WellFirst Health : **WellFirst Silver Copay Plus 100X06**

Coverage for: Individual/Family | Plan Type: EPO

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, sbc.wellfirstbenefits.com/individual or call 866-514-4194 (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 https://www.healthcare.gov/sbc-glossary or call 866-514-4194 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 / individual $200 / 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. Preventive care services 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?	$750 individual / $1,500 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.	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 wellfirstbenefits.com/find-a-doctor or call 866-514-4194 (TTY: 711) 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
		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	$5 copay/visit; deductible does not apply	Not Covered	No coverage for chiropractic maintenance or long-term therapy.
	Specialist visit	$80 copay/visit; deductible does not apply	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	Preventive care/screening/ immunization	No charge	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 Preventive Services section in your Member Certificate. You may have to pay for services that are not 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)	5% coinsurance after deductible	Not Covered	Select diagnostic testing (e.g., genetic testing) and radiology services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Imaging (CT/PET scans, MRIs)	5% coinsurance after deductible	Not Covered	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at wellfirstbenefits.com/pharmacy	Preferred generic drugs (Tier 1)	$5 copay / prescription; deductible does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 2 copays.	Not Covered (retail and mail order)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	$60 copay / prescription; deductible does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 3 copays.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	50% coinsurance / prescription; deductible does not apply (retail) Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	50% coinsurance / prescription; deductible does not apply (retail) Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	Infertility drugs not covered (retail and mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance after deductible	Not Covered	Select outpatient surgeries require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	5% coinsurance after deductible	Not Covered	

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 immediate medical attention	Emergency room care	$500 copay/visit and/or 5% coinsurance after deductible	$500 copay/visit and/or 5% coinsurance after deductible	Initial emergency services are covered with out-of-network providers. Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	5% coinsurance after deductible	5% coinsurance after deductible	None
	Urgent care	$5 copay/visit and/or 5% coinsurance after deductible	$5 copay/visit and/or 5% coinsurance after deductible	Initial urgent care services are covered with out-of-network providers. You may incur a lower copay at an SSM urgent care clinic versus a hospital based facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance after deductible	Not Covered	Elective inpatient admissions and services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	5% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/outpatient visit; deductible does not apply	Not Covered	None
	Inpatient services	5% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	5% coinsurance after deductible	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	5% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	5% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	5% coinsurance after deductible	Not Covered	100 visits/contract period. Requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member,

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)	
				will be responsible for paying 100% of the total cost.
	Rehabilitation services	Inpatient Rehabilitation services: 5% coinsurance after deductible; Physical, Occupational and Speech Therapy: $5 copay/therapy/day; deductible does not apply	Not Covered	Inpatient Rehabilitation Care - 150 days/contract period combined with skilled nursing care. Physical and Occupational Therapy - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Habilitation services	$5 copay/therapy/day; deductible does not apply	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Skilled nursing care	5% coinsurance after deductible	Not Covered	150 days/contract period combined with inpatient rehabilitative confinement. Requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.

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)	
	Durable medical equipment	5% coinsurance after deductible	Not Covered	Durable medical equipment as stated in our medical policies requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Hospice services	5% coinsurance after deductible	Not Covered	Requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
If your child needs dental or eye care	Children's eye exam	$5 copay/visit; deductible does not apply	Not Covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share.
	Children's glasses	5% coinsurance after deductible	Not Covered	One pair per contract year.
	Children's dental check-up	Not Covered	Not Covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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.)

- Abortion (except in cases when the life of the mother is endangered)
- Acupuncture
- Dental care (Adult)
- Infertility Treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

● Bariatric Surgery ● Cosmetic services including surgery	● Non-emergency care when travelling outside the U.S.	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
● Chiropractic care	● Hearing aids (Limited to one aid per ear every 36 months)	● Private-duty nursing (Limited to 82 visits per Contract Period)

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: WellFirst Health at 866-514-4194 (TTY: 711) or wellfirstbenefits.com; U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; Missouri Department of Commerce and Insurance at (573) 751-4126 or https://insurance.mo.gov/consumers; or Healthcare.gov at www.Healthcare.gov or call 1-800-318-2596. 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: Missouri Department of Commerce and Insurance, Division of Consumer Affairs at https://insurance.mo.gov/consumers/complaints/index.php or call 1-800-726-7390.

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 866-514-4194 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-514-4194 (TTY: 711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-514-4194 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-514-4194 (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 plan's overall deductible	$100
Specialist copayment	$80
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$100
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$770**

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

The plan's overall deductible	$100
Specialist copayment	$80
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$100
Copayments	$600
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$740**

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

The plan's overall deductible	$100
Specialist copayment	$80
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$100
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

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

Non-Discrimination & Language Assistance Access

For assistance understanding these materials in a language other than English, call 1-877-317-2410 (TTY: 711), and a Customer Care Center representative will assist you.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or religion.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, or other formats).

We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with the organization's Civil Rights Coordinator. If you need help filing a grievance, the Civil Rights Coordinator for the Health Plan is available to help you. You can file a written grievance in person, by mail, or by email at:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
1-608-828-2216 (TTY: 711)
civilrightscoordinator@deancare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, by mail, or phone at:

U.S. Department of Health and Human Services

Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For help to translate or understand this or other documents, please call 1-877-317-2410 (TTY: 711).

Español: tenemos servicios gratuitos de interpretación para responder a cualquier consulta sobre nuestro plan de atención médica o de cobertura de medicamentos. Para solicitar un intérprete, llame al 1-877-317-2410 (TTY:711). Un hablante de español puede ayudarle. Este servicio es gratuito.

Somali- Waxaan bixinaa adeegyada bilaashka ah si looga jawaabo su'aalo kasta ood ka qabi karto caymiskaaga caafimaadka ama daawada. Si aad u hesho turjumaan, keliya nagasoo wac 1-877-317-2410 (TTY: 711), Qof ku hadla luuqada af-Soomaaliga ayaa ku caawin kara. Kani waa adeeg bilaash ah

Tagalog- Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na maaaring mayroon ka tungkol sa aming plano sa kalusugan o gamot. Para makakuha ng interpreter, tumawag lamang sa amin sa 1-877-317-2410 (TTY: 711). Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

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Gujarati- અમારી સ્વાસ્થ્ય કે દવા યોજના વિશે જો આપને કોઈ પ્રશ્ન હોય તો તેનો જવાબ આપવા અમારી પાસે મફત દુભાષિયા સેવા ઉપલબ્ધ છે. ગુજરાતી બોલીને આપને મદદ કરી શકે એવો દુભાષિયો મેળવવા માટે, માત્ર અમને 1 877 317 2410 (TTY: 711) પર કોલ કરો. આ મફત સેવા છે.

Hindi- हमारे पास हमारे स्वास्थ्य या औषधि योजना से संबंधित आपके किसी भी प्रश्न का उत्तर देने के लिए निःशुल्क दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-317-2410 (TTY: 711) पर कॉल करें, कोई व्यक्ति जो हिंदी बोलता है, आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Hmong- Peb muaj cov kws txhais lus dawb los teb txhua nqi lus nug uas koj muaj hais txog peb li phiaj xwm kho mob los sis tshuaj muaj yees. Txhawm rau muaj tus kws pab txhais lus, thov hu rau peb tus xov tooj 1-877-317-2410 (TTY: 711), Yuav muaj tus hais ua lus Hmoob pab koj. No yog kev pab dawb.

Polish- Oferujemy bezpłatne usługi tłumacza, aby móc odpowiedzieć na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub planu lekowego. Aby skorzystać z pomocy tłumacza, wystarczy zadzwonić pod numer 1-877-317-2410 (TTY: 711). Osoba, która mówi po polsku, udzieli Państwu pomocy. Usługa jest bezpłatna.

Korean- 저희의 무료 통역 서비스를 통해 당사의 의료 보험 또는 의약품 보험에 대해 알고 싶으신 점을 질문하시고 답변을 받으십시오. 통역사가 필요하실 때는 1 877 317-2410 (TTY: 711) 으로 전화 주십시오. 한국어가 가능한 직원이 도움을 드릴 것입니다. 무료로 이용하실 수 있습니다.

Russian- Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы о нашем плане медицинского страхования или плане страхования стоимости лекарств. Чтобы получить помощь русского переводчика, просто позвоните по номеру 1-877-317-2410 (TTY: 711). Эта услуга является бесплатной.

French- Nous proposons des services d'interprétation gratuits pour répondre à toutes vos questions à propos de notre régime d'assurance maladie ou d'assurance médicaments. Pour bénéficier d'un(e) interprète, appelez simplement le 1 877 317 2410 (TTY: 711). Une personne parlant français pourra vous aider. Ce service est gratuit.

Italian- Offriamo servizi gratuiti di interpretazione per rispondere a eventuali domande in merito alla nostra assicurazione sanitaria o al nostro piano farmacologico. Per avvalersi dell'aiuto di un interprete in lingua italiana, chiamare il numero 1-877-317-2410 (TTY: 711). Il servizio è gratuito.

Chinese- 我们提供免费的口译服务，可回答您关于我们健康或药物计划的任何疑问。如需安排口译员，请致电 1-877-317-2410 (TTY: 711) 与我们联系，申请安排说中文的人员为您提供协助。此为免费服务。

Vietnamese- Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi của quý vị về chương trình bảo hiểm sức khỏe hoặc thuốc. Nếu quý vị cần thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-877-317-2410 (TTY: 711), sẽ có nhân viên nói tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

Arabic-

لدينا خدمات مترجم فوري للإجابة ن ع أي أسئلة قد تكون لديك حول خطتنا الدوائية أو الصحية. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-877-317-2410، وستجد أ صخش يتحدث اللغة العربية يمكن أن يساعدك. هذه هي خدمة مجانية.

German- Wir bieten einen kostenlosen Dolmetscher-Service für Sie an, damit wir Ihre Fragen bezüglich unseres Gesundheits- oder Medikationsplans beantworten können. Rufen Sie uns einfach unter der Nummer 1 877 317 2410 (TTY: 711) an, um einen Dolmetscher anzufordern. Ihnen wird dann auf Deutsch weitergeholfen. Dies ist ein kostenloser Service.

Urdu-

ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات دستیاب ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں صرف 1-877-317-2410 (TTY: 711) پر کال کریں، اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔