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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/single,$600/family Network $400/single,$1,200/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.
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?	$800/single,$2,400/family Network $2,400/single,$7,200/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-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, copays, deductibles 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 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
		a Network Provider (You will pay the least)	a 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	$20 copay/visit	40% coinsurance	None
	Specialist visit	$35 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	$20 copay/visit	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)	No charge at Physician; 15% coinsurance for all other places	40% coinsurance	None
	Diagnostic test (blood work)	No charge at Physician; 15% coinsurance for all other places	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge at Physician; 15% coinsurance for all other places I	40% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail - $6.00/copay/RX Mail - 12.00 Copay/RX	You pay 100% of retail cost and then file a claim with Caremark. Reimbursement will be based on the allowable network cost.	Retail – 30 days Mail Order – 90 days
For more information about prescription drug coverage, call 800-522-8159 or visit www.caremark.com	Preferred brand drugs (i.e. those drugs on the formulary – Tier 2)	Retail – 20% with $100 max/RX Mail – 20% with $300 max/RX	You pay 100% of retail cost and then file a claim with Caremark. Reimbursement will be based on the allowable network cost.	Retail – 30 days Mail Order – 90 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Network Provider (You will pay the least)	a Non-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	Retail – 40% with $125 max/RX Mail – 40% with $375 max/RX	You pay 100% of retail cost and then file a claim with Caremark. Reimbursement will be based on the allowable network cost.	Retail – 30 days Mail Order – 90 days
	Miscellaneous or Life-Style drugs (Tier 4)	Retail – 100% Mail – Not available	You pay 100% of retail cost and then file a claim with Caremark. Reimbursement will be based on the allowable network cost.	Retail – 30 days
	Specialty drugs	For injectable drugs to treat multiple sclerosis, cancer, etc. contact Caremark to learn if the drug is preferred or non-preferred		Not all prescriptions are covered and some may be subject to prior approval. Contact Caremark for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	15% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit, 15% coinsurance		None
	Emergency medical transportation	15% coinsurance		None
	Urgent care	$20 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	None
	Physician/ surgeon fee (inpatient)	15% coinsurance	40% coinsurance	None

Note: The BGSU Plan is grandfathered under the Patient Protection and Affordable Care Act. As such, our plan is not required to cover contraceptives and certain other women's preventive care services without cost-sharing. However, generic contraceptives are available without copayments or coinsurance from the Falcon Health Center Pharmacy and Caremark Home Delivery only. If you request brand oral contraceptives refer to the Miscellaneous or Life-Style drugs above. Other contraceptive methods are not covered by the plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Network Provider (You will pay the least)	a Non-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	$20 copay/visit	40% coinsurance	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	15% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	None
	Rehabilitation services (Physical Therapy)	15% coinsurance	40% coinsurance	(30 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	15% coinsurance	40% coinsurance	(30 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	15% coinsurance	40% coinsurance	(20 visits per benefit period)
	Skilled nursing care	15% coinsurance	40% coinsurance	None
	Durable medical equipment	15% coinsurance	40% coinsurance	None
	Hospice services	15% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	40% 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
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- 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
- 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.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, 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 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 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	$200
Specialist copay	$35
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$200
Copayments	$40
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,100

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

The plan's overall deductible	$200
Specialist copay	$35
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$200
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,560

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

The plan's overall deductible	$200
Specialist copay	$35
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$200
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$600

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.