyric Health 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 **866-223-8831** or visit **www.getlyric.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
- 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	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$20
Coinsurance	$3,813
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,833**

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	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$180
Coinsurance	$2,163
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,343**

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

The plan's overall deductible	$0
Specialist copay	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,425
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,425**

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