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 1-877-734-6995. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-877-734-6995 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single Plan: $300 employee Family Plan: $900 employee & family	Generally, you must pay all costs from providers up to deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Tiers 1, 2, 3 preventive services, physician office visits and routine vision exams are some of services 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 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?	Single Plan: $3,000 employee Family Plan: $3,000 person/$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 own out-of-pocket limits until overall family out-of-pocket limit is 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 HealthPlansInc.com/MSHG or call 1-877-734-6995 for a list of network providers.	You pay the least if you use a provider in Tier 1. You may pay more if you use a provider in Tiers 2 & 3. You pay the most if you use an out-of-network provider (Tier 4) 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 may see a 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 Hospitals & In-Network Providers [Tier 1]	Network Hospitals [Tier 2]	Network Hospitals [Tier 3]	Out-of-Network Hospitals & Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit; deductible waived			Not covered	You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what your plan will pay.
	Specialist visit	$45 copay/visit; deductible waived				
	Preventive care/ screening/Immunization	No charge; deductible waived				
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible waived			Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/procedure				
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at HealthPlansInc.com/MSHG	Generic drugs: Retail (30 days) Retail (90 days)* Mail Order (90 days)	 $10 copay/prescription $25 copay/prescription $25 copay/prescription			Not covered	Deductible waived. *maintenance drugs only Certain prescription drugs are subject to Step Therapy. You may be required to use a different prescription drug or pharmaceutical product first.
	Preferred brand drugs: Retail (30 days) Retail (90 days)* Mail Order (90 days)	 $30 copay/prescription $75 copay/prescription $75 copay/prescription				
	Non-preferred brand drugs: Retail (30 days) Retail (90 days)* Mail Order (90 days)	 $65 copay/prescription $165 copay/prescription $165 copay/prescription				
	Specialty drugs:	Payable as shown above for Retail (30 days)				
	Please refer to plan document for coverage requirements & limitations related to specialty drugs and mandatory specialty drug program for medical infusion treatment. ImpaxRx Medication Under Management (MUM): All specialty drugs of $2,500 or more (excluding anti-inflammatory & dermatology drugs) for 30-day supply must be filled through ImpaxRx MUM.					
If you have outpatient surgery	Facility fee (ambulatory surgery center)	$250 copay/visit			Not covered	Preauthorization required for total joint replacement & non-emergent spine surgeries
	Physician/surgeon fees	deductible only				

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 Hospitals & In-Network Providers [Tier 1] (You pay the least)	Network Hospitals [Tier 2] (You may pay more)	Network Hospitals [Tier 3] (You may pay more)	Out-of-Network Hospitals & Providers [Tier 4] (You pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit after In-network deductible				Copay waived if admitted
	Emergency medical transportation	No charge; deductible waived				None
	Urgent care Urgent Care Center Convenience Care Hospital Urgent Care	$45 copay/visit; deductible waived $30 copay/visit; deductible waived $45 copay/visit; deductible waived				None
If you have a hospital stay	Facility fee	$300 copay		$1,500 copay	Not covered	Preauthorization required
	Physician/surgeon fees	deductible only				
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office Visit	$30 copay/visit; deductible waived				Preauthorization required for Intensive outpatient treatment & Inpatient services.
	Intensive outpatient treatment	No charge; deductible waived			Not covered	
	Inpatient services	$300 copay		$1,500 copay	Not covered	
If you are pregnant	Office visits	No charge; deductible waived			Not covered	Maternity care may include tests & services described elsewhere in SBC. Requires preauthorization for stays over 48 hrs (normal delivery)/96 hrs (caesarean)
	Childbirth/delivery professional services					
	Childbirth/delivery facility services	$300 copay		$1,500 copay		
If you need help recovering or have other special health needs	Home health care	deductible only			Not covered	Requires preauthorization
	Rehabilitation services Inpatient	$300 copay		$1,500 copay	Not covered	Requires preauthorization for Inpatient & Speech therapy. 30 visits/yr each for Physical & Occupational therapies.
	Outpatient	$45 copay/visit; deductible waived				
	Habilitation services— Early Intervention	No charge; deductible waived			Not covered	To age 3
	Developmental Delay	deductible only			Not covered	Preauthorization, visit limits based on services provided.

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 Hospitals & In-Network Providers [Tier 1]	Network Hospitals [Tier 2]	Network Hospitals [Tier 3]	Out-of-Network Hospitals & Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
If you need help recovering or have other special health needs (continued)	Skilled nursing care	$300 copay		$1,500 copay	Not covered	120 days/yr. Requires preauthorization
	Durable medical equipment	deductible only			Not covered	Preauthorization required for rental over 3 months, equipment over $1,000, neuromuscular stimulator equipment and implantable loop recorders & defibrillators
		No charge (deductible waived) for blood glucose monitors, infusion devices, insulin pumps/supplies, oxygen & respiratory equipment.			Not covered	
	Hospice services	deductible only			Not covered	Preauthorization required
If your child needs dental or eye care	Children's eye exam	$30 copay/visit; deductible waived				1 exam/yr
	Children's glasses	Not covered				n/a
	Children's dental check-up	No charge; deductible waived			Not covered	2 exams/yr to age 13

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.)

- Cosmetic surgery
- Dental care (routine over age 13)
- Long term care
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 visits/yr)
- Bariatric surgery
- Chiropractic care (20 visits/yr)
- Hearing aids ($2,000/aid/ear/36 months to age 22)
- Infertility treatment
- Routine eye care (adult-1 exam/yr)

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 1-866-444-EBSA (3272) or 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-877-734-6995. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 1-877-734-6995
Portuguese (Português): De assistência em Português, ligue 1-877-734-6995
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-734-6995

[———————————*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** **$300**
- **Specialist copay** **$45**
- **Hospital (facility) copay** **$300**
- **Other *no charge***

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	$300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

- **The plan's overall deductible** **$300**
- **Specialist copay** **$45**
- **Hospital (facility) copay** **$300**
- **Other *no charge***

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

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

- **The plan's overall deductible** **$300**
- **Specialist copay** **$45**
- **Hospital (facility) copay** **$300**
- **Other copay** **$45**

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	$300
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**