



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, go to <https://wedgewood.quantum-health.com> or call (866) 871-0630. 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 Care Coordinators at (866) 871-0630 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For participating <u>providers</u> : \$1,500 person / \$3,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , outpatient surgery, outpatient professional fees, and <u>urgent care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For participating <u>providers</u> : \$3,000 person / \$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, preauthorization penalty amounts, <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://wedgewood.quantum-health.com or call (866) 871-0630 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Is a Health Reimbursement Arrangement (HRA) available under this <u>plan</u> option?	Yes. \$1,500 individual / \$3,000 employee plus one / \$3,000 employee plus family	An HRA is an account that is set up and contributed to by your employer. You may not make any contributions to the HRA. The HRA may only be used to pay a portion of your <u>out-of-pocket</u> expenses incurred under the <u>plan</u> .



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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit after <u>deductible</u>	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. After the <u>deductible</u> you pay a \$20 consult fee if you receive consultation services through Teladoc. There is no charge and the <u>deductible</u> does not apply for services received at a MinuteClinic.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit after <u>deductible</u>	Not Covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge, <u>deductible</u> does not apply	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u>	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	Not Covered	<u>Preauthorization</u> required for MRI/MRA and PET scans. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.us-rxcare.com	Generic drugs	\$15 <u>copay</u> (30-day retail or mail order)/ \$30 <u>copay</u> (90-day retail or mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply(mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained through Wedgewood. Select <u>specialty drugs</u> may qualify for <u>copay</u> assistance programs offered by US-Rx Care's Program. Please note that step therapy provisions apply.
	Preferred brand drugs	\$35 <u>copay</u> (30-day retail or mail order)/ \$70 <u>copay</u> (90-day retail or mail order)	Not Covered	
	Non-preferred brand drugs	\$70 <u>copay</u> (30-day retail or mail order)/ \$140 <u>copay</u> (90-day retail or mail order)	Not Covered	
	<u>Specialty drugs</u>	\$70 <u>copay</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copay</u> /occurrence, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	Physician/surgeon fees	No charge, <u>deductible</u> does not apply	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit after <u>deductible</u>	\$100 <u>copay</u> /visit after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	Physician/surgeon fees	No charge after <u>deductible</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit after <u>deductible</u> (office visit)/ No charge, <u>deductible</u> does not apply (all other outpatient)	Not Covered	Includes telemedicine other than Teladoc. Includes Teladoc behavioral health consultations. <u>Preauthorization</u> required for inpatient admissions and partial <u>hospitalization</u> and intensive outpatient care. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	Inpatient services	No charge after <u>deductible</u>	Not Covered	
If you are pregnant	Office visits	No charge after <u>deductible</u> (\$20 <u>copay</u> after <u>deductible</u> for initial visit)	Not Covered	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e.
	Childbirth/delivery professional services	No charge after <u>deductible</u>	Not Covered	
	Childbirth/delivery facility services	No charge after <u>deductible</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u>	Not Covered	Limited to 60 visits per year (does not apply to mental health or substance abuse disorders). <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit after <u>deductible</u>	Not Covered	Physical therapy limited to 20 visits per year. Speech/hearing & occupational therapy limited to a combined maximum of 20 visits per year. Maximums do not apply to mental health or substance abuse disorders.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit after <u>deductible</u>	Not Covered	-----none-----
	<u>Skilled nursing care</u>	No charge after <u>deductible</u>	Not Covered	Limited to 60 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	Not Covered	<u>Preauthorization</u> required for rentals or purchase over \$1,500. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.
	<u>Hospice services</u>	No charge after <u>deductible</u>	Not Covered	Bereavement counseling is covered if received within 6 months of death. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$999 maximum) of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for home health care & hospice)
- Routine eye care (Adult & Child)
- Routine foot care (except for metabolic or peripheral vascular disease)
- Weight loss programs

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

- Bariatric surgery (for morbid obesity only)
- Chiropractic care (20 visits per year)
- Hearing aids (1 aid per hearing impaired ear, up to \$1,000 per aid every 24 months up to age 16)
- Infertility treatment

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: the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (866) 871-0630. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), 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 the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (866) 871-0630.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact The Office of the Insurance Ombudsman NJ Department of Banking and Insurance at (800) 446-7467.

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-378-1179.

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Primary care physician coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$60

The total Peg would pay is	\$1,570
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Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$600
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$20

The total Joe would pay is	\$2,120
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Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other coinsurance</u>	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$0

The total Mia would pay is	\$1,800
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The plan would be responsible for the other costs of these EXAMPLE covered services.