Coverage Period: 01/01/2020 – 12/31/2020 Coverage for: Individual/Family | Plan Type: PPO

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, [insert contact information]. 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.wellaway.com or call 1-855-773-7810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers \$2,500/Individual or \$5,000/family; Out-of-network providers \$5,000 individual or \$10,000 family (does not apply to preventive care).	Generally, you must pay all of the costs from providers 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For network providers \$5,000 individual / \$10,000 family; for out-of-network providers \$10,000 individual / \$20,000 family	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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="www.wellaway.com">www.wellaway.com</a> or call 1-855-773-7810 for a list of <a href="metwork providers">network providers</a> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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 <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this <u>plan</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you visit a health	Primary care visit to treat an injury or illness	\$25 copay/visit	Deductible then 50% coinsurance	None	
	Specialist visit	\$45 <u>copay</u> /visit	Deductible then 50% coinsurance	None	
care <u>provider's</u> office or clinic	Other practitioner office visit	\$45 <u>copay</u> /visit	Deductible then 50% coinsurance	Chiropractic 15 visit limit applies.	
	Preventive care/screening/immunization	No charge	Not Covered	No cost share	
	Diagnostic test (x-ray, blood work)	\$55 <u>copay</u>	Deductible then 50% coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	\$105 <u>copay</u> /test	Deductible then 50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.	
If you need drugs to treat your illness or condition  More information about prescription drug	Generic drugs	\$10 copay/prescription	Not covered		
	Preferred brand drugs	\$25 copay/prescription	Not covered	<u>Preauthorization</u> required. Failure to obtain <u>preauthorization</u> may result in denied coverage	
	Non-preferred brand drugs	\$55 copay/prescription	Not covered	or payment for the drug.	
coverage is available at www.wellaway.com	Specialty drugs	\$105 copay/prescription	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage	
surgery	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 50% coinsurance	or up to \$500 USD penalty.	
If you need immediate medical attention	Emergency room care	\$255 <u>copay</u>	\$255 <u>copay</u>		
	Emergency medical transportation	\$105 <u>copay</u>	\$105 <u>copay</u>	None	
	<u>Urgent care</u>	\$55 <u>copay</u>	\$105 <u>copay</u>		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization required for non-maternity/non-accidental condition. Failure to	
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 50% coinsurance	obtain preauthorization may result in denied coverage or up to \$500 USD penalty.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://portal.wellaway.com/login

If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services  Mental/Behavioral health inpatient services  Inpatient services	\$45 copay/visit  Deductible then 20% coinsurance Deductible then 20%	Deductible then 50% coinsurance Deductible then 50% coinsurance Deductible then 50%	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.
If you are pregnant	Office visits  Childbirth/delivery professional services Childbirth/delivery facility services	Coinsurance  No charge  Deductible then 20%  Coinsurance  \$305 copay	coinsurance  Deductible then 50% coinsurance  Deductible then 50% coinsurance  Deductible then 50% coinsurance  Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Home health care	20% coinsurance	50% coinsurance	Following 14 days from discharge.  Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.
If you need help recovering or have other special health needs	Rehabilitation services	\$35 <u>copay</u> /visit	Deductible then 50% coinsurance	20 visit limit applies.
	Habilitation services	\$35 <u>copay</u> /visit	Deductible then 50% coinsurance	20 visit limit applies.
	Skilled nursing care	\$255 <u>copay</u> /day	Deductible then 50% coinsurance	\$765 Copay Limit. Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.
If your child needs dental or eye care	Children's eye exam	No charge	Deductible then 50% coinsurance	Coverage limited to one exam/year.
	Children's glasses	No charge	Deductible then 50% coinsurance	Limited to one pair of glasses per year.  Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.
	Children's dental check-up	No charge	Deductible then 50% coinsurance	Limited to 2 exams per policy year.

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://portal.wellaway.com/login

### **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 aid

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (with exception of diabetic care)
- Weight loss programs

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

- Bariatric surgery (lifetime maximum 1 per participant)
- Chiropractic care (limited to 15 each calendar year)
- Private-duty nursing (inpatient) only if:
  - 1. Place in an intensive or coronary unit, but the hospital does not have such facilities;
  - 2. The hospital's intensive or coronary unit cannot provide the level of care necessary for the participant's condition.
  - 3. The private duty nurse is not employed

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 <a href="https://www.dol.gov/ebsa">www.dol.gov/ebsa</a>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="https://www.HealthCare.gov">Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet 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 1-855-773-7810.

[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, kwiijigo holne' 1-855-773-7810.

-To see examples of how this plan might cover costs for a sample medical situation, see the next section.

## **About these Coverage Examples:**



**Total Example Cost** 

**This is not a cost estimator.** Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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)

In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$500	
Copayments	\$300	
Coinsurance	\$2,300	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,160	

\$12,800

# **Managing Joe's type 2 Diabetes**

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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** 

In this example, Joe would pay:			
Cost Sharing			
Deductibles*	\$800		
Copayments	\$1,200		
Coinsurance	\$300		
What isn't covered			
Limits or exclusions	\$60		
The total Joe would pay is	\$2,360		

\$7,400

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500	
■ Specialist copayment	\$50	
■ 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** 

In this example, Mia would pay:			
Cost Sharing			
Deductibles*	\$700		
Copayments	\$50		
Coinsurance	\$300		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,050		

\$1,900