




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](http://www.wellaway.com) or call 1-855-773-7810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> \$1,000/Individual or \$2,000/family; <a href="#">Out-of-network providers</a> \$2,000 individual or \$4,000 family (does not apply to preventive care).	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$3,500 individual / \$7,000 family; for <a href="#">out-of-network providers</a> \$7,000 individual / \$14,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.wellaway.com">www.wellaway.com</a> or call 1-855-773-7810 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	Deductible then 50%	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	Deductible then 50%	None
	Other practitioner office visit	\$40 <a href="#">copay</a> /visit	Deductible then 50%	Chiropractic 15 visit limit applies.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	No cost share
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a>	Deductible then 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a>	Deductible then 50% coinsurance	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellaway.com">www.wellaway.com</a>	Generic drugs	\$5 <a href="#">copay</a> /prescription	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or payment for the drug.
	Preferred brand drugs	\$20 <a href="#">copay</a> /prescription	Not covered	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">copay</a> /prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	Physician/surgeon fees	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a>	\$250 <a href="#">copay</a>	None
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a>	\$100 <a href="#">copay</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	<a href="#">Preauthorization</a> required for non-maternity/non-accidental condition. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	Physician/surgeon fees	Deductible then 10% coinsurance	Deductible then 50% coinsurance	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://portal.wellaway.com/login>

<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	\$40 <a href="#">copay</a> /visit	Deductible then 50%	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	Mental/Behavioral health inpatient services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
	Inpatient services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
<b>If you are pregnant</b>	Office visits	No Charge	Deductible then 50% coinsurance	None
	Childbirth/delivery professional services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
	Childbirth/delivery facility services	\$300 copay	Deductible then 50%	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Following 14 days from discharge. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit	Deductible then 50% coinsurance	20 visit limit applies.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit	Deductible then 50% coinsurance	20 visit limit applies.
	<a href="#">Skilled nursing care</a>	\$255 copay/day	Deductible then 50% coinsurance	\$750 Limit. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	<a href="#">Durable medical equipment</a>	Deductible then 10% coinsurance	Deductible then 50% coinsurance	None
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Deductible then 50%	Coverage limited to one exam/year.
	Children's glasses	No charge	Deductible then 50%	Limited to one pair of glasses per year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in denied coverage or up to \$500 USD penalty.
	Children's dental check-up	No charge	Deductible then 50%	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](http://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](http://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](http://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, 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.* —————

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,160</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$1,200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,360</b>

**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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$700
Copayments	\$50
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</b>