



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.healthcare.gov/coverage/preventive-care-benefits/) or call 800-540-2583 to request a copy.

| Important Questions                                                 |  | Answers                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             |  | \$500/single,\$1,000/family Network<br>\$1,000/single,\$2,000/family<br>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 preventive care and all services with copayments 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| 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> ?       |  | \$3,000/single,\$6,000/family Network<br>\$6,000/single,\$12,000/family<br>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> ?            |  | Certain <u>specialty drugs</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 <a href="https://www.MedMutual.com/SBC">MedMutual.com/SBC</a> 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 <u>referral</u> to see a <u>specialist</u> ?          |  | No                                                                                                                                             | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



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<br>(You will pay the least) | Non-Network Provider<br>(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 | \$15 copay/visit                             | 40% <u>coinsurance</u>                          | None                                                                                                                                                                               |
|                                                        | <u>Specialist</u> visit                          | \$25 copay/visit                             | 40% <u>coinsurance</u>                          | None                                                                                                                                                                               |
|                                                        | <u>Preventive care/ screening/ immunization</u>  | No charge                                    | 40% <u>coinsurance</u>                          | You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray)                   | 15% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                          | None                                                                                                                                                                               |
|                                                        | <u>Diagnostic test</u> (blood work)              | 15% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                          | None                                                                                                                                                                               |
|                                                        | Imaging (CT/PET scans, MRIs)                     | 15% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                          | None                                                                                                                                                                               |

[ For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](https://www.MedMutual.com/SBC).]

| Common Medical Event                                                                                                                                                                                      | Services You May Need                            | What You Will Pay                                                                                     |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                          | Non-Network Provider<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="https://www.MedMutual.com/SBC">MedMutual.com/SBC</a> | Generic copay - retail Tier 1                    | \$10                                                                                                  | See Plan Documents for Details                  | Covers up to a 30-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | Generic copay - home delivery Tier 1             | \$25                                                                                                  | See Plan Documents for Details                  | Covers up to a 90-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | Preferred brand copay - retail Tier 2            | \$30                                                                                                  | See Plan Documents for Details                  | Covers up to a 30-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | Preferred brand copay - home delivery Tier 2     | \$75                                                                                                  | See Plan Documents for Details                  | Covers up to a 90-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | Non-preferred brand copay - retail Tier 3        | \$50                                                                                                  | See Plan Documents for Details                  | Covers up to a 30-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | Non-preferred brand copay - home delivery Tier 3 | \$125                                                                                                 | See Plan Documents for Details                  | Covers up to a 90-day supply.                                                                                                                                                                                      |
|                                                                                                                                                                                                           | <u>Specialty drugs</u>                           | \$100 copay or the max of any available manufacturer-funded copay assistance.                         | See Plan Documents for Details                  | Covers up to a 30 day supply. Certain <u>specialty drugs</u> are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share. |
| <b>If you have outpatient surgery</b>                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)   | 15% <u>coinsurance</u>                                                                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |
|                                                                                                                                                                                                           | Physician/surgeon fees (Outpatient)              | No charge at Physician; No charge at <u>Urgent Care</u> ; 15% <u>coinsurance</u> for all other places | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |
| <b>If you need immediate medical attention</b>                                                                                                                                                            | <u>Emergency room care</u>                       | \$150 copay/visit                                                                                     |                                                 | None                                                                                                                                                                                                               |
|                                                                                                                                                                                                           | <u>Emergency medical transportation</u>          | 15% <u>coinsurance</u>                                                                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |
|                                                                                                                                                                                                           | <u>Urgent care</u>                               | \$35 copay/visit                                                                                      | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |
| <b>If you have a hospital stay</b>                                                                                                                                                                        | Facility fee (e.g., hospital room)               | 15% <u>coinsurance</u>                                                                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |
|                                                                                                                                                                                                           | Physician/ surgeon fee (inpatient)               | 15% <u>coinsurance</u>                                                                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                               |

[ For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](https://www.MedMutual.com/SBC).]

| Common Medical Event                                                      |                                                     | Services You May Need | What You Will Pay                                     |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------|-----------------------------------------------------|-----------------------|-------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                     |                       | Network Provider<br>(You will pay the least)          | Non-Network Provider<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 |                                                 | None                                                                                                                                                                                                                                                                            |
|                                                                           | Inpatient services                                  |                       | Benefits paid based on corresponding medical benefits |                                                 | None                                                                                                                                                                                                                                                                            |
|                                                                           |                                                     |                       |                                                       |                                                 |                                                                                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                                       |                       | No charge                                             | 40% <u>coinsurance</u>                          | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copay</u> , <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           |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services               |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | Home health care                                    |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
| If you need help recovering or have other special health needs            | <u>Rehabilitation services</u> (Physical Therapy)   |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | <u>Habilitation services</u> (Occupational Therapy) |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | <u>Habilitation services</u> (Speech Therapy)       |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | <u>Skilled nursing care</u>                         |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | <u>Durable medical equipment</u>                    |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | <u>Hospice services</u>                             |                       | 15% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
|                                                                           | Children's eye exam                                 |                       | No charge                                             | 40% <u>coinsurance</u>                          | None                                                                                                                                                                                                                                                                            |
| If your child needs dental or eye care                                    | Children's glasses                                  |                       | Not Covered                                           |                                                 | Excluded Service                                                                                                                                                                                                                                                                |
|                                                                           | Children's dental check-up                          |                       | Not Covered                                           |                                                 | Excluded Service                                                                                                                                                                                                                                                                |

## Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)                 |                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Children's dental check-up</li><li>• Children's glasses</li><li>• Cosmetic Surgery</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                                    |                                                                                                                                                                                                    |
| <ul style="list-style-type: none"><li>• Chiropractic Care</li></ul>                                                                                                                    | <ul style="list-style-type: none"><li>• Private-Duty Nursing</li></ul>                                                                                                                             |

**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.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)

- The plan's overall deductible \$500
- Specialist copay \$25
- 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 \$12,700

In this example, Peg would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$500   |
| Copayments                 | \$10    |
| Coinsurance                | \$1,800 |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$2,370 |

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.

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$500
- Specialist copay \$25
- 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 \$5,600

In this example, Joe would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$100 |
| Copayments                 | \$600 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$20  |
| The total Joe would pay is | \$720 |

Mia's Simple Fracture

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

- The plan's overall deductible \$500
- Specialist copay \$25
- 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 \$2,800

In this example, Mia would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$500 |
| Copayments                 | \$200 |
| Coinsurance                | \$200 |
| What isn't covered         |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$900 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

[ For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]



## Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

## Pennsylvania Dutch

WICHDIH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

## Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

## Navajo

SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[ hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-382-5729 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidzihi.

## Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

**If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at [CivilRightsCoordinator@MedMutual.com](mailto:CivilRightsCoordinator@MedMutual.com).**

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road  
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)  
Email: [CivilRightsCoordinator@MedMutual.com](mailto:CivilRightsCoordinator@MedMutual.com)

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at:  
<http://www.hhs.gov/ocr/office/file/index.html>
- This notice is available at Medical Mutual's website:  
[www.MedMutual.com](http://www.MedMutual.com)

**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.**

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.