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.

### Important Questions | Answers | Why This Matters:
---|---|---
What is the overall deductible? | $4,000/family Network $10,000/family Non-Network | Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the plan begins to pay.

Are there services covered before you meet your deductible? | Yes. Certain **preventive care** and all services with **copayments** are covered and paid by the plan before you meet your **deductible**. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a **copayment** or **coinsurance** may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](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? | $4,000/family Network $20,000/family Non-Network | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

What is not included in the out-of-pocket limit? | **Premiums**, balance-billed charges and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

Will you pay less if you use a network provider? | Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers. | This plan uses a **provider network**. You will pay less if you use a **provider** in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist? | No | You can see the **specialist** you choose without a referral.
All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray)</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (blood work)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Major Medical Drug Coverage /Rx</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does Not Apply</td>
<td>Cover up to a 30-day supply (retail and specialty drugs); 90-day supply (home delivery).</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at MedMutual.com/SBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees (Outpatient)</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>No charge after <strong>deductible</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/ surgeon fee (inpatient)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Benefits paid based on corresponding medical benefits</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Benefits paid based on corresponding medical benefits</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Physical Therapy)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services (Occupational Therapy)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services (Speech Therapy)</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge after deductible</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Private-Duty Nursing

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**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 Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform and 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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform or your plan at 800-540-2583.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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To see examples of how this plan might cover costs for sample medical situations, see the next section

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.
**About these Coverage Examples:**

*This is not a cost estimator.* Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

<table>
<thead>
<tr>
<th>Peg is having a baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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*)

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*)

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>Peg is having a baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Example Cost</strong></td>
<td>$12,800</td>
<td>$7,400</td>
<td>$1,900</td>
</tr>
</tbody>
</table>

**In this example, Peg would pay:**
- **Deductibles**: $4,000
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: Limits or exclusions $60
- **The total Peg would pay is**: $4,060

**In this example, Joe would pay:**
- **Deductibles**: $4,000
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: Limits or exclusions $60
- **The total Joe would pay is**: $4,060

**In this example, Mia would pay:**
- **Deductibles**: $1,900
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: Limits or exclusions $0
- **The total Mia would pay is**: $1,900

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-540-2583.
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

Arabic
ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر ك backdrop في المكان. اتصل برقم 1-800-382-5729 (1-800-382-5729) رقم هاتف chmod والكم (711).

Pennsylvania Dutch

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

Oromo
XIYYEEFFANNA: Afaan dub battu Oroomiffa, tajaajilä gargaarsa afaanii, kanfaltiidaan 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

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

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