




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, call 1-800-273-2509. 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 1-800-273-2509 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|---|---|---|
| What is the overall deductible? | Network \$100/self only \$100/individual \$200/family | Non-Network \$500/self only \$500/individual \$1,000/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? | Network and non-network deductibles are separate. Yes, network preventive services , services paid with a copayment , services paid at no charge. | | 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? | Medical coverage: Network \$3,000/self only \$3,000/individual \$6,000/family | Medical coverage: Non-Network \$3,000/self only \$3,000/individual \$6,000/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 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? | Prescription drug coverage : \$1,000/individual \$2,000/family Network and non-network out-of-pocket limits are separate. Premiums , balance billing charges (unless balance billing is prohibited), health care this plan doesn't cover, prescription drug brand name penalties, and penalties for failure to obtain pre-certification for services. | | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.personifyhealth.com.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| Will you pay less if you use a network provider ? | Yes. See www.personifyhealth.com or call 1-800-273-2509 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 a non-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 a non-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) | Non-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 | \$20 copay /visit, deductible does not apply; 0% coinsurance for other outpatient services | 10% coinsurance | Teladoc services are payable at \$20 copay /consultation, deductible does not apply. Visit www.teladoc.com or use the Teladoc App on your mobile device for more information. |
| | Specialist visit | | | |
| | Preventive care/screening/immunization | No charge | 10% coinsurance | |
| If you have a test | Diagnostic test (x-ray, blood work) | Office, Outpatient Hospital, & Standalone Facility X-rays: 0% coinsurance Labs: No charge Inpatient: 0% coinsurance | 10% coinsurance | Precertification may be required for certain procedures or services will not be covered. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 10% coinsurance | |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|--|
| | | Network Provider (You will pay the least) | Non-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 www.personifyhealth.com | Generic drugs | Retail* \$10/prescription | 30% of the actual cost of the drug | Covers up to a 90-day supply (retail & mail order pharmacy); however, specialty drugs are limited to a 30-day supply. *90-day retail supply filled at CVS or MSU Pharmacy is covered at 2x copay ; covered at 3x copay at all other locations Brand-name drug penalty: If your physician authorizes generic but you choose brand name, you pay the actual cost difference plus the brand name copayment. Deductible does not apply to prescription drugs. |
| | Preferred brand drugs | Mail order \$20/prescription | | |
| | Non-preferred brand drugs | Retail* \$30/prescription Mail order \$60/prescription | | |
| | Specialty drugs | Retail* \$60/prescription Mail order \$120/prescription Retail \$75/prescription Mail order Not covered | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 10% coinsurance | Precertification may be required for certain procedures or services will not be covered. |
| | Physician/surgeon fees | 0% coinsurance | 10% coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$50 copay /visit, deductible does not apply | | The copay is waived if you are admitted to the hospital directly from the emergency room. |
| | Emergency medical transportation | 20% coinsurance | | None |
| | Urgent care | \$25 copay /visit, deductible does not apply | | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | 10% coinsurance | Precertification may be required or services will not be covered. |
| | Physician/surgeon fees | 0% coinsurance | 10% coinsurance | None |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | 10% coinsurance | Teladoc services are payable at no charge. Visit www.teladoc.com or use the Teladoc App on your mobile device for more information. |
| | Inpatient services | 0% coinsurance | 10% coinsurance | Precertification may be required or services will not be covered. |
| If you are pregnant | Office visits | \$20 copay /visit, deductible does not apply | 10% coinsurance | Cost sharing does not apply for network preventive care services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 0% coinsurance | 10% coinsurance | None |
| | Childbirth/delivery facility services | 0% coinsurance | 10% coinsurance | Precertification may required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or services will not be covered. |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 10% coinsurance | Limited to 60 days/calendar year. Precertification may be required or services will not be covered. |
| | Rehabilitation services | Occupational, Physical, & Speech therapies: \$20 copay /visit, deductible does not apply | 10% coinsurance | Occupational, Physical, & Speech therapies are limited to 60 visits/calendar year combined. Limits do not apply to habilitation services for autism spectrum disorders. Precertification may be required or services will not be covered. |
| | Habilitation services | | | |
| | Skilled nursing care | 0% coinsurance | 10% coinsurance | Limited to 100 days/calendar year. Precertification may be required or services will not be covered. |
| | Durable medical equipment | 20% coinsurance | | Precertification may be required for certain DME or services will not be covered. |
| | Hospice services | 0% coinsurance | 10% coinsurance | None |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------|--|---|--|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If your child needs dental or eye care | Children’s eye exam | Not covered | Not covered | No coverage for children’s eye exam. |
| | Children’s glasses | Not covered | Not covered | No coverage for children’s glasses. |
| | Children’s dental check-up | Not covered | Not covered | No coverage for dental check-up. |

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"> • Acupuncture • Cosmetic surgery • Dental care (Adult) / (Child) | <ul style="list-style-type: none"> • Hearing aid • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) / (Child) • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Bariatric surgery (limited to once per Lifetime unless additional surgeries are medically necessary; precertification may be required; see plan document for additional details) | <ul style="list-style-type: none"> • Chiropractic care (limited to 24 visits/calendar year not including initial office visit or x-rays) • Habilitation services | <ul style="list-style-type: none"> • Infertility treatment (precertification may be required) • Routine foot care |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.personifyhealth.com.

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-800-273-2509.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-273-2509.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-273-2509.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-273-2509.

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](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other (Tests) [copayment](#) \$0

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$170 |

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](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other (Brand drug) [copayment](#) \$30

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$420 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other (Physical Therapy) [copayment](#) \$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*)

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$500 |

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