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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](http://MedMutual.com/SBC) or call 800-540-2583 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall deductible?</b>                              | <b>\$250/single, \$500/family</b> HMO 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> .   |
| <b>Are there services covered before you meet your deductible?</b>  | <b>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>.</b>   | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>           | No   | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | <b>Yes, Coinsurance Limit:</b><br>\$1,750/single, \$3,500/family HMO Network<br>N/A/single, N/A/family Non-HMO Network<br><b>Out-of-pocket Limit:</b><br>\$6,600/single, \$13,200/family HMO Network<br>N/A/single, N/A/family Non-HMO 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.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <b>Premiums</b> , 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> .   |

|   |   |  |
|---|---|--|
| <b>Will you pay less if you use a network provider?</b> | Yes, See <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers. | This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services. |
| <b>Do you need a referral to see a specialist?</b>      | No  | You can see the <b>specialist</b> you choose without a <b>referral</b> .   |



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  |
|---|--|---|--|---|
|   |  | HMO Network<br>(You will pay the least) | Non-HMO Network<br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$25 copay/visit                        | Not Covered                                | None  |
|   | <u>Specialist</u> visit                          | \$50 copay/visit                        | Not Covered                                | None  |
|   | <u>Preventive care/ screening/ immunization</u>  | No charge                               | Not Covered                                | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray)                   | 20% <u>coinsurance</u>                  | Not Covered                                | None  |
|   | <u>Diagnostic test</u> (blood work)              | 20% <u>coinsurance</u>                  | Not Covered                                | None  |
|   | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                  | Not Covered                                | None  |

| Common Medical Event   | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|
|  |  | HMO Network<br>(You will pay the least)                     | Non-HMO Network<br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> | Generic copay - retail Tier 1                    | \$5 MetroHealth Pharmacy; \$10 All Other Pharmacies         | Does Not Apply                             | Covers up to a 30-day supply.                          |
|  | Generic copay - home delivery Tier 1             | \$15 MetroHealth Pharmacy; Not Covered All Other Pharmacies | Does Not Apply                             | Covers up to a 90-day supply                           |
|  | Preferred brand copay - retail Tier 2            | \$15 MetroHealth Pharmacy; \$30 All Other Pharmacies        | Does Not Apply                             | Covers up to a 30-day supply.                          |
|  | Preferred brand copay - home delivery Tier 2     | \$45 MetroHealth Pharmacy; Not Covered All Other Pharmacies | Does Not Apply                             | Covers up to a 90-day supply.                          |
|  | Non-preferred brand copay - retail Tier 3        | \$30 MetroHealth Pharmacy; \$60 All Other Pharmacies        | Does Not Apply                             | Covers up to a 30-day supply.                          |
|  | Non-preferred brand copay - home delivery Tier 3 | \$90 MetroHealth Pharmacy; Not Covered All Other Pharmacies | Does Not Apply                             | Covers up to a 90-day supply.                          |
|  | <u>Specialty drugs</u>                           | 50% to \$200 maximum  | Does Not Apply                             | Covers up to a 30-day supply.                          |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                      | Not Covered                                | None   |
|  | Physician/surgeon fees (Outpatient)              | 20% <u>coinsurance</u>                                      | Not Covered                                | None   |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                       | \$250 copay/visit, 20% <b>coinsurance</b>                   |  | None   |
|  | <u>Emergency medical transportation</u>          | \$50 copay/visit, 20% <u>coinsurance</u>                    | Not Covered                                | None   |
|  | <u>Urgent care</u>                               | \$25 copay/visit  | Not Covered                                | None   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                                      | Not Covered                                | None   |
|  | Physician/ surgeon fee (inpatient)               | 20% <u>coinsurance</u>                                      | Not Covered                                | None   |

| Common Medical Event  | Services You May Need                               | What You Will Pay                                     |  | Limitations, Exceptions, & Other Important Information  |
|---|---|---|--|---|
|   |   | HMO Network<br>(You will pay the least)               | Non-HMO Network<br>(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 | Not Covered                                | None  |
|   | Inpatient services                                  | Benefits paid based on corresponding medical benefits | Not Covered                                | None  |
| If you are pregnant   | Office visits                                       | No charge   | Not Covered                                | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services           | 20% <u>coinsurance</u>                                | Not Covered                                | None  |
|   | Childbirth/delivery facility services               | 20% <u>coinsurance</u>                                | Not Covered                                | None  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                             | 20% <u>coinsurance</u>                                | Not Covered                                | (100 visits per benefit period)   |
|   | <u>Rehabilitation services</u> (Physical Therapy)   | 20% <u>coinsurance</u>                                | Not Covered                                | (40 visits per benefit period, combined with Occupational Therapy)  |
|   | <u>Habilitation services</u> (Occupational Therapy) | 20% <u>coinsurance</u>                                | Not Covered                                | (40 visits per benefit period, combined with Physical Therapy)  |
|   | <u>Habilitation services</u> (Speech Therapy)       | 20% <u>coinsurance</u>                                | Not Covered                                | (20 visits per benefit period)  |
|   | <u>Skilled nursing care</u>                         | 20% <u>coinsurance</u>                                | Not Covered                                | (90 days per benefit period)  |
|   | <u>Durable medical equipment</u>                    | 20% <u>coinsurance</u>                                | Not Covered                                | None  |
|   | <u>Hospice services</u>                             | 20% <u>coinsurance</u>                                | Not Covered                                | None  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                       |  | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|---|--|--|
|  |                            | HMO Network<br>(You will pay the least) | Non-HMO Network<br>(You will pay the most) |  |
| If your child needs dental or eye care | Children's eye exam        | No charge                               | Not Covered                                | 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
- 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 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
- Routine Eye Care (Adult)

**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](http://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](http://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-----

**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** \$250
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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*)  
 Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| Deductibles         | \$250   |
| Copayments          | \$0     |
| Coinsurance         | \$1,800 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,110</b> |
|-----------------------------------|----------------|

**Managing Joe's type 2 Diabetes**

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

- **The plan's overall deductible** \$250
- **Specialist coinsurance** 20%
- **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  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| Deductibles         | \$250 |
| Copayments          | \$600 |
| Coinsurance         | \$10  |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$60 |

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$920</b> |
|-----------------------------------|--------------|

**Mia's Simple Fracture**

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

- **The plan's overall deductible** \$250
- **Specialist coinsurance** 20%
- **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>\$1,900</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| Deductibles         | \$250 |
| Copayments          | \$400 |
| Coinsurance         | \$200 |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$850</b> |
|-----------------------------------|--------------|

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](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](http://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](http://hhs.gov/ocr/office/file/index.html)