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 (800-586-4509). 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 (800-586-4509) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$375**/single,**$750**/family Network **$750**/single,**$1,500**/family Non-Network	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. 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?	**Medical:** **$1,750**/single,**$3,500**/family Network **Medical Out-of-Network:** **$3,500**/single or **$7,000**/family **Prescriptions:** **$1,750**/single,**$3,500**/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 the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Infertility services, **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 (800-586-4509) 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.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral.**

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.

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	$30 copay/visit	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	40% coinsurance	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)	20% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition	Prescription Drug Coverage	$15 copay retail; $30 copay mail order	Not Covered	Long-term medications filled through mail order pharmacy are charged two 30-day prescription co-pays for three 30-day prescription fills.
	Preferred brand drugs	$40 copay retail; $80 copay mail order	Not Covered	
	Non-preferred brand drugs	$75 copay retail; $150 copay mail order	Not Covered	
	Specialty drugs	$100 copay retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay/visit, **deductible**, 20% **coinsurance**		None
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/ surgeon fee (inpatient)	20% coinsurance	40% coinsurance	None

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	Benefits paid based on corresponding medical benefits		None
	Inpatient services			
If you are pregnant	Office visits	No charge	40% coinsurance	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	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services (Physical Therapy)	$50 copay/visit	40% coinsurance	(40 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	$50 copay/visit	40% coinsurance	(40 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	$50 copay/visit	40% coinsurance	(20 visits per benefit period)
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

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
- 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
- Non-emergency care when traveling outside the U.S.
- 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 (800-586-4509).

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.

----------*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.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

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	$375
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$375
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,875**

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

The plan's overall deductible	$375
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$100
Copayments	$1,505
Coinsurance	$0
What isn't covered	
Limits or exclusions	$987
The total Joe would pay is	**$2,502**

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

The plan's overall deductible	$375
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$375
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$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: (800-586-4509).

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

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]