

[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/](http://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 <a href="#">deductible</a> ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and <a href="#">generic preventive drugs</a> are covered.	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 don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-800-922-4362 for a list of network providers.	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 plan 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 provider before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Not applicable	This plan does not cover <a href="#">specialist</a> 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	Not covered
	<a href="#">Specialist</a> visit	Not covered	Not covered	Not covered
	<a href="#">Preventive care/screening/immunization</a>	\$0 <a href="#">copay</a>	Not covered	Not covered if provided at a hospital. <a href="#">Plan</a> pays 100% of covered <a href="#">preventive and wellness services</a> . You may have to pay for services that aren't preventive. <a href="#">Deductible</a> does not apply.
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> 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
	<a href="#">Specialty drugs</a>	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 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	<a href="#">Emergency room care</a>	Not covered	Not covered	Not covered
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	Not covered
	<a href="#">Urgent care</a>	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	<a href="#">Preventive services</a> are covered for mental, behavioral health or substance abuse. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Partial hospitalization is not covered.
	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	<a href="#">Home health care</a>	Not covered	Not covered	Not covered
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	Not covered
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Not covered
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	Not covered
	<a href="#">Hospice services</a>	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 <a href="#">preventive service</a> . 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 <a href="#">preventive services</a> . <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .

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

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](http://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](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: 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): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-899-6612.

————— 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.

		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)			
<ul style="list-style-type: none"><li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a></li><li>■ <a href="#">Specialist</a> [cost sharing ]</li><li>■ Hospital (facility) [cost sharing ]</li><li>■ Other [cost sharing ]</li></ul> <p>This <b>EXAMPLE</b> 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)</p>		<ul style="list-style-type: none"><li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a></li><li>■ <a href="#">Specialist</a> [cost sharing ]</li><li>■ Hospital (facility) [cost sharing ]</li><li>■ Other [cost sharing ]</li></ul> <p>This <b>EXAMPLE</b> event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)</p>		<ul style="list-style-type: none"><li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a></li><li>■ <a href="#">Specialist</a> [cost sharing ]</li><li>■ Hospital (facility) [cost sharing ]</li><li>■ Other [cost sharing ]</li></ul> <p>This <b>EXAMPLE</b> event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)</p>	
Total Example Cost		\$12,700		\$5,600	
Total Example Cost		\$5,600		\$2,800	
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$12,600	Limits or exclusions	\$5,400	Limits or exclusions	\$2,800
The total Peg would pay is	\$12,600	The total Joe would pay is	\$5,400	The total Mia would pay is	\$2,800

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