**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 deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $5,000 individual / $10,000 family; for out-of-network providers $10,000 individual / $20,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 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 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 |
|---|---|---|---|---|
| | | 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 copay/visit | Deductible then 50% coinsurance | None |
| | Specialist visit | $45 copay/visit | Deductible then 50% coinsurance | None |
| | Other practitioner office visit | $45 copay/visit | Deductible then 50% coinsurance | Chiropractic 15 visit limit applies. |
| | Preventive care/screening/ immunization | No charge | Not Covered | No cost share |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $55 copay | Deductible then 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $105 copay/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 coverage** is available at www.wellaway.com | Generic drugs | $10 copay/prescription | Not covered | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or payment for the drug. |
| | Preferred brand drugs | $25 copay/prescription | Not covered | |
| | Non-preferred brand drugs | $55 copay/prescription | Not covered | |
| | Specialty drugs | $105 copay/prescription | Not covered | |
| **If you have outpatient surgery** | 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 or up to $500 USD penalty. |
| | Physician/surgeon fees | Deductible then 20% coinsurance | Deductible then 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $255 copay | $255 copay | None |
| | Emergency medical transportation | $105 copay | $105 copay | |
| | Urgent care | $55 copay | $105 copay | |
| **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 obtain preauthorization may result in denied coverage or up to $500 USD penalty. |
| | Physician/surgeon fees | Deductible then 20% coinsurance | Deductible then 50% coinsurance | |

* For more information about limitations and exceptions, see the plan 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 | $45 copay/visit | Deductible then 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 USD penalty. |
| | Mental/Behavioral health inpatient services | Deductible then 20% coinsurance | Deductible then 50% coinsurance | |
| | Inpatient services | Deductible then 20% coinsurance | Deductible then 50% coinsurance | |
| **If you are pregnant** | Office visits | No charge | Deductible then 50% coinsurance | Deductible then 50% coinsurance |
| | Childbirth/delivery professional services | Deductible then 20% coinsurance | Deductible then 50% coinsurance | |
| | Childbirth/delivery facility services | $305 copay | Deductible then 50% coinsurance | |
| **If you need help recovering or have other special health needs** | 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. |
| | Rehabilitation services | $35 copay/visit | Deductible then 50% coinsurance | 20 visit limit applies. |
| | Habilitation services | $35 copay/visit | Deductible then 50% coinsurance | 20 visit limit applies. |
| | Skilled nursing care | $255 copay/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. |

## 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 www.dol.gov/ebsa, or the 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 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**.
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:

**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 | $500 |
| Specialist copayment | $50 |
| 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** | **$12,800** |

**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** |

### 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 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** | **$7,400** |

**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** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $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** | **$1,900** |

**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** |

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