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 800-315-3137 or visit us at MedMutual.com/SBC. 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 www.dol.gov/ebsa/healthreform or call 800-315-3137 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network**: **$250**/single, **$500**/family Non-Network: **$500**/single, **$1,000**/family	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 services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/.**
Are there other deductibles for specific services?	Not applicable.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance** Limit: **Network**: **$1,000**/single, **$2,000**/family Non-Network: **$2,000**/single, **$4,000**/family **Out-of-pocket Limit**: **Network**: **$6,600**/single, **$13,200**/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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	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?	Yes, See **MedMutual.com/SBC** or call 800-315-3137 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 **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
		A Network Provider (You will pay the least)	A Network Provider (You will pay the least)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% **coinsurance**	30% **coinsurance**	none
	Specialist visit	10% **coinsurance**	30% **coinsurance**	none
	Preventive care/**screening**/immunization	No charge	50% **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, blood work)	10% **coinsurance**	30% **coinsurance**	none
	Imaging (CT/PET scans, MRIs)	10% **coinsurance**	30% **coinsurance**	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-776-1355.	Generic drugs	$10 Retail $20 Mail	$10 Retail $20 Mail	OTCs, Vitamins, Cosmetic products not including Acne medications
	Preferred brand drugs	$25 Retail $50 Mail	$25 Retail $50 Mail	OTCs, Vitamins, Cosmetic products not including Acne medications
	Non-preferred brand drugs	$40 Retail $80 Mail	$40 Retail $80 Mail	OTCs, Vitamins, Cosmetic products not including Acne medications
	Specialty drugs	Covered according to Preferred or Non-preferred status above	Covered according to Preferred or Non-preferred status above	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **coinsurance**	30% **coinsurance**	none
	Physician/surgeon fees	10% **coinsurance**	30% **coinsurance**	none
If you need immediate medical attention	**Emergency room care**	$50 **copay**/visit	$50 **copay**/visit	none
	Emergency medical transportation	10% **coinsurance**	30% **coinsurance**	none
	Urgent care	10% **coinsurance**	30% **coinsurance**	none

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		A Network Provider (You will pay the least)	A Network Provider (You will pay the least)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% **coinsurance**	30% **coinsurance**	——————none——————
	Physician/surgeon fee	10% **coinsurance**	30% **coinsurance**	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	——————none——————
	Inpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	——————none——————
If you are pregnant	Office visits	No charge	50% **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	10% **coinsurance**	30% **coinsurance**	——————none——————
	Childbirth/delivery facility services	10% **coinsurance**	30% **coinsurance**	——————none——————
If you need help recovering or have other special health needs	**Home health care**	10% **coinsurance**	30% **coinsurance**	——————none——————
	Rehabilitation services	10% **coinsurance**	30% **coinsurance**	——————none——————
	Habilitation services	10% **coinsurance**	30% **coinsurance**	——————none——————
	Skilled nursing care	10% **coinsurance**	30% **coinsurance**	(100 days per benefit period)
	Durable medical equipment	10% **coinsurance**	30% **coinsurance**	——————none——————
	Hospice services	10% **coinsurance**	30% **coinsurance**	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		A Network Provider (You will pay the least)	A Network Provider (You will pay the least)	
If your child needs dental or eye care	Children's eye exam	Not covered on medical but covered under separate stand-alone vision plan	Not covered on medical but covered under separate stand-alone vision plan	————————none————————
	Children's glasses	Not covered on medical but covered under separate stand-alone vision plan	Not covered on medical but covered under separate stand-alone vision plan	————————none————————
	Children's dental check-up	Not covered on medical but covered under separate stand-alone dental plan	Not covered on medical but covered under separate stand-alone dental plan	————————none————————

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.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult
- 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
- Private-duty nursing

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: . 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: 800-315-3137.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 800-315-3137.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-315-3137.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-315-3137.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-315-3137.

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 network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,400**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,000
Coinsurance	$90
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,450**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$440**

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