**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 1-877-520-6728. 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 1-877-520-6728 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000**/single Network **$2,000**/single 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 is 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?** | Yes, $100 (generic prescriptions), $200 (brand name prescriptions)/single | 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?** | **$4,900**/single Network **Unlimited**/single 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-pocket 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. | 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 www.MedMutual.com/SBC or call 1-877-520-6728 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 |
|---|---|---|---|---|
| | | an In-Network Provider (You will pay the least) | an Out-of-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 | $15 copay/visit (Medical Home), $25 copay/visit (PCP) | 40% coinsurance | None |
| | Specialist visit | $40 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) | 25% coinsurance | 30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests | None |
| | Diagnostic test (blood work) | 25% coinsurance | 30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests | None |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | an In-Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com | Generic copay - retail Tier 1 | 20% coinsurance, $4 min & $8 max (Preferred); 25% coinsurance $7 min & $11 max (Non-preferred) | Does Not Apply | Covers up to a 30-day supply |
| | Generic copay - home delivery Tier 1 | 20% coinsurance, $10 min & $20 max | Does Not Apply | Covers a 61-90 day supply |
| | Preferred brand copay - retail Tier 2 | 30% coinsurance, $30 min & $60 max (Preferred); 35% coinsurance, $35 min & $65 max (Non-preferred) | Does Not Apply | Covers up to a 30-day supply |
| | Preferred brand copay - home delivery Tier 2 | 30% coinsurance; $75 min & $150 max | Does Not Apply | Covers a 61-90 day supply |
| | Non-preferred brand copay - retail Tier 3 | Not Covered | Does Not Apply | Excluded Service |
| | Non-preferred brand copay - home delivery Tier 3 | Not Covered | Does Not Apply | Excluded Service |
| | | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees (Outpatient) | 25% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | | $250 copay/visit Non-emergency room services |
| | Emergency medical transportation | 25% coinsurance | 30% coinsurance | None |
| | Urgent care | $45 copay/visit | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 copay/confinement, plus deductible, 25% coinsurance | $250 copay/confinement, plus deductible, 30% coinsurance | (copay applies to all services except Skilled Nursing Facility) |
| | Physician/ surgeon fees (inpatient) | 25% coinsurance | 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | an In-Network Provider (You will pay the least) | an Out-of-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 | Benefits paid based on corresponding medical benefits | | None |
| **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 | 25% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | $150 copay/confinement, plus deductible; 25% coinsurance | $250 copay/confinement, plus deductible; 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | an In-Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance except no charge first 100 days for Aid/Home Visit/Skilled Nursing/Physical/Speech/ Occupational Therapies | 30% coinsurance | None |
| | Rehabilitation services (Physical Therapy) | 25% coinsurance | 40% coinsurance | (10 visits, then Medical Review - Professional; unlimited - Institutional) |
| | Habilitation services (Occupational Therapy) | 25% coinsurance | 40% coinsurance | None |
| | Habilitation services (Speech Therapy) | 25% coinsurance | 40% coinsurance | (10 visits, then Medical Review - Professional; unlimited - Institutional) |
| | Skilled nursing care | No charge after deductible | 30% coinsurance | 365 days per confinement with a 90-day renewal. Covered after a 3-day hospital stay and within 14 days of discharge |
| | Durable medical equipment | 25% coinsurance | 40% coinsurance | None |
| | Hospice services | No charge after deductible | 30% 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 |

## 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
- Infertility Treatment
- Long-Term Care
- Non-preferred brand copay - home delivery Tier 3
- Non-preferred brand copay - retail Tier 3
- 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
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing

**Your Rights to Continue Coverage:** If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-520-6728. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 or www.cciio.cms.gov.

**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 1-877-520-6728.

## 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.

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

## 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** **$1,000**
- **Specialist copay** **$40**
- **Hospital (facility) copay** **$150**
- **Other coinsurance** **25%**

**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* | $1,000 |
| Copayments | $400 |
| Coinsurance | $2,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,260** |

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

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$40**
- **Hospital (facility) copay** **$150**
- **Other coinsurance** **25%**

**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* | $1,000 |
| Copayments | $300 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,370** |

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

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$40**
- **Hospital (facility) copay** **$150**
- **Other coinsurance** **25%**

**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* | $1,000 |
| Copayments | $200 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,230** |

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: 1-877-520-6728.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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