



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](https://www.medicare.gov/coverage/preventive-care-benefits/) or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$750/single, \$1,500/family Network \$2,000/single, \$4,000/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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services 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?	Coinsurance Limit: \$2,000/single, \$4,000/family Network \$4,000/single, \$8,000/family Non-Network Out-of-pocket Limit: \$6,600/single, \$13,200/family Network Unlimited /single, Unlimited /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?	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 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
		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	\$30 copay/visit	40% coinsurance	None
	Specialist visit	\$45 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% 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)	20% coinsurance	40% coinsurance	None
	Diagnostic test (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.caremark.com	Generic copay – retail Tier 1	\$15	Does Not Apply	Not all Prescriptions are covered. To determine if a drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. You are required to use the Mail Order service after 2 retail refills
	Generic copay – home delivery Tier 1	\$30	Does Not Apply	
	Preferred brand copay – retail Tier 2	\$30	Does Not Apply	
	Preferred brand copay – home delivery Tier 2	\$60	Does Not Apply	
	Non-Preferred brand copay – retail Tier 3	\$60	Does Not Apply	
	Non-Preferred brand copay – home delivery Tier 3	\$120	Does Not Apply	
	Specialty drugs	\$100	Does Not Apply	
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

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 need immediate medical attention	Emergency room care	\$150 copay/visit		None
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	\$45 copay/visit	40% coinsurance	None
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 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	No charge	50% coinsurance	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	40% coinsurance	None	
Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	(40 visits per benefit period)	
	Rehabilitation services (Physical Therapy)	20% coinsurance	40% coinsurance	(10 visits then Medical Review - Professional; unlimited - Institutional)combined with Occupational Therapy and Chiropractic)	
	Habilitation services (Occupational Therapy)	20% coinsurance	40% coinsurance	(10 visits then Medical Review - Professional; unlimited - Institutional)combined with Physical Therapy and Chiropractic)	
	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 services	20% coinsurance	40% coinsurance	None	
	If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	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
- 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.)

- Bariatric Surgery
- 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](https://www.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](https://www.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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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)

• <u>The plan's overall deductible</u>	\$750
• <u>Specialist copay</u>	\$45
• <u>Hospital (facility) coinsurance</u>	20%
• <u>Other coinsurance</u>	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*)

Total Example Cost

<u>Specialist</u> visit (<i>anesthesia</i>)	\$12,700
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In this example, Peg would pay:

Cost Sharing

What isn't covered

Limits or exclusions	\$70
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The total Peg would pay is	\$2,820
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Deductibles	\$750
Copayments	\$0
Coinsurance	\$2,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

• <u>The plan's overall deductible</u>	\$750
• <u>Specialist copay</u>	\$45
• <u>Hospital (facility) coinsurance</u>	20%
• <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs

Total Example Cost

<u>Durable medical equipment</u> (<i>glucose meter</i>)	\$5,600
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In this example, Joe would pay:

Cost Sharing

What isn't covered

Limits or exclusions	\$4,300
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The total Joe would pay is	\$4,600
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Deductibles	\$100
Copayments	\$200
Coinsurance	\$0

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

• <u>The plan's overall deductible</u>	\$750
• <u>Specialist copay</u>	\$45
• <u>Hospital (facility) coinsurance</u>	20%
• <u>Other coinsurance</u>	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

	\$2,800
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In this example, Mia would pay:

Cost Sharing

What isn't covered

Limits or exclusions	\$10
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The total Mia would pay is	\$1,160
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Deductibles	\$750
Copayments	\$200
Coinsurance	\$200

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

كل فونته و غلا و علمات مدخ نيف، متغلا ركائحتكنا، تطوحم (711 مكب لاو مصلاقتاهمقر 1-800-382-5729 مقرب لصتا نلجلا ب)

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 nínizin: Díí saad bee yáníłtí' go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę", t'áá jiik'eh, éí ná hÓłq' , koji' hódíílnih 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 asistent, 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](mailto: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