This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at MedMutual.com/SBC or by calling 1-800-825-6169.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$350/single, $700/family Network $700/single, $1,400/family Non-Network Doesn't apply to coinsurance, copays	You must pay all the cost up to the deductible amount before this plan begins to pay for covered service you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, $1,750/single, $3,500/family Network $3,500/single, $7,000/family Non-Network	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copays, deductibles, 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.
Is there an overall annual limit on what the plan pays?	Yes, $2,000,000	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expense above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, see MedMutual.com/SBC or call 800-825-6169 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed later in the document. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-825-6169 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 1-800-825-6169 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	----------none----------
	Specialist visit	$20 copay/visit	40% coinsurance	----------none----------
	Other practitioner office visit (Chiropractic)	20% coinsurance	40% coinsurance	(12 visits per benefit period)
	Other practitioner office visit (Acupuncture)	Not Covered		Excluded Service
	Preventive care/screening/immunization	20% coinsurance	40% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.	If you choose a brand name drug or generic equivalent prescription, your co-payment will be 20% of the cost.		Oral Contraceptives/Devices, Therapeutic Device, Artificial Appliances, Fertility Drugs, Tobacco Cessation Medications, Genetically Engineered Drugs, Male Sexual Dysfunctional Drugs, Anorexiants, Diabetic Supplies, Ostomy Products
	Federal Legend Drugs			
	State Restricted Drugs			
	Compounded Medication			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance	----------none----------
	Emergency medical transportation	20% coinsurance	40% coinsurance	----------none----------
	Urgent care	20% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fee (inpatient)	20% coinsurance	40% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		----------none----------
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		----------none----------
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		----------none----------
	Substance use disorder outpatient services (drug abuse)	Benefits paid based on corresponding medical benefits		----------none----------
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		----------none----------
	Substance use disorder inpatient services (drug abuse)	Benefits paid based on corresponding medical benefits		----------none----------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	(covered for subscriber and spouse only)
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	(covered for subscriber and spouse only)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	(40 visits per benefit period)
	Rehabilitation services	20% coinsurance	40% coinsurance	----------none----------
	Habilitation services (Occupational Therapy)	20% coinsurance	40% coinsurance	----------none----------
	Habilitation services (Speech Therapy)	20% coinsurance	40% coinsurance	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	----------none----------
	Durable medical equipment	20% coinsurance	40% coinsurance	----------none----------
	Hospice service	20% coinsurance	40% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered		Excluded Service
	Glasses	Not Covered		Excluded Service
	Dental check-up	Not Covered		Excluded Service

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
- Cosmetic Surgery
- Dental Check-up (Child)
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- Weight Loss Programs

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 800-825-6169. 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 x61566 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This plan does meet the minimum standard for the benefits it provides.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: the plan at 800-825-6169. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3273) or www.dol.gov/eba/healthreform.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [800-825-6169].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800-825-6169].

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [800-825-6169].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [800-825-6169].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,790
- Patient pays $1,750

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$350
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$200
Total	$1,750

These 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 your HRA or FSA, please contact your employer group.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $3,650
- Patient pays $1,750

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$350
Copays	$100
Coinsurance	$40
Limits or exclusions	$1,260
Total	$1,750

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800-825-6169.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.