The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-540-2583. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800-540-2583 to request a copy. This plan will pay covered services only.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/single, **$0**/family Tier 1 Provider (MetroHealth Provider & designated) **Not Covered:** Tier 2 Providers N/A **Not Covered:** Tier 3 Providers N/A	No **deductible** is charged for covered services by Tier 1 Providers. Generally, you must pay all costs from providers up to the **deductible** amount before a **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.** A **deductible** is not applicable as only Tier 1 providers are covered under this plan.
Are there services covered before you meet your deductible?	**Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.**	Even when there is no **deductible** to meet, a **copayment** or **coinsurance** **cost-sharing** may apply for services. This **plan** covers certain **preventive services** without **cost-sharing**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 Provider **Out-of-pocket Limit:** **$6,600**/single, **$13,200**/family **Not Covered:** Tier 2 Providers N/A **Not Covered:** Tier 3 Providers N/A	The **out-of-pocket limit** 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 **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met. As there is no coverage under this plan for services by Tier 2 and Tier 3 providers, **out-of-pocket limits** do not apply, and your cost responsibility could be unlimited.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**

Will you pay less if you use a network provider?	Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This **plan** uses MetroHealth and its designated service providers as its **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, as their services are not covered by this plan. You might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the Tier 1 **specialist** you choose without a **referral.**

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

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

	Typically Preferred Brand & Non-Generic (Tier 2)	$25 (retail) $50 (Mail order)	$50 (retail) $80 (Mail order) $80 (Maintenance Choice)	Coverage is through CVS Caremark. Covers up to 30-day supply retail. Formulary exclusions apply. 90-day supply through CVS Maintenance Choice or mail order only. Retail coverage limited to CVS and MetroHealth pharmacies only.
	Typically Non-Preferred Brand (Tier 3)	$50 (retail); $80 (Mail order)	$100 (retail); $120 (Mail order) $120 (Maintenance Choice)	Coverage is through CVS Caremark. Covers up to 30-day supply retail. Formulary exclusions apply. 90-day supply through CVS Maintenance Choice or mail order only. Retail coverage limited to MetroHealth and CVS pharmacies only.
	Retail Specialty (Tier 4)	Not Covered (Except HIV medications)	20% up to $750 (retail); (Mail Order and Maintenance Choice N/A)	Coverage is through CVS Caremark. Covers up to 30-day supply. Formulary exclusions apply. 90-day supply may not be available. Limited to CVS Specialty Pharmacy except HIV medications.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not Covered	Preauthorization may apply.
	Physician/surgeon fees (Outpatient)	No charge	Not Covered	Preauthorization may apply.
If you need immediate medical attention	Emergency room care	$150 copay/visit		Life and limb threatening emergency room care is covered out-of-network until patient is stable for release or transfer. Balance billing may apply. Out-of-network non-emergency and non-life/limb threatening not covered.

	Emergency medical transportation	No charge	Not Covered	
	Urgent care	$40 copay/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not Covered	Preauthorization may apply. Copay applies to all services except covered Newborn Care; see "Childbirth/delivery facility services."
	Physician/ surgeon fee (inpatient)	No charge	Not Covered	Preauthorization may apply.
	Inpatient services	Benefits paid based on corresponding medical benefits	Not Covered	Preauthorization 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 services	Benefits paid based on corresponding medical benefits	Not Covered	Preauthorization may apply.
If you are pregnant	Office visits	No charge	Do Not Apply	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (such as charges may apply for ultrasound).
	Childbirth/delivery professional services	No charge	Not Covered	You must add a Newborn to your plan coverage within 30 days of birth.
	Childbirth/delivery facility services	$250 copay/admission	Not Covered	You must add a Newborn to your plan coverage within 30 days of birth.

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

If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Preauthorization may apply.
	Rehabilitation services (Physical Therapy)	$20 copay/visit	Not Covered	(30 visits per benefit period)
	Habilitation services (Occupational Therapy)	$20 copay/visit	Not Covered	(30 visits per benefit period)
	Habilitation services (Speech Therapy)	$20 copay/visit	Not Covered	(30 visits per benefit period)
	Skilled nursing care	$250 copay/admission	Not Covered	(100 days per benefit period) Preauthorization may apply.
	Durable medical equipment	No charge	Not Covered	Preauthorization may apply.
	Hospice services	No charge	Not Covered	Preauthorization 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

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

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental check-up *
- Eyeglasses *
- Cosmetic Surgery
- Dental Care *
- Infertility Treatment
- Long-Term Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs and Treatments

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Routine Hearing Exam
- Routine Eye Exam

* 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 cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov 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.]

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*)

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**

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*)

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**

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	**$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**

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

MEDICAL MUTUAL®

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:إذاكنتتتحدثاذكراللغة،فإنخدماتالمساعدةاللغويةتتوافرلك

بالمجان.اتصلبرقم1-800-382-5729 رقمهاتفالصموالبكم(711).

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hóló, kojį' 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

ATENŢ IE: Dacă vorbit,i limba română, vă stau la dispozit,ie servicii de asistent,ă lingvistică, gratuit. Sunat,i 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 DIRECTEDTO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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