



T&D Moravits & Company

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
T&D Moravitz & Company, LLC Health Benefit Plan: Medical Plan


Coverage Period: 07/01/2026-6/30/2027
Coverage for: EE/EE+SP/EE+CH(n)/FAM | Plan Type: EPO



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 CAS customer service at 855-373-8232. 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.casbenefits.com or call 855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>Tier 1 DPC or DPC Referred Provider:</u> \$0 individual/ \$0 family</p> <p><u>Tier 2 Network Provider - First Health:</u> \$5,000 individual / \$10,000 family</p> <p><u>Tier 3 Non-Network Provider:</u> Not Covered</p>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	There is no additional <u>deductible</u> amount you must meet before this <u>plan</u> begins to pay for specific services.
What is the out-of-pocket limit for this plan?	<p><u>Tier 1 DPC or DPC Referred Provider:</u> \$0 individual/ \$0 family</p> <p><u>Tier 2 Network Provider - First Health:</u> \$5,000 individual / \$10,000 family</p> <p><u>Tier 3 Non-Network Provider:</u> Not Covered</p>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.casbenefits.com or call 855-373-8232 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your

Important Questions	Answers	Why This Matters:
		<u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No, you do not need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

 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
		Tier 1 DPC or DPC Referred Provider (You will pay the least)	Tier 2 Network Provider First Health (You pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	100% covered, <u>deductible</u> waived	\$50 <u>copay</u> /visit then 100% covered, <u>deductible</u> waived	Not Covered	
	<u>Specialist</u> visit	100% covered, <u>deductible</u> waived	\$75 <u>copay</u> /visit then 100% covered, <u>deductible</u> waived	Not Covered	
	<u>Preventive care/screening/immunization</u>	100% covered, <u>deductible</u> Waived		Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
	Imaging (X-ray, CT/PET scans, MRIs)	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required
If you need drugs to treat your illness or condition	Tier 1 - Preferred Brands & Generics	\$0 <u>copay</u> / prescription	\$15 <u>copay</u> / prescription, <u>deductible</u> waived	Not Covered	Preventive drugs: No charge 30 day supply (retail)

* For more information about limitations and exceptions, see the plan or policy document at www.casbenefits.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 DPC or DPC Referred Provider (You will pay the least)	Tier 2 Network Provider First Health (You pay more)	Non-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.usrxcare.com	Tier 2 - Lower Cost Brands & Generics	\$0 <u>copay</u> / prescription	\$50 <u>copay</u> / prescription, deductible waived	Not Covered	prescription); 90 day supply (mail order prescription)
	Tier 3 - Non-Preferred Brands & Generics	\$0 <u>copay</u> / prescription	\$250 <u>copay</u> / prescription, deductible waived	Not Covered	DAW provisions apply
	Tier 4 - Specialty	\$0 <u>copay</u> / prescription	\$250 <u>copay</u> / prescription, deductible waived	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required.
	Physician/surgeon fees	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	100% after \$5,000 <u>deductible</u>	100% after <u>deductible</u>	100% after <u>deductible</u>	
	<u>Emergency medical transportation</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	100% after <u>deductible</u>	
	<u>Urgent care</u>	100% covered, <u>deductible</u> waived	\$250 copay/visit, then 100% covered <u>deductible</u> waived	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
	Physician/surgeon fees	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
	Inpatient services	100% after <u>deductible</u>	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required for Hospital Facility

* For more information about limitations and exceptions, see the plan or policy document at www.casbenefits.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 DPC or DPC Referred Provider (You will pay the least)	Tier 2 Network Provider First Health (You pay more)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visit	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Global Maternity	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
	Childbirth/delivery birthing center facility services and hospital facility services	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 60 visits per calendar year
	<u>Rehabilitation /Habilitation services</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	
	Occupational Therapy	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>		Limited to 60 visits per year combined for Physical Therapy, Speech Therapy and Occupational Therapy.
	<u>Skilled nursing care</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	Preauthorization required for DME over \$500.
	<u>Hospice services</u>	100% covered, <u>deductible</u> waived	100% after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 60 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered			
	Children's glasses	Not covered			
	Children's dental check-up	Not covered			

* For more information about limitations and exceptions, see the plan or policy document at www.casbenefits.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.)

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|---|--|---|
| <ul style="list-style-type: none">• Cosmetic Surgery• Hearing Aids• Dental Care (Adult) | <ul style="list-style-type: none">• Long Term Care• Non-emergency care when traveling outside the U.S.• Routine Eye Care (Adult) | <ul style="list-style-type: none">• Private Duty Nursing• Routine Foot Care• Bariatric Surgery• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---|---|---|
| <ul style="list-style-type: none">• Chiropractic Services (Limited to 15 visits per Calendar year.) | <ul style="list-style-type: none">• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) | <ul style="list-style-type: none">• Acupuncture (Limited to 15 visits per Calendar year.) |
|---|---|---|

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/ebsa/healthreform>. 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: 1-855-373-8232

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 855-373-8232

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 \$5,000
- Specialist copayment \$75
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$75
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,075

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$5,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$5,000
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$5,050

Mia's Simple Fracture

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

- The plan's overall deductible \$5,000
- Emergency Room copayment 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$5,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$5,000

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