

 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 1-888-421-2199 or visit [www.myMPCbenefits.com](http://www.myMPCbenefits.com). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-888-421-2199 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-network \$600 person / \$1,200 family. Out-of-network \$1,200 person / \$2,400 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> 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 <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network <a href="#">preventive care</a> is covered 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 <a href="#">deductible</a> 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 <a href="#">deductible</a> . 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?	Yes. \$100 person/\$200 family for <a href="#">prescription drug coverage</a> at retail.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> 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> ?	For <a href="#">network providers</a> \$3,500 individual / \$7,000 family; for <a href="#">out-of-network providers</a> \$7,000 individual / \$14,000 family	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">pre-authorization</a> or for non-compliance 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. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-855-698-5676 for a list of in-network providers, or see <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 1-877-207-1357 for participating pharmacies.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	20 visit limit on manipulations, network and out-of-network combined.
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for imaging. If you don't get <a href="#">preauthorization</a> for imaging (CT/PET scans, MRIs), benefits could be reduced or services not covered.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information	Common Medical Event
<p><b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myMPCbenefits.com">www.myMPCbenefits.com</a></p>	Generic drugs	\$10 <a href="#">copay</a> /prescription at retail; \$25 <a href="#">copay</a> /prescription at mail order	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Retail prescription subject to \$100/\$200 <a href="#">deductible</a> per individual/family per year. You will pay 100% of the cost of a maintenance drug upon 3 <sup>rd</sup> fill at pharmacy. Mail order or Walgreens Smart90 programs should be used. Does not apply to maintenance drugs where only 30-day fill is permitted. When formulary brand is purchased and generic is available, you will pay cost difference between generic and brand. For drugs covered under medical (Anthem), coinsurance is 20% in-network and 40% out-of-network. **Please see "Important Questions" / "What is not included in the out-of-pocket limit?" above regarding certain specialty drugs that are considered non-essential health benefits.
	Formulary brand drugs	\$30 <a href="#">copay</a> /prescription at retail; \$75 <a href="#">copay</a> /prescription at mail order	Not covered	
	Non-formulary brand drugs	\$60 <a href="#">copay</a> /prescription at retail; \$150 <a href="#">copay</a> /prescription at mail order	Not covered	
	<a href="#">Specialty drugs**</a>	Subject to brand copays listed above.**	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced or services not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit and 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> /visit and 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies first, then <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Copay</a> waived if admitted. You will pay \$200 <a href="#">copay</a> /visit and 40% <a href="#">coinsurance</a> for non-emergency use of <a href="#">network</a> and <a href="#">out-of-network</a> ER use.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced or services not covered.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information	Common Medical Event
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /office visit	40% <a href="#">coinsurance</a>	
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient services. If you don't get <a href="#">preauthorization</a> , benefits could be reduced or services not covered. <a href="#">Out-of-network</a> inpatient facilities must be licensed and accredited.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> /office visit	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Limited to 4 hours per visit.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient. Physical, Occupational and Speech Therapy: review required at 30 <sup>th</sup> visit.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All rehabilitation/habilitation visit count toward rehabilitation limit.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Limited to 180 days per calendar year and 365 days lifetime maximum per member.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> for medical necessity is required for some durable medical equipment/prosthetics.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

## 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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture (limitations apply)
- Bariatric surgery (advance approval required with treatment at Plan-recognized Center of Excellence)
- Chiropractic care (manipulations, regardless of service provider type, limited to 20 visits per member per year)
- Hearing aids (limitations apply)
- Infertility treatment (network provider only - lifetime limit of one attempt or cycle IVF or AI; lifetime maximum prescription drug treatment coverage not to exceed \$15,000)
- Private-duty nursing (in-home)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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. For information on continuing coverage under this plan, contact the plan at 1-888-421-2199.

**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: You can contact Anthem Member Services a 1-855-698-5676 for medical/surgical and Express Scripts Member Services at 1-877-207-1357 for prescription. You can also contact the Marathon Petroleum Health Plan Administrator, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-698-5676.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-698-5676.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-698-5676.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-698-5676.

-----To see examples of how this plan might cover costs for a sample medical situation, 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](#) \$600
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- Primary care 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>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$2,450
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,110</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$50
- 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 (*via mail order*)
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,055
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,715</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$300
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,285</b>