

[Plan Sponsor Name]: WellMEC

Coverage for: Plan Participants | 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, please call 1-844-899-6612. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive care and generic preventive drugs are covered.	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 ?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. See www.multiplan.com or call 1-800-922-4362 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 ?	Not applicable	This plan does not cover specialist visits.

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	Not covered	Not covered	Not covered
	Specialist visit	Not covered	Not covered	Not covered
	Preventive care/screening/immunization	\$0 copay	Not covered	Not covered if provided at a hospital. Plan pays 100% of covered preventive and wellness services . You may have to pay for services that aren't preventive. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	Not covered
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	Not covered
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-877-635-9545.	Generic drugs	No charge	Not covered	Limited to preventive generic drugs.
	Preferred brand drugs	Not covered	Not covered	Not covered
	Non-preferred brand drugs	Not covered	Not covered	Not covered
	Specialty drugs	Not covered	Not covered	Not covered.

* For more information about limitations and exceptions, see the plan or policy document.

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need immediate medical attention	<u>Emergency room care</u>	Not covered	Not covered	Not covered
	<u>Emergency medical transportation</u>	Not covered	Not covered	Not covered
	<u>Urgent care</u>	Not covered	Not covered	Not covered
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	<p>Preventive services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventive services. Partial hospitalization is not covered.</p>
	Inpatient services	Not covered	Not covered	Not covered
If you are pregnant	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document.

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 need help recovering or have other special health needs	Home health care	Not covered	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered	Not covered
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	One vision screening for children 3-5 years is covered as a preventive service . Cost sharing does not apply for preventive services.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services . Cost sharing does not apply for preventive services .

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
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

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* For more information about limitations and exceptions, see the plan or policy document.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: 1-844-899-6612.

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 the Minimum Value Standards? No

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 1-844-899-6612.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-899-6612.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-844-899-6612.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 1-844-899-6612.

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

* For more information about limitations and exceptions, see the plan or policy document.

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.

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

■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist [cost sharing]	\$0	■ Specialist [cost sharing]	\$0	■ Specialist [cost sharing]	\$0
■ Hospital (facility) [cost sharing]	0%	■ Hospital (facility) [cost sharing]	0%	■ Hospital (facility) [cost sharing]	0%
■ Other [cost sharing]	0%	■ Other [cost sharing]	0%	■ Other [cost sharing]	0%

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)

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)

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	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,600
The total Peg would pay is	\$12,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,400
The total Joe would pay is	\$5,400

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,800
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these **EXAMPLE** covered services.