



 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 [Wellfirstbenefits.com/medicaemployees](https://wellfirstbenefits.com/medicaemployees) or call 833-942-2159 (TTY: 711). 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 833-942-2159 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,500 / Individual \$4,500 / Family	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> ?	Yes. <a href="#">Preventive care services</a> 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 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> ?	\$4,000 individual / \$8,000 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="#">Premiums</a> , balance billing 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="https://wellfirstbenefits.com/find-a-doc/">wellfirstbenefits.com/find-a-doc/</a> or call 833-942-2159 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). 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 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
		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	<b>Primary care:</b> \$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. <b>Chiropractic:</b> \$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. <b>Virtual:</b> \$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not Covered	In-network primary care visits provided at an outpatient facility may be subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . No coverage for Chiropractic maintenance or long-term therapy.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not Covered	In-network <a href="#">specialist</a> visits provided at an outpatient facility may be subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not Covered	Services under the Affordable Care Act (ACA) guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the <a href="#">Preventive Services</a> section in your Member Certificate. You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Lab:</b> No charge. <a href="#">Deductible</a> does not apply. <b>Xray:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Lab tests performed in a setting other than office, outpatient hospital/ASC or inpatient hospital will incur <a href="#">deductible</a> and <a href="#">coinsurance</a> cost share.

	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
<p><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="#">navitus.com</a>.</p>	Preferred generic drugs (Tier 1)	<b>Retail:</b> \$15 <a href="#">copay</a> /prescription (retail). <a href="#">Deductible</a> does not apply. <b>Mail order:</b> 93-day supply for 2 <a href="#">copays</a> . <a href="#">Deductible</a> does not apply.	Not Covered (retail and mail order)	Up to a 31-day supply/ retail or 93-day supply/ mail order prescription. Insulin: Your cost-share will not exceed \$25 per retail prescription unit.
	Non-Preferred generic, Preferred brand drugs (Tier 2)	<b>Retail:</b> \$55 <a href="#">copay</a> /prescription (retail). <a href="#">Deductible</a> does not apply. <b>Mail order:</b> 93-day supply for 2 <a href="#">copays</a> . <a href="#">Deductible</a> does not apply.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	<b>Retail:</b> \$100 <a href="#">copay</a> /prescription (retail). <a href="#">Deductible</a> does not apply. <b>Mail order:</b> 93-day supply for 2 <a href="#">copays</a> . <a href="#">Deductible</a> does not apply.	Not Covered (retail and mail order)	
	<a href="#">Specialty drugs</a> (Tier 4)	<b>Preferred:</b> 20% <a href="#">coinsurance</a> . No more than \$200 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply. <b>Non-preferred:</b> 40% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply. <b>Mail order:</b> Not covered.	Not Covered (retail and mail order)	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after in-network <a href="#">deductible</a>	Initial emergency services are covered with <a href="#">out-of-network providers</a> .

	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after in-network <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Initial <a href="#">urgent care</a> services are covered with <a href="#">out-of-network providers</a> . Some services received during an <a href="#">urgent care</a> visit may be covered under another benefit in this document. The most specific and appropriate benefit will apply for each service received during an <a href="#">urgent care</a> visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not Covered	Includes intensive outpatient programs.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Residential treatment is covered as part of inpatient services.
<b>If you are pregnant</b>	Office visits	No charge. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, 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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	120 visits/calendar year.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /therapy/day. <a href="#">Deductible</a> does not apply.	Not Covered	Services for custodial care are a policy exclusion.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /therapy/day. <a href="#">Deductible</a> does not apply.	Not Covered	Services for custodial care are a policy exclusion.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Limited to 120 days/calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None

		Insulin pumps/supplies: 20% <a href="#">coinsurance</a>		
	<a href="#">Hospice services</a>	No charge. <a href="#">Deductible</a> does not apply.	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <a href="#">Deductible</a> does not apply.	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Glasses are not covered by the <a href="#">plan</a> .
	Children's dental check-up	Not Covered	Not Covered	Dental check-ups are not covered by the <a href="#">plan</a> .

### Excluded Services & Other Covered Services:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic services including surgery</li> <li>• Dental care (Adult)</li> <li>• Dental check-up</li> <li>• Glasses</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when travelling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight Loss Programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (Limited to 15 visits per calendar year)</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids (Limited to one aid per ear every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment (\$5,000 medical/\$3,000 pharmacy per calendar year)</li> <li>• Routine eye care (Adult)</li> </ul>

**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: Medica Employee Health Plan at 833-942-2159 (TTY: 711); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://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 your [plan](#) administrator or you may contact Medica Employee Health Plan at [Wellfirstbenefits.com/medicaemployees](http://Wellfirstbenefits.com/medicaemployees) or 833-942-2159 (TTY: 711); You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://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 833-942-2159 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-942-2159 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码833-942-2159 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-942-2159 (TTY: 711).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,270</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,300</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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