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 800-367-3762. 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 MutualHealthServices.com/SBC or call 800-367-3762 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000**/single Preferred **$2,500**/single Network $3,000/single 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.
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**/single Preferred **$6,550**/single Network $22,500/single 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**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been 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 MutualHealthServices.com/SBC or call 800-367-3762 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (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% coinsurance	30% coinsurance	40% coinsurance	Includes labs, x-rays, injections and medical supplies only
	Specialist visit	20% coinsurance	30% coinsurance	40% coinsurance	Includes labs, x-rays, injections and medical supplies only
	Preventive care/ screening/ immunization	No charge	No charge	40% coinsurance	You may have to pay for services that aren't preventive. 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)	20% coinsurance	30% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	20% coinsurance	30% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	40% coinsurance	Prior authorization required for all CT, PET and MRI scans

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MutualHealthServices.com/SBC	Generic copayment - retail 30 day supply Tier 1	20% coinsurance, $5 minimum, $50 maximum	Does Not Apply	Does Not Apply	31 day supply Southwest 10% coinsurance, $5 minimum, $50 maximum
	Generic copayment - home delivery 90 day supply Tier 1	20% coinsurance, $10 minimum, $125 maximum	Does Not Apply	Does Not Apply	90 day supply Southwest 10% coinsurance, $5 minimum, $50 maximum
	Formulary brand copayment - 30 day supply Tier 2	30% coinsurance, $30 minimum, $75 maximum	Does Not Apply	Does Not Apply	31 day supply Southwest 20% coinsurance, $30 minimum, $75 maximum
	Formulary brand copayment - home delivery 90 day supply Tier 2	30% coinsurance, $75 minimum, $188 maximum	Does Not Apply	Does Not Apply	90 day supply Southwest 20% coinsurance, $30 minimum, $75 maximum
	Non-formulary brand copayment - retail 30 day supply Tier 3	50% coinsurance, $70 minimum, $200 maximum	Does Not Apply	Does Not Apply	31 day supply Southwest 50% coinsurance, $70 minimum, $200 maximum
	Non-formulary brand copayment - home delivery 90 day supply Tier 3	50% coinsurance, $175 minimum, $500 maximum	Does Not Apply	Does Not Apply	90 day supply Southwest 40% coinsurance, $140 minimum, $400 maximum
	Specialty drugs	20% coinsurance	Does Not Apply	Does Not Apply	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	30% coinsurance	40% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	40% coinsurance	None
	Emergency medical transportation	No charge after **deductible**			None
	Urgent care	20% coinsurance	30% coinsurance	40% coinsurance	Includes facility
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	40% coinsurance	Pre-certification is required
	Physician/ surgeon fee (inpatient)	20% coinsurance	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits			None
	Inpatient services	Benefits paid based on corresponding medical benefits			None
If you are pregnant	Office visits	No charge	No charge	40% coinsurance	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 (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	40% coinsurance	All females covered on plan (benefits paid are based on corresponding medical benefits)
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	40% coinsurance	All females covered on plan (benefits paid are based on corresponding medical benefits)

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	40% coinsurance	75 visits per benefit period
	Rehabilitation services (Physical Therapy)	20% coinsurance	30% coinsurance	40% coinsurance	(30 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	20% coinsurance	30% coinsurance	40% coinsurance	(30 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	20% coinsurance	30% coinsurance	40% coinsurance	(30 visits per benefit period)
	Skilled nursing care	20% coinsurance	30% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	30% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	30% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	40% coinsurance	None
	Children's glasses	Not Covered			Excluded Service
	Children's dental check-up	Not Covered			Excluded Service

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

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

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

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.The contact information for those agencies is: the Department of 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 800-367-3762.

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.

Language Access Services **800-367-3762**

Para obtener asistencia en Español, llame al

如果需要中文的帮助，请拨打这个号码

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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: 800-367-3762.

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

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

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 1-800-367-3762.

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 1-800-367-3762。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

Arabic

ملحوظة:إذاكنتتتحدثاذكراللغة،فإنخدماتالمساعدةاللغويةتتوافرلك بالمجان.اتصلبرقم1-800-367-3762رقمهاتفالصموالبكم

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-367-3762.

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

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。1-800-367-3762 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 1-800-367-3762.

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.

Nondiscrimination Notice

Mutual Health Services 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. Mutual Health Services 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.

- Mutual Health Services 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.).
- Mutual Health Services 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 Mutual Health Services 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