



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 wellaway.com/en/studentplans/ or by calling 1-855-773-7810. 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.healthcare.gov/sbc-glossary/ or call 1-855-773-7810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For each Plan Year, In- Network : individual \$450 Out-of-Network: individual \$500.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. In- network office visits & preventive care and prescription drugs are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In- Network : individual \$5,000. Out-of-Network: individual: \$5,500	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.wellaway.com or call 1-855-773-7810 for a list of network providers .	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.	You can see the specialist you choose 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
		In-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 /visit	50% coinsurance	None
	Specialist visit	\$20 copay /visit	50% coinsurance	None
	Preventive care/screening/immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellaway.com	Generic drugs	\$15 copay /prescription deductible doesn't apply	50% coinsurance after \$15 copay /prescription deductible doesn't apply	Covers 30 day supply (retail). 31-90 day supply may be available. Includes contraceptive drugs & devices obtainable from a pharmacy. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Prescriptions above \$250 require Preauthorization . Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Preferred brand drugs	\$40 copay /prescription deductible doesn't apply	50% coinsurance after \$40 copay /prescription deductible doesn't apply	
	Non-preferred brand drugs	\$75 copay /prescription deductible doesn't apply	50% coinsurance after \$75 copay /prescription deductible doesn't apply	
	Specialty drugs	\$100 copay /prescription deductible doesn't apply	50% coinsurance after \$100 copay /prescription deductible doesn't apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance , after \$100 copay /visit deductible doesn't apply	50% coinsurance , after \$100 copay /visit deductible doesn't apply	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellaway.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$200 copay /visit (waived if admitted)	\$200 copay /visit (waived if admitted)	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$50 copay /visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required for non-maternity/non-accidental condition. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /visit (office visit), 20% coinsurance (other outpatient services)	50% coinsurance (office visit and other outpatient services)	Preauthorization required for other outpatient services and inpatient services. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Within 14 days from discharge. Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Rehabilitation services	20% coinsurance	50% coinsurance	Out-of-Network-40 visit limit for physical therapy (outpatient). Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellaway.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	20% coinsurance	50% coinsurance	Out-of-Network-40 visit limit for physical therapy (outpatient). Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Coverage limited to one exam/ plan year up to age 19.
	Children's glasses	No charge	50% coinsurance	Coverage limited to one pair of glasses or lenses/ plan year up to age 19.
	Children's dental check-up	No charge	50% coinsurance	Limited to 2 exams per policy year.

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Routine eye care (Adult) | <ul style="list-style-type: none"> • Routine foot care –except for required diabetic care • Weight loss programs -except for required preventive services |
|---|---|---|

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

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture – limited to 15 visits combined with other alternative care services • Bariatric surgery – lifetime maximum 1 per covered person | <ul style="list-style-type: none"> • Chiropractic care- limited to 15 visits per benefit period • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing – inpatient only |
|---|--|---|

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellaway.com.

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: U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.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 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: WellAway Limited at 1-855-773-7810.

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? Not applicable.

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 1-855-773-7810.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-773-7810.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-773-7810.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-773-7810.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$450
- [Specialist copayment](#) \$20
- 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*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$40
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,890

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$450
- [Specialist copayment](#) \$20
- 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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$100
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,550

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$450
- [Specialist copayment](#) \$20
- 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*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$200
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150

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