

 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 <u>deductible</u> ?	\$900/single, \$1,800/family Network \$900/single, \$1,800/family Non-Network	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .	
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .	
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.	
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Coinsurance Limit: \$900/single, \$1,800/family Network \$2,700/single, \$5,400/family Non-Network Out-of-pocket Limit: \$7,900/single, \$15,800/family Network Unlimited/single, Unlimited/family Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.	
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .	
Will you pay less if you use a <u>network provider</u> ?	Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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
		Network Provider (You will pay the least)	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 <u>Specialist visit</u>	\$15 copay/visit \$30 copay/visit	\$15 copay/visit, 40% coinsurance \$30 copay/visit, 40% coinsurance	None None
	<u>Preventive care/ screening/ immunization</u>	No charge	\$15 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	<u>Diagnostic test (x-ray)</u> <u>Diagnostic test (blood work)</u> Imaging (CT/PET scans, MRIs)	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance	None None None
If you need drugs to treat your illness or condition	Generic copay - retail Tier 1 Generic copay - home delivery Tier 1 Preferred brand copay - retail Tier 2 Preferred brand copay - home delivery Tier 2	\$10 \$20 \$30	Does Not Apply Does Not Apply Does Not Apply	Covers up to a 30-day supply. Covers up to a 90-day supply. Covers up to a 30-day supply. Covers up to a 90-day supply.
More information about prescription drug coverage is available at MedMutual.com/SBC	Preferred brand copay - home delivery Tier 3 Non-preferred brand copay - retail Tier 3 Non-preferred brand copay - home delivery Tier 3 <u>Specialty drugs</u>	\$60 \$50 \$100 25% up to \$150	Does Not Apply Does Not Apply Does Not Apply Does Not Apply	Covers up to a 30-day supply. Covers up to a 30-day supply. Covers up to a 90-day supply. Covers up to a 30-day supply.

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
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	
	<u>Emergency room care</u>	\$300 copay/visit	40% copay/visit	None	
	<u>Emergency medical transportation</u>	20% coinsurance	40% coinsurance	None	
	<u>Urgent care</u>	\$50 copay/visit	\$50 copay/visit; 40% coinsurance	None	
If you need immediate medical attention	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None	
	Physician/ surgeon fee (inpatient)	20% coinsurance	40% coinsurance	None	
	Outpatient services	Benefits paid based on corresponding medical benefits		None	
If you have a hospital stay	Inpatient services	Benefits paid based on corresponding medical benefits		None	
	Office visits	No charge	40% coinsurance	Cost sharing does not apply to certain <u>preventive services</u> .	
If you need mental health, behavioral health, or substance abuse services	Childbirth/delivery professional services	20% coinsurance	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 facility services	20% coinsurance	40% coinsurance	None	
If you are pregnant				None	

Common Medical Event Services You May Need What You Will Pay Network Provider (You will pay the least) Non-Network Provider (You will pay the most) Limitations, Exceptions, & Other Important Information

Common Medical Event	Services You May Need	What You Will Pay	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Rehabilitation services (Physical Therapy)</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period, combined with Occupational Therapy)
	<u>Habilitation services (Occupational Therapy)</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period, combined with Physical Therapy)
	<u>Habilitation services (Speech Therapy)</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Skilled nursing care</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If your child needs dental or eye care	<u>Hospice services</u>		20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Children's eye exam		No charge	\$15 copay/visit, 40% <u>coinsurance</u>	None
	Children's glasses		Not Covered	Not Covered	Excluded Service
	Children's dental check-up		Not Covered	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
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- 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.)

- Chiropractic Care
- 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 ccio.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.

<ul style="list-style-type: none"> ■ <u>The plan's overall deductible</u> ■ <u>Specialist copay</u> ■ <u>Hospital (facility) coinsurance</u> ■ <u>Other coinsurance</u> 	<ul style="list-style-type: none"> ■ <u>The plan's overall deductible</u> ■ <u>Specialist copay</u> ■ <u>Hospital (facility) coinsurance</u> ■ <u>Other coinsurance</u> 	<ul style="list-style-type: none"> ■ <u>The plan's overall deductible</u> ■ <u>Specialist copay</u> ■ <u>Hospital (facility) coinsurance</u> ■ <u>Other coinsurance</u> 	<ul style="list-style-type: none"> ■ <u>The plan's overall deductible</u> ■ <u>Specialist copay</u> ■ <u>Hospital (facility) coinsurance</u> ■ <u>Other coinsurance</u>
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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*)

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*)

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	\$12,800	\$7,400	\$1,900
In this example, Peg would pay:			
<i>Cost Sharing</i>			
Deductibles	\$900	\$100	\$900
Copayments	\$0	\$900	\$300
Coinsurance	\$900	\$0	\$40
<i>What isn't covered</i>			
Limits or exclusions	\$60	\$60	\$0
The total Peg would pay is	\$1,860	\$1,060	\$1,240

In this example, Mia would pay:

Cost Sharing

Deductibles	\$900
Copayments	\$300
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,240

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.

Multi-Language Interpreter Services & Nondiscrimination Notice



This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك (بالمجان). اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíłnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711)まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html