

 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](http://www.MedMutual.com/SBC) or call 1-800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$7,900/single,\$15,800/family Network \$14,200/single,\$28,400/family Non-Network	Generally, you must pay all of the costs from providers up to the <b>deductible</b> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Certain <a href="#">preventive care</a> and all services with <a href="#">copayments</a> are covered and paid by the <a href="#">plan</a> before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <b>deductible</b> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,900/single,\$15,800/family Network Unlimited/single, Unlimited/family Non-Network	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <b>out-of-pockets limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<b>Premiums</b> , balance-billed charges and health care this <a href="#">plan</a> 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 <b>out-of-pocket limit</b> .  The cost of these drugs (though reimbursed by the manufacturer at not cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers.	This <a href="#">plan</a> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <a href="#">plan's network</a> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <a href="#">plan</a> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$20.00 copay – retail; \$40.00 copay – mail order	\$20.00 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	\$45.00 copay- retail; \$90.00 copay – mail order	\$45.00 copay- retail Not covered – mail order	Your plan uses a preferred drug list that identifies the status of covered drugs.
	Non-preferred brand drugs	\$75.00 copay- retail; \$150.00 copay – mail order	\$75.00 copay- retail Not covered – mail order	
	<u>Specialty drugs</u>	Same as Retail Copays	Same as Retail Copays	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	No charge after <u>deductible</u>		None
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.MedMutual.com/SBC](http://www.MedMutual.com/SBC) or [www.express-scripts.com](http://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 after <u>deductible</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees (inpatient)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	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	Office visits	No charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<a href="#">Rehabilitation services (Physical Therapy)</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	(10 visits per benefit period, then Medical Review)
	<a href="#">Habilitation services (Occupational Therapy)</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	(10 visits per benefit period, then Medical Review)
	<a href="#">Habilitation services (Speech Therapy)</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	(10 visits per benefit period, then Medical Review)
	<a href="#">Skilled nursing care</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<a href="#">Durable medical equipment</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<a href="#">Hospice services</a>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

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## 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](http://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](http://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.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,900
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$7,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1000
<b>The total Peg would pay is</b>	<b>\$8,900</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,900
■ <a href="#">Specialist copay</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$700
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$6,200
<b>The total Joe would pay is</b>	<b>\$7,000</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,900
■ <a href="#">Specialist copay</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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.