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 800-540-2583. 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 800-521-6492 to request a copy.

<table>
<thead>
<tr>
<th>Important</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500/single, $1,000/family Network $1,000/single, $2,000/family Non-Network</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical In-Network $2,250/single, $4,500/family Medical Out-of-Network $3,500/single, $7,000/family Prescriptions: $2,250/single, $4,500/family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>a Network Provider (You will pay the least) $30 copay/visit; a Non-Network Provider (You will pay the most) 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (blood work)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Prescription Drug Coverage</td>
<td>$15 copay retail; $30 copay mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.MedImpact.com">www.MedImpact.com</a></td>
<td>Preferred brand drugs</td>
<td>$40 copay retail; $80 copay mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$75 copay retail; $150 copay mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$100 copay retail</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees (Outpatient)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$200 copay/visit, <strong>deductible</strong>, 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee (inpatient)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Benefits paid based on corresponding medical benefits</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Benefits paid based on corresponding medical benefits</td>
<td>None</td>
</tr>
</tbody>
</table>

*If you visit a health care provider's office or clinic*:
- **Primary care visit to treat an injury or illness**
  - a Network Provider: $30 copay/visit
  - a Non-Network Provider: 40% coinsurance
- **Specialist visit**
  - a Network Provider: $50 copay/visit
  - a Non-Network Provider: 40% coinsurance
- **Preventive care/ screening/ immunization**
  - a Network Provider: No charge
  - a Non-Network Provider: 40% coinsurance

*If you have a test*:
- **Diagnostic test (x-ray)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: 40% coinsurance
- **Diagnostic test (blood work)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: 40% coinsurance
- **Imaging (CT/PET scans, MRIs)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: 40% coinsurance

*If you need drugs to treat your illness or condition*:
- **Prescription Drug Coverage**
  - a Network Provider: $15 copay retail; $30 copay mail order
  - a Non-Network Provider: Not Covered
- **Preferred brand drugs**
  - a Network Provider: $40 copay retail; $80 copay mail order
  - a Non-Network Provider: Not Covered
- **Non-preferred brand drugs**
  - a Network Provider: $75 copay retail; $150 copay mail order
  - a Non-Network Provider: Not Covered
- **Specialty drugs**
  - a Network Provider: $100 copay retail
  - a Non-Network Provider: Not Covered

*If you have outpatient surgery*:
- **Facility fee (e.g., ambulatory surgery center)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: 40% coinsurance
- **Physician/surgeon fees (Outpatient)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: 40% coinsurance

*If you need immediate medical attention*:
- **Emergency room care**
  - a Network Provider: $200 copay/visit, **deductible**, 20% coinsurance
  - a Non-Network Provider: None
- **Emergency medical transportation**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: None
- **Urgent care**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: None

*If you have a hospital stay*:
- **Facility fee (e.g., hospital room)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: None
- **Physician/surgeon fee (inpatient)**
  - a Network Provider: 20% coinsurance
  - a Non-Network Provider: None

*If you need mental health, behavioral health, or substance abuse services*:
- **Outpatient services**
  - a Network Provider: Benefits paid based on corresponding medical benefits
  - a Non-Network Provider: None
- **Inpatient services**
  - a Network Provider: Benefits paid based on corresponding medical benefits
  - a Non-Network Provider: None
<table>
<thead>
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<th>What You Will Pay</th>
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</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Physical Therapy)</td>
<td>$50 copay/visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Occupational Therapy)</td>
<td>$50 copay/visit</td>
<td>(40 visits per benefit period, combined with Occupational Therapy)</td>
</tr>
<tr>
<td></td>
<td>Habilitation services (Speech Therapy)</td>
<td>$50 copay/visit</td>
<td>(40 visits per benefit period, combined with Physical Therapy)</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>(20 visits per benefit period)</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
</tbody>
</table>
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
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Private-Duty Nursing
- 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 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 or your plan at 800-540-2583.

**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.

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To see examples of how this plan might cover costs for sample medical situations, see the next section-----------------------------------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.
### 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.

<table>
<thead>
<tr>
<th>Peg is having a baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

#### Cost Sharing

- **Deductibles**
  - Peg: $375
  - Joe: $375
  - Mia: $375

- **Copayments**
  - Peg: $0
  - Joe: $1,505
  - Mia: $0

- **Coinsurance**
  - Peg: 20%
  - Joe: 20%
  - Mia: 20%

#### What isn’t covered

- **Limits or exclusions**
  - Peg: $100
  - Joe: $987
  - Mia: $0

#### The total you would pay is

- Peg: $1,875
- Joe: $2,592
- Mia: $975

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: 800-540-2583.

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