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 1-855-469-1245. 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 1-855-469-1245 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.
	Network and non-network deductibles are separate.		
Are there services covered before you meet your deductible?	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.
	Prescription drug coverage: $1,000/individual $2,000/family		
	Network and non-network out-of-pocket limits are separate.		
What is not included in the out-of-pocket limit?	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.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.personifyhealth.com or call 1-855-469-1245 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	None
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 **Mail order or MSU Pharmacy** $20/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 retail supply. *90-day retail supply filled at a location other than MSU Pharmacy or via mail order is covered at 3x copay 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	**Retail*** $30/prescription **Mail order or MSU Pharmacy** $60/prescription		
	Non-preferred brand drugs	**Retail*** $60/prescription **Mail order or MSU Pharmacy** $120/prescription		
	Specialty drugs	**Retail** $75/prescription		
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 Habilitation services	**Occupational, Physical, & Speech therapies:** $20 copay/visit, deductible does not apply **Cardiac Rehab:** 0% coinsurance	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.
	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

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

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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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) / (Child)
- Hearing aid
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery (limited to once per Lifetime unless additional surgeries are medically necessary; precertification may be required; see plan document for additional details)
- Chiropractic care (limited to 24 visits/calendar year not including initial office visit or x-rays)
- Habilitation services
- Infertility treatment (precertification may be required)
- Routine foot care

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 1-855-469-1245.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-469-1245.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-469-1245.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-469-1245.

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:	
Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$0
What isn't covered	
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:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
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:	
Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$200
What isn't covered	
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.

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