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 877-330-6664. 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 MedMutual.com/SBC or call 877-330-6664 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/single,**$0**/family HMO Network **$0**/single**$0**/family Non-HMO Network	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there services covered before you meet your deductible?	**Yes. Certain preventive care and all services with copayments are covered and paid by the plan 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 service**s 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, Coinsurance Limit:** **$0**/single,**$0**/family HMO Network **N/A**/single,**N/A**/family Non-HMO Network **Out-of-pocket Limit:** **$2,000**/single,**$6,000**/family HMO Network **N/A**/single,**N/A**/family Non-HMO Network	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 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 MedMutual.com/SBC or call 877-330-6664 for a list of participating 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 an **out-of-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 an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (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	$15 copay/visit	Not Covered	None
	Specialist visit	$30 copay/visit	Not Covered	None
	Preventive care/ screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	No charge	Not Covered	None
	Diagnostic test (blood work)	No charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail Tier 1	$15 (MetroHealth Pharmacy); $25 (All other Pharmacies)	Does Not Apply	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$15 (MetroHealth Pharmacy); Not Covered (All other Pharmacies)	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	$30 (MetroHealth Pharmacy); $40 (All other Pharmacies)	Does Not Apply	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	$30 (MetroHealth Pharmacy); Not Covered (All other Pharmacies)	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	$30 (MetroHealth Pharmacy); $40 (All other Pharmacies)	Does Not Apply	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	$30 (MetroHealth Pharmacy); Not Covered (All other Pharmacies)	Does Not Apply	Covers up to a 90-day supply.
	Specialty drugs	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 copay/visit	Not Covered	None
	Physician/surgeon fees (Outpatient)	$30 copay/visit at Physician, no charge all other services	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 copay/visit		None
	Emergency medical transportation	$50 copay/visit	Not Covered	None
	Urgent care	$15 copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not Covered	None
	Physician/ surgeon fee (inpatient)	No charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		None
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		None
	Substance use disorder outpatient services (alcoholism)	$15 copay/visit for Individual; $5 for Group; Benefits paid based on corresponding medical benefits for all other services	Not Covered	None
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		None
	Substance use disorder outpatient services (drug use)	$15 copay/visit for Individual; $5 for Group; Benefits paid based on corresponding medical benefits for all other services	Not Covered	None
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not Covered	None
	Childbirth/delivery facility services	No charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	(100 visits per benefit period)
	Rehabilitation services (Physical Therapy)	$15 copay/visit	Not Covered	(30 visits per benefit period)
	Habilitation services (Occupational Therapy)	$15 copay/visit	Not Covered	(30 visits per benefit period)
	Habilitation services (Speech Therapy)	$15 copay/visit	Not Covered	(30 visits per benefit period)
	Skilled nursing care	No charge	Not Covered	(100 days per benefit period)
	Durable medical equipment	No charge	Not Covered	None
	Hospice services	No charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

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
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the 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.)

- Routine Eye Care (Adult)

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 Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform, your state insurance department at 800-686-1526 and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform, your state insurance department at 800-686-1526 or your plan at 877-330-6664.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

----------*To see examples of how this plan might cover costs for sample medical situations, 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** **$0**
- **Specialist copay** **$30**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$30**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,160**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$30**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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	**$1,900**

In this example, Mia would pay:

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 877-330-6664.

The plan would be responsible for the other costs of these EXAMPLE covered services.