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 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?	In-Network: $1,500 individual / $3,000 family. Out-of-network: $3,000 individual / $6,000 family	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. Prescription Drugs; in-network office visits & Preventive care 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: $4,500 individual / $9,000 family. Out-of-network: $9,000 individual / $18,000 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?	Premiums, balance-billing charges, and 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	$50 copay/visit, then 10% coinsurance deductible doesn't apply Virtual visit: No charge	50% coinsurance	Physician administered drugs may have a higher copayment. Virtual visit services are only covered for in-network providers.
	Specialist visit	$60 copay/visit then 10% coinsurance deductible doesn't apply	50% coinsurance	Physician administered drugs may have a higher copayment. Virtual visit services are only covered for in-network providers.
	Preventive care/screening/ immunization	No charge	Not covered	Physician administered drugs may have a higher copayment. 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)	Independent Clinical Lab: $50 copay/test, then 10% coinsurance deductible doesn't apply Independent Diagnostic Testing Center: $200 copay/test, then 10% coinsurance deductible doesn't apply Outpatient Hospital Facility: $300 copay/test, then 10% coinsurance deductible doesn't apply	50% coinsurance	Lab work performed in an Independent Diagnostic Testing Center may have higher cost share than an Independent Clinical Lab. Tests performed in hospitals may have higher cost share than Independent Diagnostic Testing Centers.

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)	
	Imaging (CT/PET scans, MRIs)	Specialist: $250 copay/test, then 10% coinsurance deductible doesn't apply Independent Diagnostic Testing Center: $250 copay/test, then 10% coinsurance deductible doesn't apply Outpatient Hospital Facility: $400 copay/test, then 10% coinsurance deductible doesn't apply	50% coinsurance	Tests performed in hospitals may have higher cost share than Independent Diagnostic Testing Centers. 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	Preventive care: No charge / Condition care: $10 copay/prescription deductible doesn't apply/ All other generic: $30 copay/prescription deductible doesn't apply	Not covered	Covers 30-day supply (retail) includes contraceptive drugs & devices obtainable from a pharmacy. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Prescriptions above $400 require Preauthorization. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Preferred brand drugs	$60 copay/prescription deductible doesn't apply	Not covered	
	Non-preferred brand drugs	50% coinsurance/prescription deductible doesn't apply	Not covered	
	Specialty drugs	50% coinsurance/prescription deductible doesn't apply	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $400 copay/visit, then 10% coinsurance deductible doesn't apply Outpatient Hospital: 10% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Physician/surgeon fees	Ambulatory Surgical Center:10% coinsurance deductible doesn't apply Outpatient Hospital: 10% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	Facility fee:$400 copay/visit, then 10% coinsurance deductible doesn't apply Physician fee: 10% coinsurance	Facility fee:$400 copay/visit, then 10% coinsurance deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance deductible doesn't apply	10% coinsurance deductible doesn't apply	Non-emergency transport not covered, except if preauthorized.
	Urgent care	$60 copay/visit then 10% coinsurance deductible doesn't apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% 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	10% coinsurance	50% coinsurance	

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 mental health, behavioral health, or substance abuse services	Outpatient services	Primary Care office visit and all other locations: $50 copay/visit then 10% coinsurance deductible doesn't apply; Specialist office visit and all other locations: $60 copay/visit then 10% coinsurance deductible doesn't apply; Facility fee: 10% coinsurance	50% coinsurance (office visit and all other locations and facility fee)	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Inpatient services	10% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Initial visit: $60 copay/visit then 10% coinsurance deductible doesn't apply	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	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	Birth Center: $400 copay/visit then 10% coinsurance deductible doesn't apply Hospital: 10% coinsurance	50% coinsurance	

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 help recovering or have other special health needs	Home health care	10% 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	Inpatient: 10% coinsurance Outpatient: $60 copay/visit then 10% coinsurance deductible doesn't apply	Inpatient: 50% coinsurance Outpatient: 50% coinsurance	45 day limit applies (inpatient); 20 visit limit applies (outpatient). Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Habilitation services	Inpatient: 10% coinsurance Outpatient: $60 copay/visit then 10% coinsurance deductible doesn't apply	Inpatient: 50% coinsurance Outpatient: 50% coinsurance	45 day limit applies (inpatient); 20 visit limit applies (outpatient).Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Skilled nursing care	10% coinsurance	50% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $500 penalty.
	Durable medical equipment	10% coinsurance Motorized wheelchair: 50% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Motorized wheelchair must be medically necessary.
	Hospice services	10% 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	0% coinsurance Usual, Reasonable and Customary	0% coinsurance Usual, Reasonable and Customary	Coverage limited to one exam/plan year up to age 19.
	Children's glasses	0% coinsurance Usual, Reasonable and Customary	0% coinsurance Usual, Reasonable and Customary	Coverage limited to one pair of glasses or lenses/plan year up to age 19.
	Children's dental check-up	0% coinsurance Usual, Reasonable and Customary	0% coinsurance Usual, Reasonable and Customary	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 aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- 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.)

- Bariatric surgery - lifetime maximum 1 per covered person
- Chiropractic care - limited to 15 visits per benefit period
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - inpatient only

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, 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** **$1,500**
- **Specialist copayment/coinsurance** **$60/10%**
- **Hospital (facility) coinsurance** **10%**
- **Other copayment** **$50**

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:	
Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,800**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment/coinsurance** **$60/10%**
- **Hospital (facility) coinsurance** **10%**
- **Other copayment** **$50**

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:	
Cost Sharing	
Deductibles	$800
Copayments	$100
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,600**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment/coinsurance** **$60/10%**
- **Hospital (facility) coinsurance** **10%**
- **Other copayment** **$400**

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:	
Cost Sharing	
Deductibles	$1,500
Copayments	$500
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,080**

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