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 <u>deductible</u> ?	Network providers \$3,500/Individual or \$7,000/family; Out-of-network providers individual or \$14,000 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 <u>deductible?</u>	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</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
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> limit for this <u>plan</u> ?	For <u>network providers</u> \$7,150 individual / \$14,300 family; for <u>out-of-network providers</u> \$14,300 individual / \$28,600 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 <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <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 <u>network provider</u> ?	Yes. See <u>www.wellaway.com</u> or call 1-855-773-7810 for a list of <u>network providers</u> .	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</u> <u>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 specialist you choose without permission from this plan.

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

Common		What Y	ou 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 care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /office visit	Deductible	None	
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	Deductible	None	
	Other practitioner office visit	\$35 copay/visit	Deductible	Physical and Speech Therapy.	
	Preventive care/screening/ immunization	No charge	Not Covered	No cost share	
	Diagnostic test (x-ray, blood work)	\$60 <u>copay</u> /test	Deductible	None	
If you have a test	Imaging (CT/PET scans, MRIs)	\$110 <u>copay</u> /test	Deductible	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	Generic drugs	\$15 copay/prescription	Not covered		
condition More information about	Preferred brand drugs	\$30 copay/prescription	Not covered	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or payment for the drug.	
prescription drug coverage is available at	Non-preferred brand drugs	\$60 copay/prescription	Not covered		
www.wellaway.com	Specialty drugs	\$110 copay/prescription	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$260 copay	Deductible	Preauthorization required. Failure to obtain preauthorization may result in denied coverage	
surgery	Physician/surgeon fees	\$260 copay	Deductible	or up to \$500 USD penalty.	
	Emergency room care	\$260 <u>copay</u>	Deductible	-	
If you need immediate medical attention	Emergency medical transportation	\$110 <u>copay</u>	Deductible	None	
	Urgent care	\$60 <u>copay</u>	Deductible		
If you have a hospital	Facility fee (e.g., hospital room)	Deductible	Deductible	Preauthorization_required for non- maternity/non-accidental condition. Failure to	
stay	Physician/surgeon fees	Deductible	Deductible	obtain preauthorization may result in denied coverage or up to \$500 USD penalty.	

If you need mental health, behavioral	Mental/Behavioral health outpatient services	\$50 <u>copay</u> /office visit	Deductible	Preauthorization required. Failure to obtain preauthorization may result in denied coverag or up to \$500 USD penalty.	
health, or substance abuse services	Mental/Behavioral health inpatient services	Deductible	Deductible		
	Inpatient services	Deductible	Deductible		
	Office visits	\$65 copay	Deductible		
If you are pregnant	Childbirth/delivery professional services	\$310 copay	Deductible	None	
	Childbirth/delivery facility services	\$310 copay	Deductible		
	Home health care	\$175 copay/day	Deductible	Following 14 days from discharge. <u>Preauthorization</u> required. Failure to obtain <u>preauthorization</u> may result in denied coverage or up to \$500 USD penalty.	
If you need help	Rehabilitation services	\$35 copay/office visit	Deductible	20 visit limit applies.	
If you need help	Habilitation services	\$35 copay/office visit	Deductible	20 visit limit applies.	
recovering or have other special health needs	Skilled nursing care	\$175 copay/day	Deductible	\$765 Copay Limit. <u>Preauthorization</u> required. Failure to obtain <u>preauthorization</u> may result in denied coverage or up to \$500 USD penalty.	
	Durable medical equipment	\$110 copay	Deductible	None	
	Hospice services	Inpatient: no charge after deductible Outpatient : No charge after deductible	Deductible	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to \$500 USD penalty.	
	Children's eye exam	No charge	Deductible	Coverage limited to one exam/year.	
If your child needs dental or eye care	Children's glasses	No charge	Deductible	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	Limited to 2 exams per policy year.	

Excluded Services & Other Covered Services:		
Services Your Plan Generally Does NOT Cover	Check your policy or <u>plan</u> document for more information	ion and a list of any other <u>excluded services</u> .)
 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 <u>plan</u> 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.
		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: [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 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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.—



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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,500 \$80 0% 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,500 \$0 0% 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,50 \$0 0% 0%
This EXAMPLE event includes service Specialist office visits (prenatal care) Childbirth/Delivery Professional Services		This EXAMPLE event includes service Primary care physician office visits (inclu disease education) Diagnostic tests (blood work)		This EXAMPLE event includes servi Emergency room care (including medi supplies) Diagnostic test (x-ray)	
Diagnostic tests (ultrasounds and blood v	work)	Prescription drugs Durable medical equipment (glucose me	ter)	Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical thera</i>)	
Diagnostic tests (ultrasounds and blood v	work) \$12,800	Prescription drugs	ter) \$7,400	Durable medical equipment (crutches)	
		Prescription drugs Durable medical equipment (glucose me Total Example Cost	,	Durable medical equipment (crutches) Rehabilitation services (physical thera Total Example Cost	oy)
Diagnostic tests (<i>ultrasounds and blood v</i> Specialist visit (<i>anesthesia</i>) Total Example Cost In this example, Peg would pay:		Prescription drugs Durable medical equipment (glucose me Total Example Cost In this example, Joe would pay:	,	Durable medical equipment (crutches) Rehabilitation services (physical thera Total Example Cost In this example, Mia would pay:	o <i>y</i>)
Diagnostic tests (<i>ultrasounds and blood</i>) Specialist visit (<i>anesthesia</i>) Total Example Cost	\$12,800	Prescription drugs Durable medical equipment (glucose me Total Example Cost	\$7,400	Durable medical equipment (crutches) Rehabilitation services (physical thera Total Example Cost	oy) \$1,900
Diagnostic tests (<i>ultrasounds and blood v</i> Specialist visit (<i>anesthesia</i>) Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles	\$12,800 \$3,500	Prescription drugs Durable medical equipment (glucose me Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles*	\$7,400 \$3,500	Durable medical equipment (crutches) Rehabilitation services (physical thera Total Example Cost In this example, Mia would pay: Cost Sharing Deductibles*	sy) \$1,900 \$3,500
Diagnostic tests (<i>ultrasounds and blood v</i> Specialist visit (<i>anesthesia</i>) Total Example Cost In this example, Peg would pay: Cost Sharing	\$12,800	Prescription drugs Durable medical equipment (glucose me Total Example Cost In this example, Joe would pay: Cost Sharing	\$7,400	Durable medical equipment (crutches) Rehabilitation services (physical therap Total Example Cost In this example, Mia would pay: Cost Sharing	oy) \$1,900
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Diagnostic tests (<i>ultrasounds and blood</i> of Specialist visit (<i>anesthesia</i>) Total Example Cost In this example, Peg would pay: Cost Sharing Deductibles Copayments Coinsurance	\$12,800 \$3,500 \$	Prescription drugs Durable medical equipment (glucose me Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles* Copayments Coinsurance	\$7,400 \$3,500 \$	Durable medical equipment (crutches) Rehabilitation services (physical therap Total Example Cost In this example, Mia would pay: Cost Sharing Deductibles* Copayments Coinsurance	(\$3,500) \$3,500

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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