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 877-728-3935. 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 877-728-3935 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750**/single, **$1,500**/family HMO 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?	**$2,500**/single, **$5,000**/family HMO 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?	**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 877-728-3935 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
		HMO Network (You will pay the least)	Non-HMO Network (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	$20 copay/visit	Not Covered	None
	Specialist visit	$40 copay/visit	Not Covered	None
	Preventive care/ screening/ immunization	No charge	Not Covered	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	Not Covered	None
	Diagnostic test (blood work)	20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Pharmacy Benefits Manager	CVS Caremark		None
	Generic copay - retail Tier 1	$10	Does Not Apply	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$25	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - retail Tier 2	$25 or 20% (whichever is greater), with a maximum of $75	Does Not Apply	Covers up to a 30-day supply.
	Preferred brand name copay - home delivery Tier 2	$60 or 20% (whichever is greater), with a maximum of $150	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - retail Tier 3	$40 or 40% (whichever is greater), with a maximum of $150	Does Not Apply	Covers up to a 30-day supply.
	Non-preferred brand name copay - home delivery Tier 3	$90 or 40% (whichever is greater), with a maximum of $300	Does Not Apply	Covers up to a 90-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit		None
	Emergency medical transportation	20% coinsurance	Not Covered	None
	Urgent care	$25 copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	(365 days per confinement with a 60 day renewal for all services except Skilled Nursing Facility) —
	Physician/ surgeon fee (inpatient)	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits	Not Covered	None
	Inpatient services	Benefits paid based on corresponding medical benefits	Not Covered	None
If you are pregnant	Office visits	No charge	Not Covered	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	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Network (You will pay the least)	Non-HMO Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	(100 visits per benefit period)
	Rehabilitation services (Physical Therapy)	20% coinsurance	Not Covered	(40 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	20% coinsurance	Not Covered	(40 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	20% coinsurance	Not Covered	(20 visits per benefit period)
	Skilled nursing care	20% coinsurance	Not Covered	(120 days per benefit period)
	Durable medical equipment	20% coinsurance	Not Covered	(1 per benefit period, when hair loss is due to chemotherapy or radiation)
	Hospice services	No charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	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
- Abortions, unless the pregnancy would endanger the life of the mother
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- 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
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact your plan at 877-728-3935. 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 your plan at 877-728-3935.

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*----------

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 plan's overall deductible	$750
Specialist copay	$40
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	$750
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$750
Specialist copay	$40
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	$2,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,560**

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

The plan's overall deductible	$750
Specialist copay	$40
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	$750
Copayments	$270
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,090**

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: 877-728-3935.

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