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 www.MedMutual.com/SBC or call 1-800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/single,**$0**/family Network **$200**/single,**$400**/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 services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Coinsurance Limit:** **$0**/single,**$0**/family Network **$500**/single,**$500**/family Non-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-pockets limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Cost sharing** for **prescription drugs**, **premiums**, balance-billed charges and health care this **plan** doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a network provider?	Yes. See MedMutual.com/SBC or call 800-540-2583 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	$10 copay/visit	20% coinsurance	None
	Specialist visit	$10 copay/visit	20% coinsurance	None
	Other practitioner office visit (Chiropractic)	$10 copay/visit	20% coinsurance	(40 visits per benefit period combined with Physical and Occupational Therapies)
	Other practitioner office visit (Accupuncture)	Not Covered		Excluded Service
	Preventive care/screening/ immunization	$10 copay/visit	No charge	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)	No charge		None
	Imaging (CT/PET scans, MRIs)	No charge		None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5.00 copay – retail; $5.00 copay – mail order	$5.00 copay - retail Not covered – mail order	Covers up to a 30-day supply (retail); Covers up to a 90-day supply (mail order); Prior Authorization – Some drugs may require a prior authorization. If necessary prior authorization is not obtained, the drug may not be covered.
	Preferred brand drugs	$15.00 copay- retail; $15.00 copay – mail order	$15.00 copay- retail Not covered – mail order	Your plan uses a preferred drug list that identifies the status of covered drugs.
	Non-preferred brand drugs	$30.00 copay- retail; $30.00 copay – mail order	$30.00 copay- retail Not covered – mail order	
	Specialty drugs	Same as Retail Copays	Same as Retail Copays	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge		None
	Emergency medical transportation	No charge	No charge after deductible	None
	Urgent care	$10 copay/visit	20% coinsurance	None

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

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	$200 copay/admission	None
	Physician/surgeon fees (inpatient)	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Prenatal and postnatal care	No charge	No charge after deductible	None
	Delivery and all inpatient services	No charge	No charge after deductible	None
	Childbirth/delivery facility services	No charge	$200 copay/admission, no charge after deductible at Physician	None
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	(100 visits per benefit period)
	Rehabilitation services (Physical Therapy)	$10 copay/visit	20% coinsurance	(40 visits per benefit period, combined with Occupational Therapy and Chiropractic)
	Habilitation services (Occupational Therapy)	$10 copay/visit	20% coinsurance	(40 visits per benefit period combined with Physical Therapy and Chiropractic)
	Habilitation services (Speech Therapy)	No charge	20% coinsurance	(40 visits per benefit period, then Medical Review)
	Skilled nursing care	No charge	$200 copay/admission	(100 days per benefit period)
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge	No charge after deductible	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	20% coinsurance	Inclusive with a preventive well child visit
	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	• Dental Care Adult)	• Non-emergency care when traveling outside the U.S.
• Children's dental check-up	• Hearing Aids	• Routine Eye Care (Adult)
• Children's glasses	• Infertility Treatment	• Routine Foot Care
• Cosmetic Surgery	• Long-Term 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: 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 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 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 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.

To see examples of how this plan might cover costs for a sample medical situation, 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 www.MedMutual.com]/SBC or www.express-scripts.com.]

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	$ 10
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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$110**

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	$ 10
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	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,090**

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

The plan's overall deductible	$ 0
Specialist copay	$ 10
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	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$50**

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.