




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 visit the website: <https://www.member.medxoom.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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf> or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$1,500 individual / \$3,000 family <a href="#">Out of Network</a> : \$2,500 Individual / \$5,000 family	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care 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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	There are no other <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$4,000 individual / \$6,000 family; for <a href="#">out-of-network</a> providers \$6,000 individual / \$9,000 family	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.member.medxoom.com">www.member.medxoom.com</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.	You may see any <a href="#">specialist</a> 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$10 copay	\$20 copay	Includes diagnostic services.
	<a href="#">Specialist</a> visit	\$35 copay	\$50 copay	Includes diagnostic services
	<a href="#">Preventive care/screening/immunization</a>	100%	\$25 copay	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% after deductible	30% after deductible	None
	Imaging (CT/PET scans, MRIs)	\$75 copay (up to \$375 maximum)	\$100 copay (up to \$500 maximum)	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail: \$5 copay Mail Order: \$10 copay	N/A	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Retail: \$20 copay Mail Order: \$40 copay	N/A	
	Non-preferred brand drugs (Tier 3)	Retail: \$40 copay Mail Order: \$80 copay	N/A	
	<a href="#">Specialty drugs</a> (Tier 4)	20% coinsurance (\$100 max)	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced \$500. Outpatient Facility (DXL) covered 100%.
	Physician/surgeon fees	20% after deductible	30% after deductible	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% after deductible		Includes Physician Fee and Diagnostics. Non-Emergent use of ER is not covered.
	<a href="#">Emergency medical transportation</a>	20% after deductible		None
	<a href="#">Urgent care</a>	\$25 copay	\$50 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced \$500. Also included are miscellaneous Hospital services and supplies

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)	
				required for treatment during a Hospital confinement. Includes Inpatient Maternity Care (delivery and postpartum care).
	Physician/surgeon fees	20% after deductible	30% after deductible	Includes Inpatient Surgery. Anesthesia is paid at the same level as Surgery
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 copay	\$50 copay	Includes Autism Behavioral Therapy, Rehab and Detox office visits
	Inpatient services	20% after deductible	30% after deductible	Includes Autism Behavioral Therapy, Rehab, and Detox Inpatient. Prior authorization is required if prior authorization is not received your benefits will be reduces by \$500.
If you are pregnant	Office visits	100%	30% after deductible	Prior Authorization is not required for a Hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery.
	Childbirth/delivery professional services	20% after deductible	30% after deductible	
	Childbirth/delivery facility services	20% after deductible	30% after deductible	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% after deductible	30% after deductible	Up to 100 visits per plan year
	<a href="#">Rehabilitation services</a>	20% after deductible	30% after deductible	Rehabilitation and Habilitation services for autism are a \$35 copay per visit
	<a href="#">Habilitation services</a>	20% after deductible	30% after deductible	
	<a href="#">Skilled nursing care</a>	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced \$500. Up to 60 days per plan year.
	<a href="#">Durable medical equipment</a>	20% after deductible	30% after deductible	None
	<a href="#">Hospice services</a>	20% after deductible	30% after deductible	Includes Bereavement Counseling
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)

## 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Sex change operation

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

- Allergy injections
- Birthing Center
- Chiropractic Treatment
- Infertility treatment
- Organ Transplant
- Private-duty nursing
- Orthotics
- Prosthetic devices

**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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'

*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 in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay: \$

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$2,480

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$4,080</b>
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### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay: \$

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,489
<a href="#">Copayments</a>	\$565
<a href="#">Coinsurance</a>	\$372

<i>What isn't covered</i>	
Limits or exclusions	\$55

<b>The total Joe would pay is</b>	<b>\$2,482</b>
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay: \$

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$859
<a href="#">Copayments</a>	\$105
<a href="#">Coinsurance</a>	\$215

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$1,179</b>
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