



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, call 855-897-4816. 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 <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits> or call 855-897-4816 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$500 Individual / \$1,000 Family Applies to Inpat/Outpatient facility charges (including ER) Does not apply to preventive care.	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , <a href="#">non-hospital and other</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical Limit - \$1,500 Individual \$3,000 Family per plan year Rx Limit - \$1,000 Individual \$2,000 Family per plan year	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover; and noncompliance penalties.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Not Applicable	For help finding a provider, see <a href="http://www.homesteadproviders.com">www.homesteadproviders.com</a> , or call 855-897-4816.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the plan or policy document or go to [member.medxoom.com](http://member.medxoom.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits>

Common Medical Event	Services You May Need	What You will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a>	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a>	None
	Teladoc	\$0 <a href="#">copay</a>	
	Teladoc Primary 360	\$0 <a href="#">copay</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	Urgent Care	\$30 <a href="#">copay</a>	
	Woods Health Services	\$0 <a href="#">copay</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, radiology)	\$20 <a href="#">copay</a>	None
	<a href="#">Diagnostic test</a> (lab, blood work)	\$20 <a href="#">copay</a>	
	Imaging (CT/PET scans, MRIs)	\$50 <a href="#">copay</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at your employer	Tier 1 – Preferred brands and Generics	\$5 <a href="#">copay</a> per prescription for retail up to 30-day supply	Covers up to a 30-day supply  Many oral contraceptives and contraceptive delivery devices (e.g. birth control patches) will be paid at 100% (i.e. <a href="#">copayment</a> and <a href="#">deductible</a> waived). Please see the Medical portion of your <a href="#">Plan</a> for further details on contraception
	Tier 2 - Lower Cost Brands and Generics	20% <a href="#">coinsurance</a> per prescription for retail up to 30-day supply (\$25 min to \$50 max)	
	Tier 3 - Non-Preferred Brand Drugs and Generics	30% <a href="#">coinsurance</a> per prescription for retail up to 30-day supply (\$55 min to \$80 max)	
	Mail Order	2X retail copay	

<b>If you have outpatient surgery</b>	Outpatient facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> after <a href="#">deductible</a>	Pre-certification required. Charges based on Allowable Claim Limits.
	Physician/surgeon fees	\$30 <a href="#">copay</a>	Pre-certification required. Charges based on Allowable Claim Limits.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> after deductible waived if admitted	Benefit includes all related charges. Pre-certification required if admitted for inpatient services, or no coverage will be provided. Charges based on Allowable Claim Limits. Pre-certification required for air ambulance.
	<a href="#">Emergency medical transportation</a>	No charge	
<b>If you have a hospital stay</b>	Inpatient facility fee (e.g., hospital room)	\$200 <a href="#">copay</a> after deductible	Pre-certification required. Charges based on Allowable Claim Limits.
	Physician fees	No charge	Pre-certification required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient facility services	\$30 <a href="#">copay</a>	Charges based on Allowable Claims Limits.
	Inpatient facility services	\$200 <a href="#">copay</a> after deductible	Pre-certification required, or no coverage will be provided. Charges based on Allowable Claims Limits.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copay</a> for 1 <sup>st</sup> visit	Pre-notification requested. Charges based on Allowable Claim Limits.
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery Inpatient facility services	\$200 <a href="#">copay</a> after deductible	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	Pre-certification required. Charges based on Allowable Claim Limits.
	<a href="#">Physical, Speech, Occupational Therapy</a>	\$20 <a href="#">copay</a>	Pre-certification required after 12 <sup>th</sup> visit. Charges based on Allowable Claim Limits.
	<a href="#">Skilled nursing care – Inpatient facility</a>	\$200 <a href="#">copay</a> after deductible	Coverage is limited to 180 days per calendar year max. Pre-certification required after 12 <sup>th</sup> visit. Charges based on Allowable Claim Limits.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Pre-certification required for purchase over \$1500. Charges based on Allowable Claim Limits. Manual breast pumps are covered at 100%, <a href="#">deductible</a> waived.

	<a href="#">Hospice services – Inpatient facility</a>	\$200 <a href="#">copay</a> after deductible	Pre-certification required
<b>If your child needs dental or eye care</b>	Children’s eye exam	\$10 <a href="#">copay</a>	Coverage limited to one exam/year.
	Children’s glasses	\$100 maximum	Coverage limited to one pair of glasses/year.
	Children’s dental check-up	N/A	Separate Coverage provided by employer

## 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           | • Hearing Aids                                       | • Custodial Care    |
| • Cosmetic surgery      | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Corrective Appliances | • Dental care                                        | • Long term care    |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: [insert applicable contact information from instructions].

### 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 1-888-446-3327

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 pre-natal care and a hospital delivery)

■ The yearly <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$20
■ Inpatient Facility <a href="#">copayment</a>	\$200
■ Other	\$2,650

This EXAMPLE event includes services like: [Specialist](#) office visits (*prenatal care*), Childbirth/Delivery Professional Services, Childbirth/Delivery Inpatient Facility Services, [Diagnostic tests](#) (*ultrasounds and blood work*), [Specialist](#) visit (*anesthesia*)

**Total Example Cost** **\$3,370**

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

##### Cost Sharing

Yearly Plan <a href="#">Deductibles</a> *	\$500
Inpatient Facility <a href="#">Copayments</a>	\$200
Specialty <a href="#">Copayments</a>	\$20
Other	\$0

##### What isn't covered

Limits or exclusions	\$0
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**The total Peg would pay is** **\$720**

### Managing Joe's Type 2 Diabetes

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

■ The yearly <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30
■ Inpatient Facility <a href="#">copayment</a>	\$200
■ Other	\$720

This EXAMPLE event includes services like: [Specialist](#) office visits (*including disease education*), [Diagnostic tests](#) (*blood work*), [Prescription drugs](#), [Durable medical equipment](#) (*glucose meter*)

**Total Example Cost** **\$1,450**

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

##### Cost Sharing

Yearly Plan <a href="#">Deductibles</a> *	\$0
Inpatient Facility <a href="#">Copayments</a>	\$0
Specialty <a href="#">Copayments</a>	\$120
Other	\$550

##### What isn't covered

Limits or exclusions	\$20
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**The total Joe would pay is** **\$670**

### Mia's Simple Fracture

(emergency room visit and follow up care)

■ The yearly <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30
■ Inpatient Facility <a href="#">copayment</a>	\$200
■ Other	\$175

This EXAMPLE event includes services like: [Emergency room care](#) (*includes medical supplies and diagnostic tests*) [Durable medical equipment](#) (*crutches*)

**Total Example Cost** **\$905**

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

##### Cost Sharing

Yearly Plan <a href="#">Deductibles</a> *	\$500
Inpatient Facility <a href="#">Copayments</a>	\$0
Specialty <a href="#">Copayments</a>	\$180
Other	\$200

##### What isn't covered

Limits or exclusions	\$0
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**The total Mia would pay is** **\$880**

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.