



# Summary of Benefits and Coverage (SBCs)

1/1/2027 – 12/31/2027

## **LOOK INSIDE FOR:**

- MetroHealth Select (Skyway Plan)
- Medical Mutual SuperMed EPO
- Medical Mutual SuperMed PPO
- MetroHealth Select High-Deductible Health Plan (Skyway): Single Coverage
- MetroHealth Select High-Deductible Health Plan (Skyway): Family Coverage
- Glossary of Health Coverage and Medical Terms



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 undefined terms see the Glossary. You can view the Glossary at [MedMutual.com/SBC](https://www.metrohealth.com/SBC) or call 800-540-2583 to request a copy. This plan will pay covered services only.

| Important Questions                                                 |  | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             |  | \$0/single, \$0/family Tier 1 Provider (MetroHealth Provider & designated)<br><b>Not Covered:</b> Tier 2 Providers N/A<br><b>Not Covered:</b> Tier 3 Providers N/A            | No <u>deductible</u> is charged for covered services by Tier 1 Providers. Generally, you must pay all costs from providers up to the <u>deductible</u> amount before a <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> . A <u>deductible</u> is not applicable as only Tier 1 providers are covered under this plan.                                                                                                                                                                                                                                           |
| 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> .                  | Even when there is no <u>deductible</u> to meet, a <u>copayment</u> or <u>coinsurance cost-sharing</u> may apply for services. This <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</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> ?       |  | Tier 1 Provider<br><b>Out-of-pocket Limit:</b><br>\$6,600/single, \$13,200/family<br><br><b>Not Covered:</b> Tier 2 Providers N/A<br><b>Not Covered:</b> Tier 3 Providers N/A | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services before your cost responsibility stops. 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. The <u>out-of-pocket limit</u> includes the deductible, coinsurance payments, medical plan copays, and prescription drug copays. Once your <u>out-of-pocket limit</u> has been reached for an individual or family, the plan pays 100% of covered expenses for the remainder of the plan year. As there is no coverage under this plan for services by Tier 2 and Tier 3 providers, <u>out-of-pocket limits</u> do not apply, and your cost responsibility could be unlimited. |
| 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                                         |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 MetroHealth and its designated service providers as its <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> , as their services are not covered by this plan. 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 Tier 1 <b>specialist</b> you choose without a <b>referral</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                                                                                                                                                                                                   | Services You May Need                            | What You Will Pay                           |                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                        |                                                  | Tier 1 Provider<br>(You will pay the least) | Tier 2 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 | \$20 copay/visit                            | Not Covered                                |                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                        | <u>Specialist visit</u>                          | \$40 copay/visit                            | Not Covered                                |                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                        | <u>Preventive care/ screening/ immunization</u>  | No charge                                   | Not Covered                                | You may have to pay for services that aren't <u>preventive</u> under the Affordable Care Act. 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)                   | No charge                                   | Not Covered                                |                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                        | <u>Diagnostic test</u> (blood work)              | No charge                                   | Not Covered                                |                                                                                                                                                                                                                 |
| If you need drugs to treat your illness or condition<br>More information about <a href="http://www.caremark.com">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> | <b>Prescription Drug Coverage</b>                | <b>MetroHealth Pharmacy</b>                 | <b>CVS Pharmacy</b>                        | <b>Limitations, Exceptions, &amp; Other Important Information</b>                                                                                                                                               |
|                                                                                                                                                                                                                        | Typically Generic (Tier 1)                       | \$10 (retail)<br>\$10 (Mail order)          | \$20 (retail)<br>\$20 (Mail order)         | Coverage is through CVS Caremark. Covers up to 30-day supply retail. Formulary exclusions apply.                                                                                                                |
|                                                                                                                                                                                                                        |                                                  |                                             | \$20 (Maintenance Choice)                  | 90-day supply through MetroHealth, CVS Maintenance Choice or mail order only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only.                                                            |

|                                            | Typically Preferred Brand & Non-<br>Generic (Tier 2) | \$25 (retail)<br><br>\$50 (Mail order)      | \$50 (retail)<br><br>\$80 (Mail order)<br><br>\$80 (Maintenance Choice)     | Coverage is through CVS Caremark.<br>Covers up to 30-day supply retail.<br>Formulary exclusions apply.<br><br>90-day supply through MetroHealth,<br>CVS, Maintenance Choice or mail order<br><br>Retail coverage limited to CVS and<br>MetroHealth pharmacies only.                      |
|--------------------------------------------|------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                            | Typically Non-Preferred Brand (Tier 3)               | \$50 (retail);<br><br>\$80 (Mail order)     | \$100 (retail);<br><br>\$120 (Mail order)<br><br>\$120 (Maintenance Choice) | Coverage is through CVS Caremark.<br>Covers up to 30-day supply retail.<br>Formulary exclusions apply.<br><br>90-day supply through MetroHealth,<br>CVS, Maintenance Choice or mail order                                                                                                |
|                                            | Retail Specialty (Tier 4)                            | Not Covered<br><br>(Except HIV medications) | 20% up to \$750 (retail);<br><br>(Mail Order and<br>Maintenance Choice N/A) | Retail coverage limited to MetroHealth<br>and CVS pharmacies only.<br><br>Coverage is through CVS Caremark.<br>Covers up to 30-day supply.<br>Formulary exclusions apply.<br><br>90-day supply may not be available.<br><br>Limited to CVS Specialty Pharmacy<br>except HIV medications. |
| Common Medical Event                       | Services You May Need                                | What You Will Pay                           |                                                                             | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                                                                                                |
|                                            |                                                      | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay the most)                                  |                                                                                                                                                                                                                                                                                          |
| If you have outpatient<br>surgery          | Facility fee (e.g., ambulatory surgery<br>center)    | No charge                                   | Not Covered                                                                 | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                       |
|                                            | Physician/surgeon fees (Outpatient)                  | No charge                                   | Not Covered                                                                 | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                       |
| If you need immediate<br>medical attention | <u>Emergency room care</u>                           | \$150 copay/visit                           |                                                                             | Life and limb threatening emergency<br>room care is covered out-of-network<br>until patient is stable for release or<br>transfer. <u>Balance billing</u> may apply.<br>Out-of-network non-emergency and<br>non-life/limb threatening not covered.                                        |

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

|                                    |                                         |                       |             |                                                                                                                                            |
|------------------------------------|-----------------------------------------|-----------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------|
|                                    | <u>Emergency medical transportation</u> | No charge             | Not Covered |                                                                                                                                            |
|                                    | <u>Urgent care</u>                      | \$40 copay/visit      | Not Covered |                                                                                                                                            |
| <b>If you have a hospital stay</b> | Facility fee (e.g., hospital room)      | \$250 copay/admission | Not Covered | <u>Preauthorization</u> may apply. Copay applies to all services except covered Newborn Care; see “Childbirth/delivery facility services.” |
|                                    | Physician/ surgeon fee (inpatient)      | No charge             | Not Covered | <u>Preauthorization</u> may apply.                                                                                                         |

|  |                    |                                                       |             |                                    |
|--|--------------------|-------------------------------------------------------|-------------|------------------------------------|
|  | Inpatient services | Benefits paid based on corresponding medical benefits | Not Covered | <u>Preauthorization</u> may apply. |
|--|--------------------|-------------------------------------------------------|-------------|------------------------------------|

|                                                                                  |                     |                                                       |             |                                    |
|----------------------------------------------------------------------------------|---------------------|-------------------------------------------------------|-------------|------------------------------------|
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services | Benefits paid based on corresponding medical benefits | Not Covered |                                    |
|                                                                                  | Inpatient services  | Benefits paid based on corresponding medical benefits | Not Covered | <u>Preauthorization</u> may apply. |

|                            |                                           |                       |              |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------|-------------------------------------------|-----------------------|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you are pregnant</b> | Office visits                             | No charge             | Do Not Apply | <u>Cost sharing</u> does not apply to certain preventive services. 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 (such as charges may apply for ultrasound).<br>You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.<br>You must add a Newborn to your <u>plan</u> coverage within 30 days of birth. |
|                            | Childbirth/delivery professional services | No charge             | Not Covered  |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                            | Childbirth/delivery facility services     | \$250 copay/admission | Not Covered  |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                                                |                                                     |                       |             |                                                                          |
|----------------------------------------------------------------|-----------------------------------------------------|-----------------------|-------------|--------------------------------------------------------------------------|
| If you need help recovering or have other special health needs | <u>Home health care</u>                             | No charge             | Not Covered | <u>Preauthorization</u> may apply.                                       |
|                                                                | <u>Rehabilitation services (Physical Therapy)</u>   | \$20 copay/visit      | Not Covered | (30 visits per benefit period)                                           |
|                                                                | <u>Habilitation services (Occupational Therapy)</u> | \$20 copay/visit      | Not Covered | (30 visits per benefit period)                                           |
|                                                                | <u>Habilitation services (Speech Therapy)</u>       | \$20 copay/visit      | Not Covered | (30 visits per benefit period)                                           |
|                                                                | <u>Skilled nursing care</u>                         | \$250 copay/admission | Not Covered | (100 days per benefit period)<br><u>Preauthorization</u> may apply.      |
| If your child needs dental or eye care                         | <u>Durable medical equipment</u>                    | No charge             | Not Covered | <u>Preauthorization</u> may apply.                                       |
|                                                                | <u>Hospice services</u>                             | No charge             | Not Covered | <u>Preauthorization</u> may apply.                                       |
|                                                                | Children's eye exam                                 | No charge             | Not Covered |                                                                          |
|                                                                | Children's glasses                                  | Not Covered           | Not Covered | Excluded Service – See separate benefit plans for vision care and dental |
|                                                                | Children's dental check-up                          | Not Covered           | Not Covered | Excluded Service– See separate benefit plans for vision care and dental  |

## Excluded Services & Other Covered Services (This isn't a complete list):

| 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>• Dental check-up *</li><li>• Eyeglasses *</li><li>• Cosmetic Surgery</li></ul>                            | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Medications, Programs and Treatments (Except Bariatric Surgery)</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>• Bariatric Surgery</li><li>• STRIDES Diabetes Prevention Program</li></ul>                   | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Routine Eye Exam</li><li>• Routine Hearing Exam</li></ul> |

\* See separate Cuyahoga County-sponsored benefits plans for dental care and eyeglasses coverage.

**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, 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.

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

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 \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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)

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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)

Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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 \$12,700

In this example, Peg would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$300 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$70  |
| The total Peg would pay is | \$370 |

Note: These costs assume the patient does not participate in the plan's Total Health or chronic condition management program. If you participate in the plan's Total Health or chronic condition management program, you may be able to reduce your costs. For more information, please contact: 800-540-2583.

Total Example Cost \$5,600

In this example, Joe would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$900 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$20  |
| The total Joe would pay is | \$920 |

Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$300 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$10  |
| The total Mia would pay is | \$310 |

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.]

# 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 إحدى اللغات، فإن خدمات المساعدة اللغوية متوفرة لك (بالمجان). اتصل برقم 1-800-382-5729 رقم هاتفنا بالصوماليين (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 yáníłtí' go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę'', t'áá jiik'eh, éí ná hólq', kójjí' hódííłnih 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](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)



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. The plan will pay covered services only.

| Important Questions                                                 |  | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             |  | <p>\$0/single,\$0/family Tier 1 Provider<br/>                     \$1,000/single,\$2,000/family Tier 2 Provider</p> <p><b>Not Covered:</b> Tier 3 Provider</p>                                                                                                                                                                                                                                                                                           | <p>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>.</p>                                                                                                                                                                                  |
| Are there services covered before you meet your <u>deductible</u> ? |  | <p><b>Yes. Certain preventive care and all services with copayments are covered and paid by the <u>plan</u> before you meet your deductible.</b></p>                                                                                                                                                                                                                                                                                                     | <p>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>.</p>                                                        |
| Are there other <u>deductibles</u> for specific services?           |  | No                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>You don't have to meet <u>deductibles</u> for specific services.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       |  | <p><b>Coinsurance Limit:</b><br/>                     \$1,250/single,\$2,500/family Tier 1 Provider<br/>                     \$6,000/single,\$12,000/family Tier 2 Provider</p> <p><b>Not Covered:</b> Tier 3 Provider</p> <p><b>Out-of-pocket Limit:</b><br/>                     \$6,600/single,\$13,200/family Tier 1 Provider<br/>                     \$7,000/single,\$14,000/family Tier 2 Provider</p> <p><b>Not Covered:</b> Tier 3 Provider</p> | <p>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. The <u>out-of-pocket limit</u> includes the deductible, coinsurance payments, medical plan copays, and prescription drug copays. Once your <u>out-of-pocket limit</u> has been reached for an individual or family, the plan pays 100% of covered expenses for the remainder of the plan year.</p> |
| What is not included in the <u>out-of-pocket limit</u> ?            |  | <p><b>Premiums</b>, balance-billed charges and health care this <u>plan</u> doesn't cover.</p>                                                                                                                                                                                                                                                                                                                                                           | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                                                |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>Will you pay less if you use a network provider?</u></b> | Yes, See <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers. | You pay the least if you use a <b><u>provider</u></b> in the MetroHealth network. You pay more if you use a <b><u>provider</u></b> in the SuperMed network. You will pay the most if you use an <b><u>out-of-network provider</u></b> , and you might receive a bill from a <b><u>provider</u></b> for the difference between the <b><u>provider's</u></b> charge and what your <b><u>plan</u></b> pays ( <b><u>balance billing</u></b> ). Be aware your <b><u>network provider</u></b> might use an <b><u>out-of-network provider</u></b> for some services (such as lab work). Check with your <b><u>provider</u></b> before you get services. |
| <b><u>Do you need a referral to see a specialist?</u></b>      | No                                                                                                                            | You can see the Tier 1 or Tier 2 <b><u>specialist</u></b> you choose without a <b><u>referral</u></b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                                                 | Services You May Need                            | What You Will Pay                                     |                        |                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                 |
|----------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------|------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      |                                                  | Tier 1<br>Provider<br>(You will pay<br>pay the least) | Tier 2<br>Provider     | Tier 3<br>Provider<br>(You will pay<br>the most) |                                                                                                                                                                                                                        |
| <b><u>If you visit a health care provider's office or clinic</u></b> | Primary care visit to treat an injury or illness | \$20 copay/visit                                      | \$30 copay/visit       | Not Covered                                      |                                                                                                                                                                                                                        |
|                                                                      | <u>Specialist</u> visit                          | \$40 copay/visit                                      | \$50 copay/visit       | Not Covered                                      |                                                                                                                                                                                                                        |
|                                                                      | <u>Preventive care/ screening/ immunization</u>  | No charge                                             | No charge              | Not Covered                                      | You may have to pay for services that aren't <u>preventive</u> under the Affordable Care Act. 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><u>If you have a test</u></b>                                     | <u>Diagnostic test</u> (x-ray)                   | No charge                                             | 20% <u>coinsurance</u> | Not Covered                                      |                                                                                                                                                                                                                        |
|                                                                      | <u>Diagnostic test</u> (blood work)              | No charge                                             | 20% <u>coinsurance</u> | Not Covered                                      |                                                                                                                                                                                                                        |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | No charge                                             | 20% <u>coinsurance</u> | Not Covered                                      | <u>Preauthorization</u> may apply.                                                                                                                                                                                     |

**If you need drugs to treat your illness or condition**  
 More information about [prescription drug coverage](http://www.caremark.com) is available at [www.caremark.com](http://www.caremark.com)

| Prescription Drug Coverage                       | MetroHealth Pharmacy                 | CVS Pharmacy                                                         | Out of Network | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                           |
|--------------------------------------------------|--------------------------------------|----------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Typically Generic (Tier 1)                       | \$10 (retail);<br>\$10 (Mail order)  | \$10 (retail)<br>\$10 (Mail order)<br>\$10 (Maintenance Choice)      | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply retail. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only. |
| Typically Preferred Brand & Non-Generic (Tier 2) | \$40 (retail);<br>\$80 (Mail order)  | \$40 (retail);<br>\$80 (Mail order)<br>\$80 (Maintenance Choice)     | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only.        |
| Typically Non-Preferred Brand (Tier 3)           | \$60 (retail);<br>\$120 (Mail order) | \$60 (retail);<br>\$120 (Mail order)<br>\$120 (Maintenance Choice)   | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only.        |
| Retail Specialty (Tier 4)                        | Not Covered                          | 20% up to \$750 (retail);<br>(Mail Order and Maintenance Choice N/A) | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply may not be available<br><br>Limited to CVS Specialty Pharmacy only except HIV medications.                                        |

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

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                         |                                                                                          |                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                |
|---------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Tier 1<br>Provider<br>(You will pay the least)                                            | Tier 2<br>Provider                                                                       | Tier 3<br>Provider<br>(You will pay the most) |                                                                                                                                                                                                                                       |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                                                                    | 20% <u>coinsurance</u>                                                                   | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees (Outpatient)            | No charge at Physician; 10% <u>coinsurance</u> for all other places; no <u>deductible</u> | No charge at Physician; 20% <u>coinsurance</u> for all other places no <u>deductible</u> | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     |                                                                                           | \$150 copay/visit                                                                        |                                               | Life and limb threatening emergency room care is covered out-of-network until patient is stable for release or transfer. Non-emergency and non-life or limb threatening out-of-network not covered. <u>Balance billing</u> may apply. |
|                                                                           | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>                                                                    | 10% <u>coinsurance</u>                                                                   | 10% <u>coinsurance</u>                        | <u>Balance billing</u> may apply for out-of-network services                                                                                                                                                                          |
|                                                                           | <u>Urgent care</u>                             | \$40 copay/visit                                                                          | \$60 copay/visit                                                                         | Not Covered                                   |                                                                                                                                                                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$250 copay/admission, 10% <u>coinsurance</u> no <u>deductible</u>                        | 20% <u>coinsurance</u>                                                                   | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                    |
|                                                                           | Physician/ surgeon fee (inpatient)             | 10% <u>coinsurance</u> no <u>deductible</u>                                               | 20% <u>coinsurance</u>                                                                   | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Benefits paid based on corresponding medical benefits                                     |                                                                                          | Not Covered                                   |                                                                                                                                                                                                                                       |
|                                                                           | Inpatient                                      | Benefits paid based on corresponding medical benefits                                     |                                                                                          | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                    |

| Common Medical Event                                           |  | Services You May Need                               |  |  | What You Will Pay                              |                        |                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                |  |
|----------------------------------------------------------------|--|-----------------------------------------------------|--|--|------------------------------------------------|------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|                                                                |  |                                                     |  |  | Tier 1<br>Provider<br>(You will pay the least) | Tier 2<br>Provider     | Tier 3<br>Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                       |  |
| If you are pregnant                                            |  | Office visits                                       |  |  | No charge                                      | No charge              | Not Covered                                   | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> .<br>Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (such as charges may apply for ultrasound). |  |
|                                                                |  | Childbirth/delivery professional services           |  |  | No charge                                      |                        | Not Covered                                   | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                          |  |
|                                                                |  | Childbirth/delivery facility services               |  |  | \$250 copay/admission, 10% <u>coinsurance</u>  | 20% <u>coinsurance</u> | Not Covered                                   | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                          |  |
| If you need help recovering or have other special health needs |  | <u>Home health care</u>                             |  |  | 10% <u>coinsurance</u>                         | 20% <u>coinsurance</u> | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                    |  |
|                                                                |  | <u>Rehabilitation services</u> (Physical Therapy)   |  |  | \$20 copay/visit                               | \$30 copay/visit       | Not Covered                                   | (20 visits per benefit period)                                                                                                                                                                                                                                                        |  |
|                                                                |  | <u>Habilitation services</u> (Occupational Therapy) |  |  | \$20 copay/visit                               | \$30 copay/visit       | Not Covered                                   | (20 visits per benefit period)                                                                                                                                                                                                                                                        |  |
|                                                                |  | <u>Habilitation services</u> (Speech Therapy)       |  |  | \$20 copay/visit                               | \$30 copay/visit       | Not Covered                                   | (20 visits per benefit period)                                                                                                                                                                                                                                                        |  |
|                                                                |  | <u>Skilled nursing care</u>                         |  |  | \$250 copay/admission, 10% <u>coinsurance</u>  | 20% <u>coinsurance</u> | Not Covered                                   | (100 days per benefit period)<br><u>Preauthorization</u> may apply.                                                                                                                                                                                                                   |  |
|                                                                |  | <u>Durable medical equipment</u>                    |  |  | 10% <u>coinsurance</u>                         | 20% <u>coinsurance</u> | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                    |  |
|                                                                |  | <u>Hospice services</u>                             |  |  | 10% <u>coinsurance</u>                         | 20% <u>coinsurance</u> | Not Covered                                   | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                    |  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                              |                    |                                               | Limitations, Exceptions, & Other Important Information                   |
|----------------------------------------|----------------------------|------------------------------------------------|--------------------|-----------------------------------------------|--------------------------------------------------------------------------|
|                                        |                            | Tier 1<br>Provider<br>(You will pay the least) | Tier 2<br>Provider | Tier 3<br>Provider<br>(You will pay the most) |                                                                          |
| If your child needs dental or eye care | Children's eye exam        | No charge                                      | No charge          | Not Covered                                   |                                                                          |
|                                        | Children's glasses         |                                                | Not Covered        |                                               | Excluded Service – See separate benefit plans for vision care and dental |
|                                        | Children's dental check-up |                                                | Not Covered        |                                               | Excluded Service – See separate benefit plans for vision care and dental |

## Excluded Services & Other Covered Services (This isn't a complete list):

| 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>• Dental check-up *</li><li>• Eyeglasses *</li><li>• Cosmetic Surgery</li></ul>                            | <ul style="list-style-type: none"><li>• Dental Care *</li><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Hearing Aids</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Medications, Programs and Treatments (Except Bariatric Surgery)</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>• Bariatric Surgery</li><li>• STRIDES Diabetes Prevention Program</li></ul>                                                      | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Routine Eye Exam</li><li>• Routine Hearing Exam</li></ul>                                                                                                                                                                                                                                 |

\* See separate Cuyahoga County-sponsored benefits plans for dental care and eyeglasses coverage.

**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](http://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](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.

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.

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

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 under Tier 1.



**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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)

**Managing Joe's Type 2 Diabetes**

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

- The plan's overall deductible \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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)

**Mia's Simple Fracture**

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

- The plan's overall deductible \$0
- Specialist copay \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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** \$12,700

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$800          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$1,170</b> |

**Total Example Cost** \$5,600

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,300        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

**Total Example Cost** \$2,800

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

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$300        |
| <u>Coinsurance</u>                | \$100        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$10         |
| <b>The total Mia would pay is</b> | <b>\$410</b> |

Note: These costs assume the patient does not participate in the plan's Total Health or chronic condition management program. If you participate in the plan's Total Health or chronic condition management program, you may be able to reduce your costs. For more information, please contact: 800-540-2583.

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.]

# 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 إحدى اللغات، فإن خدمات المساعدة اللغوية متوفرة لك (بالمجان). اتصل برقم 1-800-382-5729 رقم هاتفنا بالصوماليين (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

CHÚY: 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 yáníłtí' go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę'', t'áá jiik'eh, éí ná hólq', kójjí' hódííłnih 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](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)



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. The plan will pay covered services only.

| Important Questions                                                 |  | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             |  | <p><b>\$750/single, \$1,500/family</b> Tier 1 Provider</p> <p><b>\$1,000/single, \$2,000/family</b> Tier 2 Provider</p> <p><b>\$3,000/single, \$6,000/family</b> Tier 3 Provider</p>                                                                                                                                                                                                                                                          | 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 <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> ?       |  | <p><b>Coinurance Limit:</b></p> <p><b>\$1,750/single, \$3,500/family</b> Tier 1 Provider</p> <p><b>\$4,000/single, \$8,000/family</b> Tier 2 Provider</p> <p><b>\$3,000/single, \$6,000/family</b> Tier 3 Provider</p> <p><b>Out-of-pocket Limit:</b></p> <p><b>\$2,500/single, \$5,000/family</b> Tier 1 Provider / <b>\$5,000/single, \$10,000/family</b> Tier 2 Provider</p> <p><b>\$6,000/single, \$12,000/family</b> Tier 3 Provider</p> | 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. The <u>out-of-pocket limit</u> includes the deductible, coinsurance payments, medical plan copays, and prescription drug copays. Once your <u>out-of-pocket limit</u> has been reached for an individual or family, the plan pays 100% of covered expenses for the remainder of the plan year. |
| 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                                                |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>Will you pay less if you use a network provider?</u></b> | Yes, See <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers. | You pay the least if you use a <b><u>provider</u></b> in the Metrohealth network. You pay more if you use a <b><u>provider</u></b> in the SuperMed network. You will pay the most if you use an <b><u>out-of-network provider</u></b> , and you might receive a bill from a <b><u>provider</u></b> for the difference between the <b><u>provider's</u></b> charge and what your <b><u>plan</u></b> pays ( <b><u>balance billing</u></b> ). Be aware your <b><u>network provider</u></b> might use an <b><u>out-of-network provider</u></b> for some services (such as lab work). Check with your <b><u>provider</u></b> before you get services. |
| <b><u>Do you need a referral to see a specialist?</u></b>      | No                                                                                                                            | You can see the <b><u>specialist</u></b> you choose without a <b><u>referral</u></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                                                                                                                                                                 |
|---------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|----------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay more) | Tier 3 Provider<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                            | \$25 copay/visit                       | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                        |
|                                                               | <u>Specialist</u> visit                          | \$50 copay/visit                            | \$50 copay/visit                       | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                        |
|                                                               | <u>Preventive care/ screening/ immunization</u>  | No charge                                   | No charge                              | 40% <u>coinsurance</u>                     | You may have to pay for services that aren't <u>preventive</u> under the Affordable Care Act. 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)                   | No charge                                   | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                        |
|                                                               | <u>Diagnostic test</u> (blood work)              | No charge                                   | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                        |
|                                                               | Imaging (CT/PET scans, MRIs)                     | No charge                                   | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                                                                                                                     |

| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="http://www.caremark.com">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></p> | Prescription Drug Coverage                       |  | MetroHealth Pharmacy                 | CVS Pharmacy                                                         | Out of Network | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|--------------------------------------|----------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                          | Typically Generic (Tier 1)                       |  | \$10 (retail);<br>\$10 (Mail order)  | \$10 (retail);<br>\$10 (Mail order)<br>\$10 (Maintenance Choice)     | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply retail. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only. |
|                                                                                                                                                                                                                                          | Typically Preferred Brand & Non-Generic (Tier 2) |  | \$40 (retail);<br>\$80 (Mail order)  | \$40 (retail);<br>\$80 (Mail order)<br>\$80 (Maintenance Choice)     | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only.        |
|                                                                                                                                                                                                                                          | Typically Non-Preferred Brand (Tier 3)           |  | \$60 (retail);<br>\$120 (Mail order) | \$60 (retail);<br>\$120 (Mail order)<br>\$120 (Maintenance Choice)   | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply through CVS mail order and Maintenance Choice only.<br><br>Retail coverage limited to CVS and MetroHealth pharmacies only.        |
|                                                                                                                                                                                                                                          | Retail Specialty (Tier 4)                        |  | Not Covered                          | 20% up to \$750 (retail);<br>(Mail Order and Maintenance Choice N/A) | Not Covered    | Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply.<br><br>90-day supply may not be available<br><br>Limited to CVS Specialty Pharmacy only except HIV medications.                                        |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                     |                                        |                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------|----------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Tier 1 Provider<br>(You will pay the least)           | Tier 2 Provider<br>(You will pay more) | Tier 3 Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | No charge                                             | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees (Outpatient)            | No charge                                             | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | <u>Emergency room care</u>                     |                                                       | \$150 copay/visit                      |                                            | Additional costs for non-emergency and non-life or limb threatening. <u>Balance billing plus deductible</u> apply to Tier 3 Provider coverage.                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                   | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>                                | 10% <u>coinsurance</u>                 | 10% <u>coinsurance</u>                     | <u>Balance billing plus deductible</u> apply to Tier 3 Provider coverage.                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                           | <u>Urgent care</u>                             | \$75 copay/visit                                      | \$75 copay/visit                       | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Facility fee (e.g., hospital room)             | No charge                                             | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you have a hospital stay                                               | Physician/ surgeon fee (inpatient)             | 10% <u>coinsurance</u>                                | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Outpatient services                            | Benefits paid based on corresponding medical benefits |                                        |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Inpatient services                             | Benefits paid based on corresponding medical benefits |                                        |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Office visits                                  | No charge                                             | 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, copay, coinsurance or deductible may apply. <u>Maternity care</u> may include tests and services described elsewhere in the SBC (such as charges may apply to ultrasound). You must add a Newborn to your <u>plan</u> coverage within 30 days of birth. You must add a Newborn to your <u>plan</u> coverage within 30 days of birth. |
|                                                                           | Childbirth/delivery professional services      | No charge                                             | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services          | No charge                                             | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Common Medical Event                                           |  | Services You May Need                               |  |  | What You Will Pay                           |                                        |                                            | Limitations, Exceptions, & Other Important Information                                                             |
|----------------------------------------------------------------|--|-----------------------------------------------------|--|--|---------------------------------------------|----------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
|                                                                |  |                                                     |  |  | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay more) | Tier 3 Provider<br>(You will pay the most) |                                                                                                                    |
| If you need help recovering or have other special health needs |  | <u>Home health care</u>                             |  |  | 10% <u>coinsurance</u>                      | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | (60 visits per benefit period)<br><u>Preauthorization</u> may apply.                                               |
|                                                                |  | <u>Rehabilitation services</u> (Physical Therapy)   |  |  | \$25 copay/visit                            | \$25 copay/visit                       | 40% <u>coinsurance</u>                     | (20 visits per benefit period)                                                                                     |
|                                                                |  | <u>Habilitation services</u> (Occupational Therapy) |  |  | \$25 copay/visit                            | \$25 copay/visit                       | 40% <u>coinsurance</u>                     | (20 visits per benefit period)                                                                                     |
|                                                                |  | <u>Habilitation services</u> (Speech Therapy)       |  |  | \$50 copay/visit                            | \$50 copay/visit                       | 40% <u>coinsurance</u>                     | (20 visits per benefit period)                                                                                     |
| If your child needs dental or eye care                         |  | <u>Skilled nursing care</u>                         |  |  | No charge                                   | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | (100 days per benefit period combined with Physical Medicine Rehabilitation)<br><u>Preauthorization</u> may apply. |
|                                                                |  | <u>Durable medical equipment</u>                    |  |  | 10% <u>coinsurance</u>                      | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | <u>Preauthorization</u> may apply.                                                                                 |
|                                                                |  | <u>Hospice services</u>                             |  |  | 10% <u>coinsurance</u>                      | 10% <u>coinsurance</u>                 | 40% <u>coinsurance</u>                     | (360 days per lifetime)<br><u>Preauthorization</u> may apply.                                                      |
|                                                                |  | Children's eye exam                                 |  |  | No charge                                   | No charge                              | 40% <u>coinsurance</u>                     |                                                                                                                    |
|                                                                |  | Children's glasses                                  |  |  |                                             | Not Covered                            |                                            | Excluded Service – See separate benefit plans for vision care and dental                                           |
|                                                                |  | Children's dental check-up                          |  |  |                                             | Not Covered                            |                                            | Excluded Service – See separate benefit plans for vision care and dental                                           |
|                                                                |  |                                                     |  |  |                                             |                                        |                                            |                                                                                                                    |

## Excluded Services & Other Covered Services (This isn't a complete list):

| Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan document</u> for more information and a list of other <u>excluded services</u> .) |                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Dental check-up *</li><li>• Eyeglasses *</li><li>• Cosmetic Surgery</li></ul>                 | <ul style="list-style-type: none"><li>• Dental Care *</li><li>• Hearing Aids</li><li>• Infertility Treatment</li><li>• Long- Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Medications, Programs and Treatments (Except Bariatric Surgery)</li></ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u> .) |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• STRIDES Diabetes Prevention Program</li></ul>                    | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Routine Hearing Exam</li><li>• Routine Eye Exam</li></ul> |

\* See separate Cuyahoga County-sponsored benefits plans for dental care and eyeglasses coverage.

**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.

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

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 under Tier 1.



Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$750
- Specialist copay \$50
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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)

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$750
- Specialist copay \$50
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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)

Mia's Simple Fracture

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

- The plan's overall deductible \$750
- Specialist copay \$50
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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

\$12,700

In this example, Peg would pay:

| Cost Sharing               |      |
|----------------------------|------|
| Deductibles                | \$0  |
| Copayments                 | \$0  |
| Coinsurance                | \$0  |
| What isn't covered         |      |
| Limits or exclusions       | \$70 |
| The total Peg would pay is | \$70 |

Total Example Cost

\$5,600

In this example, Joe would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$0     |
| Copayments                 | \$1,400 |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$1,420 |

Total Example Cost

\$2,800

In this example, Mia would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$750   |
| Copayments                 | \$300   |
| Coinsurance                | \$50    |
| What isn't covered         |         |
| Limits or exclusions       | \$10    |
| The total Mia would pay is | \$1,110 |

Note: These costs assume the patient does not participate in the plan's Total Health or chronic condition management program. If you participate in the plan's Total Health or chronic condition management program, you may be able to reduce your costs. For more information, please contact: 800-540-2583.

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.]

# 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 إحدى اللغات، فإن خدمات المساعدة اللغوية متوفرة لك (بالمجان). اتصل برقم 1-800-382-5729 رقم هاتفنا بالصوماليين (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 yáníłtí' go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę'', t'áá jiik'eh, éí ná hólq', kójjí' hódííłnih 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](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)



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.metrohealth.com/SBC) or call 800-540-2583 to request a copy. The plan will pay covered services only.

| Important Questions                                                 | Answers                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <b>\$2,800</b> /single Tier 1 Provider<br><b>Not Covered:</b> Tier 2 Provider<br><b>Not Covered:</b> Tier 3 Provider                                               | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                                                            |
| Are there services covered before you meet your <u>deductible</u> ? | <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> .                                                         |
| 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> ?       | <b>\$6,650</b> /single Tier 1 Provider<br><b>Not Covered:</b> Tier 2 Provider<br><b>Not Covered:</b> Tier 3 Provider                                               | 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> , the overall family <u>out-of-pocket</u> limit must be 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 <a href="https://www.metrohealth.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers.                               | This <u>plan</u> uses the MetroHealth <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 Tier 1 <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                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care provider's office or clinic                                                                                                                                        | Primary care visit to treat an injury or illness | Tier 1 Provider<br>(You will pay the least)<br>20% <u>coinsurance</u> | Tier 2 Provider<br>(You will pay the most)<br>Not Covered |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Specialist visit</u>                          | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Preventive care/ screening/ immunization</u>  | No charge                                                             | Not Covered                                               | You may have to pay for services that aren't <u>preventive</u> under the Affordable Care Act. Ask your <u>provider</u> 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)                   | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Diagnostic test</u> (blood work)              | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                | Not Covered                                               | <u>Preauthorization</u> may apply.                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<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                    | 20% <u>coinsurance</u>                                                | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Generic copay - home delivery Tier 1             | Not covered                                                           | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Preferred brand copay - retail Tier 2            | 20% <u>coinsurance</u>                                                | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Preferred brand copay - home delivery Tier 2     | Not covered                                                           | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |

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

|                                                                                  |                                                  |                                                       |                                                    |                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  | Non-preferred brand copay - retail Tier 3        | 50% <u>coinsurance</u>                                | 50% <u>coinsurance</u>                             | Scripts and MetroHealth pharmacies                                                                                                                                                                                                 |
|                                                                                  | Non-preferred brand copay - home delivery Tier 3 | Not covered                                           | 50% <u>coinsurance</u>                             | Covers up to a 90-day supply. Tier 2 Medical Mutual/Express Scripts Formulary exclusions apply.                                                                                                                                    |
|                                                                                  | <u>Specialty drugs</u>                           | 50% coinsurance                                       | 50% <u>coinsurance</u>                             | Covers up to a 90-day supply. Tier 2 Medical Mutual/Express Scripts Formulary exclusions apply.                                                                                                                                    |
|                                                                                  |                                                  |                                                       |                                                    | Covers up to a 90-day supply. Tier 2 Medical Mutual/Express Scripts Formulary exclusions apply. Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies.                                                              |
| <b>Common Medical Event</b>                                                      | <b>Services You May Need</b>                     | <b>What You Will Pay</b>                              |                                                    | <b>Limitations, Exceptions, &amp; Other Important Information</b>                                                                                                                                                                  |
|                                                                                  |                                                  | <b>Tier 1 Provider<br/>(You will pay the least)</b>   | <b>Tier 2 Provider<br/>(You will pay the most)</b> |                                                                                                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                | Not Covered                                        | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees (Outpatient)              | 20% <u>coinsurance</u>                                | Not Covered                                        | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                       | 20% <u>coinsurance</u>                                |                                                    | Life and limb threatening emergency room care is covered out-of-network until patient is stable for release or transfer. <u>Balance billing</u> may apply. Out-of-network non-emergency and non-life/limb threatening not covered. |
|                                                                                  | <u>Emergency medical transportation</u>          | 20% <u>coinsurance</u>                                | Not Covered                                        |                                                                                                                                                                                                                                    |
| <b>If you have a hospital stay</b>                                               | <u>Urgent care</u>                               | 20% <u>coinsurance</u>                                | Not Covered                                        |                                                                                                                                                                                                                                    |
|                                                                                  | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                                | Not Covered                                        | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Physician/ surgeon fee (inpatient)               | 20% <u>coinsurance</u>                                | Not Covered                                        | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
|                                                                                  | Outpatient services                              | Benefits paid based on corresponding medical benefits | Not Covered                                        |                                                                                                                                                                                                                                    |
|                                                                                  | Inpatient services                               | Benefits paid based on corresponding medical benefits | Not Covered                                        | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |

| Common Medical Event                                           |  | Services You May Need                               |                        | What You Will Pay                           |                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|--|-----------------------------------------------------|------------------------|---------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |  |                                                     |                        | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                           |
| If you are pregnant                                            |  | Office visits                                       | No charge              | Not Covered                                 | Do Not Apply                               | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as charges may apply for ultrasound). |
|                                                                |  | Childbirth/delivery professional services           | 20% <u>coinsurance</u> | Not Covered                                 |                                            | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                              |
|                                                                |  | Childbirth/delivery facility services               | 20% <u>coinsurance</u> | Not Covered                                 |                                            | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                              |
|                                                                |  | <u>Home health care</u>                             | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs |  | <u>Rehabilitation services</u> (Physical Therapy)   | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Habilitation services</u> (Occupational Therapy) | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Habilitation services</u> (Speech Therapy)       | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Skilled nursing care</u>                         | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (100 days per benefit period)                                                                                                                                                                                                                                                             |
|                                                                |  | <u>Durable medical equipment</u>                    | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
|                                                                |  | <u>Hospice services</u>                             | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
|                                                                |  | Children's eye exam                                 | No charge              | Not Covered                                 |                                            |                                                                                                                                                                                                                                                                                           |
| If your child needs dental or eye care                         |  | Children's glasses                                  | Not Covered            |                                             |                                            | Excluded Service – See separate benefit plans for vision care and dental                                                                                                                                                                                                                  |
|                                                                |  | Children's dental check-up                          | Not Covered            |                                             |                                            | Excluded Service – See separate benefit plans for vision care and dental                                                                                                                                                                                                                  |

## Excluded Services & Other Covered Services (This isn't a complete list):

| 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>• Dental check-up *</li><li>• Eyeglasses *</li><li>• Cosmetic Surgery</li></ul>                            | <ul style="list-style-type: none"><li>• Dental Care *</li><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Hearing Aids</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Medications, Programs and Treatments (Except Bariatric Surgery)</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>• Bariatric Surgery</li><li>• STRIDES Diabetes Prevention Program</li></ul>                                                      | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Routine Hearing Exams</li><li>• Routine Eye Exam</li></ul>                                                                                                                                                                                                                                |

\* See separate Cuyahoga County-sponsored benefits plans for dental care and eyeglasses coverage.

**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.

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

## 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 \$2,800
- 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*)

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$2,800
- 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*)

### Mia's Simple Fracture

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

- The plan's overall deductible \$2,800
- 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*)

**Total Example Cost**

**\$12,700**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,860</b> |

**Total Example Cost**

**\$5,600**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$500          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,320</b> |

**Total Example Cost**

**\$2,800**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

Note: These costs assume the patient does not participate in the plan's Total Health or chronic condition management program. If you participate in the plan's Total Health or chronic condition management program, you may be able to reduce your costs. For more information, please contact: 800-540-2583.

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.]

# 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 تحدثنا ذكر اللغة، فإن خدماتنا المساعدة اللغوية متوفرة لك  
(بالمجان). اتصل برقم 1-800-382-5729 رقم هاتفنا 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 yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'dé'ę", t'áá jiik'eh, éí ná hólq', kóji' 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 asistentă 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](https://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](https://hhs.gov/ocr/office/file/index.html)



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.metrohealth.com/SBC) or call 800-540-2583 to request a copy. The plan will pay covered services only.

| Important Questions                                                 |  | Answers                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             |  | \$5,250/family Tier 1 Provider<br>Not Covered: Tier 2 Provider<br>Not Covered: Tier 3 Provider                                                               | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                                                            |
| 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 <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> ?       |  | \$13,200/family Tier 1 Provider<br>Not Covered: Tier 2 Provider<br>Not Covered: Tier 3 Provider                                                              | 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> , the overall family <u>out-of-pocket</u> limit must be 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 <a href="https://www.metrohealth.com/SBC">MedMutual.com/SBC</a> or call 800-540-2583 for a list of participating providers.                         | This <u>plan</u> uses the MetroHealth <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 Tier 1 <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                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care provider's office or clinic                                                                                                                                        | Primary care visit to treat an injury or illness | Tier 1 Provider<br>(You will pay the least)<br>20% <u>coinsurance</u> | Tier 2 Provider<br>(You will pay the most)<br>Not Covered |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Specialist visit</u>                          | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Preventive care/ screening/ immunization</u>  | No charge                                                             | Not Covered                                               | You may have to pay for services that aren't <u>preventive</u> under the Affordable Care Act. Ask your <u>provider</u> 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)                   | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | <u>Diagnostic test</u> (blood work)              | 20% <u>coinsurance</u>                                                | Not Covered                                               |                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                | Not Covered                                               | <u>Preauthorization</u> may apply.                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<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                    | 20% <u>coinsurance</u>                                                | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Generic copay - home delivery Tier 1             | Not covered                                                           | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Preferred brand copay - retail Tier 2            | 20% <u>coinsurance</u>                                                | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               | Preferred brand copay - home delivery Tier 2     | Not covered                                                           | 20% <u>coinsurance</u>                                    | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express Scripts and MetroHealth pharmacies                                          |
|                                                                                                                                                                                               |                                                  |                                                                       |                                                           |                                                                                                                                                                                                                        |

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

|                                                                                  |                                                  |                                                       |                                                    |  |                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  |                                                       |                                                    |  | Scripts and MetroHealth pharmacies                                                                                                                                                                                                 |
|                                                                                  | Non-preferred brand copay - retail Tier 3        | 50% <u>coinsurance</u>                                | 50% <u>coinsurance</u>                             |  | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.                                                                                                                              |
|                                                                                  | Non-preferred brand copay - home delivery Tier 3 | Not covered                                           | Not covered                                        |  | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.                                                                                                                              |
|                                                                                  | <u>Specialty drugs</u>                           | 50% coinsurance                                       | 50% <u>coinsurance</u>                             |  | Covers up to a 90-day supply.<br>Tier 2 Medical Mutual/Express Scripts<br>Formulary exclusions apply.<br>Limited to Medical Mutual/Express<br>Scripts and MetroHealth pharmacies.                                                  |
| <b>Common Medical Event</b>                                                      | <b>Services You May Need</b>                     | <b>What You Will Pay</b>                              |                                                    |  | <b>Limitations, Exceptions, &amp; Other<br/>Important Information</b>                                                                                                                                                              |
|                                                                                  |                                                  | <b>Tier 1 Provider<br/>(You will pay the least)</b>   | <b>Tier 2 Provider<br/>(You will pay the most)</b> |  |                                                                                                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                | Not Covered                                        |  | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees (Outpatient)              | 20% <u>coinsurance</u>                                | Not Covered                                        |  | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                       | 20% <u>coinsurance</u>                                |                                                    |  | Life and limb threatening emergency room care is covered out-of-network until patient is stable for release or transfer. <u>Balance billing</u> may apply. Out-of-network non-emergency and non-life/limb threatening not covered. |
|                                                                                  | <u>Emergency medical transportation</u>          | 20% <u>coinsurance</u>                                | Not Covered                                        |  |                                                                                                                                                                                                                                    |
| <b>If you have a hospital stay</b>                                               | <u>Urgent care</u>                               | 20% <u>coinsurance</u>                                | Not Covered                                        |  |                                                                                                                                                                                                                                    |
|                                                                                  | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                                | Not Covered                                        |  | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Physician/ surgeon fee (inpatient)               | 20% <u>coinsurance</u>                                | Not Covered                                        |  | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |
|                                                                                  | Outpatient services                              | Benefits paid based on corresponding medical benefits | Not Covered                                        |  |                                                                                                                                                                                                                                    |
|                                                                                  | Inpatient services                               | Benefits paid based on corresponding medical benefits | Not Covered                                        |  | <u>Preauthorization</u> may apply.                                                                                                                                                                                                 |

| Common Medical Event                                           |  | Services You May Need                               |                        | What You Will Pay                           |                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|--|-----------------------------------------------------|------------------------|---------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |  |                                                     |                        | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                           |
| If you are pregnant                                            |  | Office visits                                       | No charge              | Not Covered                                 | Do Not Apply                               | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as charges may apply for ultrasound). |
|                                                                |  | Childbirth/delivery professional services           | 20% <u>coinsurance</u> | Not Covered                                 |                                            | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                              |
|                                                                |  | Childbirth/delivery facility services               | 20% <u>coinsurance</u> | Not Covered                                 |                                            | You must add a Newborn to your <u>plan</u> coverage within 30 days of birth.                                                                                                                                                                                                              |
| If you need help recovering or have other special health needs |  | <u>Home health care</u>                             | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
|                                                                |  | <u>Rehabilitation services</u> (Physical Therapy)   | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Habilitation services</u> (Occupational Therapy) | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Habilitation services</u> (Speech Therapy)       | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (30 visits per benefit period)                                                                                                                                                                                                                                                            |
|                                                                |  | <u>Skilled nursing care</u>                         | 20% <u>coinsurance</u> | Not Covered                                 |                                            | (100 days per benefit period)                                                                                                                                                                                                                                                             |
|                                                                |  | <u>Durable medical equipment</u>                    | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
|                                                                |  | <u>Hospice services</u>                             | 20% <u>coinsurance</u> | Not Covered                                 |                                            | <u>Preauthorization</u> may apply.                                                                                                                                                                                                                                                        |
| If your child needs dental or eye care                         |  | Children's eye exam                                 | No charge              | Not Covered                                 |                                            |                                                                                                                                                                                                                                                                                           |
|                                                                |  | Children's glasses                                  | Not Covered            |                                             |                                            | Excluded Service – See separate benefit plans for vision care and dental                                                                                                                                                                                                                  |
|                                                                |  | Children's dental check-up                          | Not Covered            |                                             |                                            | Excluded Service – See separate benefit plans for vision care and dental                                                                                                                                                                                                                  |

## Excluded Services & Other Covered Services (This isn't a complete list):

| 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>• Dental check-up *</li><li>• Eyeglasses *</li><li>• Cosmetic Surgery</li></ul>                            | <ul style="list-style-type: none"><li>• Dental Care *</li><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Hearing Aids</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Medications, Programs and Treatments (Except Bariatric Surgery)</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>• Bariatric Surgery</li><li>• STRIDES Diabetes Prevention Program</li></ul>                                                      | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Routine Hearing Exams</li><li>• Routine Eye Exam</li></ul>                                                                                                                                                                                                                                |

\* See separate Cuyahoga County-sponsored benefits plans for dental care and eyeglasses coverage.

**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.

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

## 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 \$2,800
- 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*)

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$2,800
- 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*)

### Mia's Simple Fracture

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

- The plan's overall deductible \$2,800
- 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*)

**Total Example Cost**

**\$12,700**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,860</b> |

**Total Example Cost**

**\$5,600**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$500          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,320</b> |

**Total Example Cost**

**\$2,800**

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

Note: These costs assume the patient does not participate in the plan's Total Health or chronic condition management program. If you participate in the plan's Total Health or chronic condition management program, you may be able to reduce your costs. For more information, please contact: 800-540-2583.

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.]

# 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 تحدثنا ذكر اللغة، فإن خدماتنا المساعدة اللغوية متوفرة لك  
(بالمجان). اتصل برقم 1-800-382-5729 رقم هاتفنا 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 yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'dé'ę", t'áá jiik'eh, éí ná hólq', kóji' 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 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](https://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](https://hhs.gov/ocr/office/file/index.html)

# Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance policy](#). Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

## Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

## Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

## Balance Billing

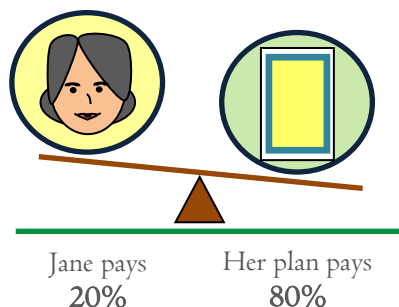
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

## Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

## Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



## Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

## Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

## Cost Sharing

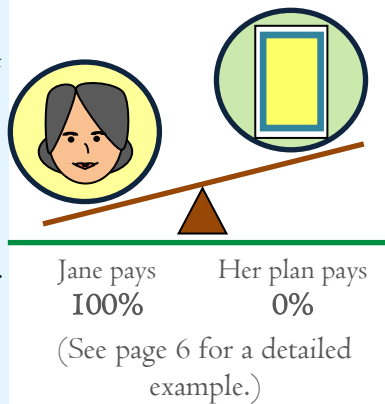
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

## Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

## Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



## Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

## Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

## Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

## Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

## Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

## Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

## Grievance

A complaint that you communicate to your health insurer or [plan](#).

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

## Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

## In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

## Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

## Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

## Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

## Minimum Essential Coverage

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](#).

## Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

## Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

## Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

## Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

## Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

## Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do **not** contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

## Out-of-network Provider (Non-Preferred Provider)

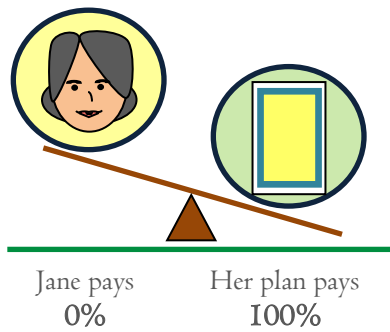
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

## Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

## Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

## Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

## Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

## Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

## Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

## Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

## Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

## Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

## Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

## Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

## Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

## Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

## Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

## Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

## Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

# How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Coinsurance: 20%

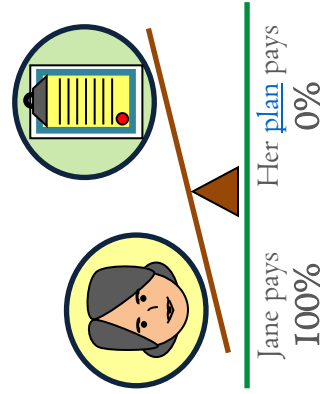
Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>

Beginning of Coverage Period

December 31<sup>st</sup>

End of Coverage Period



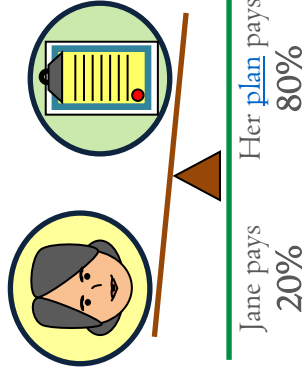
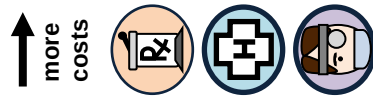
**Jane hasn't reached her \$1,500 deductible yet**

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



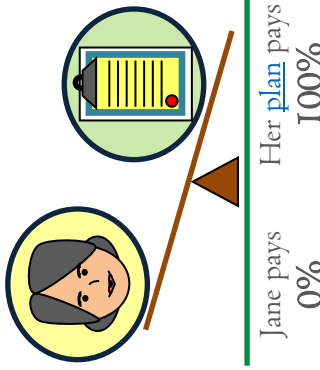
**Jane reaches her \$1,500 deductible, coinsurance begins**

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



**Jane reaches her \$5,000 out-of-pocket limit**

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

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Attn: Employee Benefits  
2079 East 9th Street  
Cleveland, OH 44115

