

 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 [www.wellnet.com](http://www.wellnet.com). 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 1-267-348-3492 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 individual / \$0 family for In-Network providers N/A individual / N/A family for Out-of-Network providers	Generally, you must pay all of the costs from <a href="#">providers</a> 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> ?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
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> ?	\$3,000 individual / \$6,000 family for In-Network providers N/A individual / N/A family for Out-of-Network providers	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> ?	Premiums, balance-billed charges, precertification penalties, cost containment penalties, non-covered expenses, amounts that exceed an allowable charge, amounts that exceed benefit maximums, and health care this plan does not 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="https://providerlocator.firsthealth.com/home/index">https://providerlocator.firsthealth.com/home/index</a> or call 1-267-348-3492 for a list of participating 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 <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 a <a href="#">referral</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
		In-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	\$30 copay/visit	Not covered	Services rendered during an office visit will apply to the office visit copay. If there is no office visit copay charged, the services are subject to the plan schedule
	<a href="#">Specialist</a> visit	\$50 copay/visit	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Labs: No charge X-Rays: Office, free-standing facility or independent lab: No charge All Other: 25% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$150 copay/visit	Not covered	Certain services require preauthorization. If preauthorization is not obtained, benefits may be reduced or denied.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.wellnet.com</a> or 1-267-348-3492	Generic drugs	Retail: \$15 copay/prescription Mail Order: \$30 copay/prescription	Not covered	Coverage is limited to a 30-day supply for a retail prescription. 90-day supply may be obtained at retail or through mail order. Cost share of 90-day supply through retail is the same as the cost share for mail order. There is no charge for preventive drugs.
	Preferred brand drugs	Retail: \$50 copay/prescription Mail Order: \$100 copay/prescription	Not covered	
	Non-preferred brand drugs	Retail: \$80 copay/prescription Mail Order: \$160 copay/prescription	Not covered	
	<a href="#">Specialty drugs</a>	Generic: 20% coinsurance Maximum \$150 Preferred Brand: 20% coinsurance Maximum \$300 Non-Preferred Brand: 20% coinsurance Maximum \$300 Prudent: Opt In: No charge Opt Out: 30% coinsurance	Not covered	Specialty medications are limited to a 30-day supply and must be obtained directly from the specialty pharmacy program. Refer to plan details for more information.  For more information regarding Prudent eligible prescriptions, contact an advocate.

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)	25% coinsurance	Not covered	Certain services require preauthorization. If preauthorization is not obtained, benefits may be reduced or denied.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay/visit		Copayment waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$100 copay/visit		None
	<a href="#">Urgent care</a>	\$60 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization is required. If preauthorization is not obtained, benefits may be reduced or denied.
	Physician/surgeon fee	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/visit	Not covered	None
	Inpatient services	25% coinsurance	Not covered	Preauthorization is required. If preauthorization is not obtained, benefits may be reduced or denied.
If you are pregnant	Office visits	\$30 copay/visit	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a possible penalty.

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 copay/visit	Not covered	Preauthorization is required. If preauthorization is not obtained, benefits may be reduced or denied.
	<a href="#">Rehabilitation services</a>	\$50 copay/visit	Not covered	Physical, Speech and Occupational therapy limits are combined. Benefits limited to 60 visits per calendar year.
	<a href="#">Habilitation services</a>	\$50 copay/visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Preauthorization is required. If preauthorization is not obtained, benefits may be reduced or denied. Benefits limited to 45 days per calendar year.
	<a href="#">Durable medical equipment</a>	50% coinsurance	Not covered	Certain services require preauthorization. If preauthorization is not obtained, benefits may be reduced or denied.
	<a href="#">Hospice services</a>	No charge	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Vision exams for children required by the Affordable Care Act, are covered under preventive services.
	Children's glasses	Not covered	Not covered	Vision hardware for children required by the Affordable Care Act, is covered under preventive services.
	Children's dental check-up	Not covered	Not covered	None

### 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.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty Nursing</li><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
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#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"><li>• Bariatric Surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic Care (limited to: 30 visits per calendar year)</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment (limited to: a lifetime maximum of \$10,000)</li></ul>
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**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-EBSA (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 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 the plan at 1-267-348-3492. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

#### 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? 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 1-267-348-3492.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-267-348-3492.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-267-348-3492 uff.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-267-348-3492.

*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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	25%	■ Hospital (facility) <a href="#">coinsurance</a>	25%	■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%	■ Other <a href="#">coinsurance</a>	25%	■ Other <a href="#">coinsurance</a>	25%
<b>This EXAMPLE event includes services like:</b> <a href="#">Specialist</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$500	<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$2,200	<a href="#">Coinsurance</a>	\$200	<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,270</b>	<b>The total Joe would pay is</b>	<b>\$720</b>	<b>The total Mia would pay is</b>	<b>\$900</b>