Axiom Staffing Group, Inc. Employee Benefit Plan

Coverage Period: 1/1/2021 – 12/31/2021

Summary of Benefits and Coverage: What this Plan Covers and What it Costs

Coverage For: Employee, Spouse, Children | Plan Type: Preventive Plus Plan (Minimum Essential Coverage)

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, please call: 888-820-5687. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call: 888-820-5687 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall Deductible?	$0	See the chart starting on Page 2 for your costs for services this Plan covers.
Are there services covered before you meet your Deductible?	Yes. This Plan does not include any Deductibles.	This Plan does not contain any services to which a Deductible must be met. Note the chart starting Page 2 for other costs for services this Plan covers.
Are there other Deductibles for specific services?	No	You don't have to meet Deductibles for specific services. Note the chart starting Page 2 for other costs for services this Plan covers.
What is the Out–of–Pocket Limit for this Plan?	This is a limited benefit plan that does not include an Out-of-Pocket maximum benefit.	This is a limited benefit Plan, therefore, note the covered benefits and the limitations for those benefits.
What is not included in the Out–of–Pocket Limit?	This is a limited benefit plan that does not include an Out-of-Pocket maximum benefit.	This is a limited benefit Plan that does not include an out-of-pocket maximum benefit.
Will you pay less if you use a Network Provider?	Yes. See the First Health, Limited Benefit Plan, Network at: www.firsthealthlbp.com or call 1-800-226-5116.	The Plan utilizes the First Health Network. Providers not included in the First Health Network are not covered by the Plan. Be aware, your in-network doctor or hospital may use an out-of-network Provider for some services.
Do you need a Referral to see a Specialist?	No. Specialist are not covered by the Plan.	Specialists are not covered by the Plan.

(DT-OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL-OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS-OMB control number: 0938-1146/Expiration date: 10/31/2022)

All Copayment and Coinsurance costs shown in this chart are after 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	$25 for First Health, Limited Benefit Plan Providers	Not Covered, you pay 100%	Visit limit of three (3) per Benefit Year per Plan Member. Applies to the primary care physician's office visit charge only. All other services performed in the office are not covered by the Plan. Primary Care Physicians include areas of: General Pediatrics, Internal Medicine, OB/Gynecology, Family Practice, and General Medicine.
	Specialist visit	Not Covered, you pay 100%	Not Covered, you pay 100%	Services provided by a Specialist are not covered by the Plan.
	Preventive Care/ Screening/ Immunization	$0, Plan pays 100%	Not Covered, you pay 100%	Preventive Care Services performed by a First Health, Limited Benefit Plan, Provider and required by the Patient Protection and Affordable Care Act are covered by the Plan. Ask your Provider if the services you need are Preventive, then review the benefits of your Plan for covered services.
If you have a test:	Diagnostic Test (x-ray, blood work)	Not Covered, you pay 100%	Not Covered, you pay 100%	Not Covered by the Plan.
	Imaging (CT/PET scans, MRIs)	Not Covered, you pay 100%	Not Covered, you pay 100%	

*For more information about limitations and exceptions, see the Plan or policy document from your human resource office.

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 drugs to treat your illness or condition: More information about Prescription Drug Coverage is available on the back of the Plan Member's ID Card, to include the participating pharmacy network name, phone number and website.	Generic drugs	20% per Prescription. $0 for ACA required Preventive Prescriptions	Not Covered, you pay 100%	Limit of 12 generic Prescriptions per Benefit Year per Plan Member. Retail only up to 30-day supply. Mail Order is not covered by the Plan. Generic Preventive Prescriptions required by the Patient Protection and Affordable Care Act are paid at 100% for participating pharmacies with no limit to the number of Prescriptions filled. All Prescriptions must be included on the participating pharmacy network's formulary of approved prescription drugs.
	Preferred brand drugs	Not Covered, you pay 100%	Not Covered, you pay 100%	
	Non-preferred brand drugs	Not Covered, you pay 100%	Not Covered, you pay 100%	
	Specialty Drugs	Not Covered, you pay 100%	Not Covered, you pay 100%	
If you have outpatient surgery:	Facility fee (e.g., hospital room)	Not Covered, you pay 100%	Not Covered, you pay 100%	Outpatient surgery is Not Covered by the Plan.
	Physician/surgeon fees	Not Covered, you pay 100%	Not Covered, you pay 100%	Outpatient surgeon or Physician fee for surgery is Not Covered by the Plan.
If you need immediate medical attention:	Emergency Room Care	Not Covered, you pay 100%	Not Covered, you pay 100%	Services listed are Not Covered by the Plan.
	Emergency Medical Transportation	Not Covered, you pay 100%	Not Covered, you pay 100%	
	Urgent Care	Not Covered, you pay 100%	Not Covered, you pay 100%	
If you have a hospital stay:	Facility fee (e.g., hospital room)	Not Covered, you pay 100%	Not Covered, you pay 100%	Hospital stays are Not Covered by the Plan.
	Physician/surgeon fees	Not Covered, you pay 100%	Not Covered, you pay 100%	Physician visits/fees in the Hospital are Not Covered by the Plan.
If you need mental health, behavioral health, or substance abuse services:	Outpatient services	Not Covered, you pay 100%	Not Covered, you pay 100%	Unless provided by the Preventive Care Services and required by the Patient Protection and Affordable Care Act, services are not covered.
	Inpatient services	Not Covered, you pay 100%	Not Covered, you pay 100%	
If you are pregnant:	Office visits	Not Covered, you pay 100%	Not Covered, you pay 100%	Unless provided by the Preventive Care Services and required by the Patient Protection and Affordable Care
	Childbirth/delivery professional services	Not Covered, you pay 100%	Not Covered, you pay 100%	

*For more information about limitations and exceptions, see the Plan or policy document from your human resource office.

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)	
	Childbirth/delivery facility services	Not Covered, you pay 100%	Not Covered, you pay 100%	Act or is a Primary Care Physician office visit charged outside of the global fee (see Physician Office Visit benefit for details), services are not covered.
If you need help recovering or have other special health needs	Home Health Care	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
	Rehabilitation Services	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
	Habilitation Services	Not Covered, you pay 100%	Not Covered, you pay 100%	
	Skilled Nursing Care	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
	Durable Medical Equipment	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
	Hospice Services	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
If your child needs dental or eye care	Children's eye exam	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan, unless service is for a child vision acuity test performed in the Primary Care Physicians office for Preventive.
	Children's glasses	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.
	Children's dental check-up	Not Covered, you pay 100%	Not Covered, you pay 100%	Not covered by the Plan.

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other Excluded Services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency Care (Outside the U.S.)
- Adult Routine Eye Care
- Diagnostic Tests

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

- Primary Care Physician Office Visits
- Generic Prescriptions
- Preventive Prescriptions
- Adult and children Preventive Care Services required by the Patient Protection and Affordable Care Act

*For more information about limitations and exceptions, see the Plan or policy document from your human resource office.

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 your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at: 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at: 877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are 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 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 the Plan at 888-820-5687.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **Plan**, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 888-820-5687. A claimant may submit a written request for a review of the denied claim within sixty (60) days after receipt of written notification of denial and he/she may review any pertinent documents. Any issues and comments to be considered must be in writing and delivered to the **Plan**'s Program Manager. The Program Manager will submit all information to the **Plan** administrator.

The **Plan** administrator will make a decision with regard to such claim not later than sixty (60) days after the receipt of the request for review, unless special circumstances necessitate an extension of time. If such an extension is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial sixty (60) day period. The extension notice will explain the special circumstances requiring an extension and the date the **Plan** expects to render to the decision which will be within one hundred twenty (120) days. The decision on review will be in writing, will include the specific reason for the decision, and will reference the pertinent provisions on which the decision is based.

You are covered under a Self-Funded Employer Health **Plan**. Your employer makes contributions to cover your medical expenses. The employer determines what benefits are paid, such as **Deductible, Coinsurance** and PPO network. The employer at all times responsible for funding the **Plan** to pay claims and for tax reporting.

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 Coverage Meet the Minimum Value Standard? 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.**

*For more information about limitations and exceptions, see the **Plan** or policy document from your human resource office.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al: 855-212-9544
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: 855-212-9544
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: 855-212-9544
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': 855-212-9544

To see examples of how this **Plan** might cover costs for a sample medical situation, see the next page.

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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.

Having a Baby
(9 months of First Health in-network, pre-natal care and a hospital delivery)

■ The Plan's overall Deductible	$0
■ Specialist Copayment	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	**$12,700**

In this example, Plan Member would pay:

Cost Sharing	
Deductibles	$0
Copayments	$25
Coinsurance	$7
What isn't covered	
Limits or exclusions	$12,636
The total the Plan Member would pay is	**$12,668**

Managing Type 2 Diabetes
(a year of routine First Health in-network care of a well-controlled condition)

■ The Plan's overall Deductible	$0
■ Specialist Copayment	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	**$5,600**

In this example, Plan Member would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$75
Coinsurance	$135
What isn't covered	
Limits or exclusions	$4,391
The total the Plan Member would pay is	**$4,601**

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

■ The Plan's overall Deductible	$0
■ Specialist Copayment	$0
■ 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	**$2,800**

In this example, Plan Member would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total the Plan Member would pay is	**$2,800**

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