Microsoft Health Connect Plan

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 1-800-676-1411 (TTY 711) or visit us at aka.ms/benefits. 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 1-800-676-1411 (TTY 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Health Connect network:** $0 **Extended network and Out of Network*:** $1,000 Individual/$3,000 Family, *limited coverage	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. Does not apply to services listed below as "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?	**Yes** **Individual:** $2,000 **Family:** $6,000	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-billed charges, 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?	You'll generally pay less out of pocket when you receive care from a Health Connect provider, versus an Extended network provider. See the Summary Plan Description at aka.ms/benefits for details or call 1-800-676-1411.	You pay the least if you use a provider in our preferred network. You pay more if you use a provider in our non-preferred 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 our 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 I 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 overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		Health Connect Network In-Network Provider (You will pay the least)	Extended Network In-Network Provider	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	$20 copay/visit	40% coinsurance	50% coinsurance	None
	Specialist visit	$40 copay/visit	40% coinsurance	50% coinsurance	None
	Preventive care / screening / immunization	No charge	No charge	50% coinsurance	You may have to pay for services that aren't 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)	10% coinsurance	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	50% coinsurance	Prior authorization recommended for some outpatient imaging tests.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available here	Generic drugs	$10 copay/prescription (retail), $10 - $20 copay/prescription (mail)		50% coinsurance	Retail up to a 30-day supply/generic maintenance up to 90 days. Mail order up to a 90-day supply. No charge for certain preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$30 copay/prescription (retail), $60 copay/prescription (mail)		50% coinsurance	Retail up to a 30-day supply / mail order up to a 90-day supply. Prior authorization required for some drugs.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		Health Connect Network In-Network Provider (You will pay the least)	Extended Network In-Network Provider	Out-Of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	$60 copay/prescription (retail), $120 copay/prescription (mail)		50% coinsurance	Retail up to a 30-day supply / mail order up to a 90-day supply. Prior authorization required for some drugs.
	Specialty drugs	$30 - $60 copay/prescription		Not Covered	Covers up to a 30-day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	50% coinsurance	Prior authorization recommended for some services.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	50% coinsurance	Prior authorization recommended for some services.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	$250 copay/visit	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	None
	Urgent care	$40 copay/visit	40% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient admissions.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		Health Connect Network In-Network Provider (You will pay the least)	Extended Network In-Network Provider	Out-Of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $20 copay/visit Facility:10% coinsurance	Office visit: $20 copay/visit (but in no event more than 40% coinsurance) Facility:10% coinsurance	10% coinsurance	None
	Inpatient services	10% coinsurance	10% coinsurance	10% coinsurance	Prior authorization recommended for all planned inpatient admissions.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		Health Connect Network In-Network Provider (You will pay the least)	Extended Network In-Network Provider	Out-Of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	50% coinsurance	None
	Rehabilitation services	Outpatient: $40 copay/visit Inpatient: 10% coinsurance	Outpatient: $40 copay/visit Inpatient: 40% coinsurance	50% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day.
	Habilitation services	Outpatient: $40 copay/visit Inpatient: 10% coinsurance	Outpatient: $40 copay/visit Inpatient: 40% coinsurance	50% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day.
	Skilled nursing care	10% coinsurance	40% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays or partial hospital care services. 120-day limit.
	Durable medical equipment	10% coinsurance	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		Health Connect Network In-Network Provider (You will pay the least)	Extended Network In-Network Provider	Out-Of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Elective plan option

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery (except as covered under the Reconstruction Surgery Benefit)
- Long-term care
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Infertility treatment
- Chiropractic care or other spinal manipulations
- Dental care (Adult)
- Hearing aids
- Routine foot care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Weigh loss program

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: for ERISA plans, contact the Department of Labor's Employee Benefit's 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, contact: your plan at 1-800-676-1411 or TTY 711, or the state insurance department at 1-800-562-6900, or Department of Labor's 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 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 **1-800-508-4722** or TTY **1-800-842-5357**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-508-4722** or TTY **1-800-842-5357**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码1-800-508-4722** or TTY **1-800-842-5357**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-508-4722** or TTY **1-800-842-5357**.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.*

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	None
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$40
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$0
The Total Peg would pay is	**$1,340**

Note: These numbers assume the patient received care from a Health Connect provider. If you receive care from a non-Health Connect provider your costs may be higher.

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

The plan's overall deductible	None
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The Total Joe would pay is	**$1,220**

Note: These numbers assume the patient received care from a Health Connect provider. If you receive care from a non-Health Connect provider your costs may be higher.

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

The plan's overall deductible	None
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The Total Mia would pay is	**$600**

Note: These numbers assume the patient received care from a Health Connect provider. If you receive care from a non-Health Connect provider your costs may be higher.

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
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無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
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