**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?** | **$3,750**/single, **$7,500**/family Network<br>**$3,750**/single, **$7,500**/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 **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.** |
| **Are there benefit changes related to COVID-19?** | Yes, in accordance with Families First Coronavirus Response Act and Ohio Department of Insurance Bulletin 2020-05. | Testing for COVID-19 is covered with no member cost sharing. Also, all treatment related to a COVID-19 diagnosis is covered as an emergency service, at the in-network benefit level. |
| **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/. |
| **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?** | **Coinsurance Limit:**<br>**$2,500**/single, **$5,000**/family Network<br>**$6,250**/single, **$12,500**/family Non-Network<br>**Out-of-pocket Limit:**<br>**$6,250**/single, **$12,500**/family Network<br>**$10,000**/single, **$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**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | **Deductibles**, **premiums**, balance-billed charges and health care this **plan** doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. |
| **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.

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network 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 | $50 copay/visit | $50 copay/visit, 50% coinsurance | None |
| | Specialist visit | $100 copay/visit | $100 copay/visit, 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge | $50 copay/visit, 50% 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, blood work) | 30% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information is available at www.ExpressScripts.com | Generic Copay – Retail<br>Generic Copay – Mail Order<br>Generic Copay – Specialty Mail Order<br>Preferred Copay – Retail<br>Preferred Copay – Mail Order<br>Preferred Copay – Specialty Mail Order<br>Non- Preferred Copay – Retail<br>Non- Preferred Copay – Mail Order<br>Non-Preferred Copay – Specialty Mail Order | $10<br>$20<br>$400<br>$50<br>$100<br>$400<br>$100<br>$200<br>$400 | Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply<br>Does Not Apply | Covers up to a 30-day supply<br>Covers up to a 90-day supply<br>Covers up to a 90-day supply<br>Covers up to a 30-day supply<br>Covers up to a 90-day supply<br>Covers up to a 90-day supply<br>Covers up to a 30-day supply<br>Covers up to a 90-day supply<br>Covers up to a 90-day supply |
| | **See HESE Health Benefit Plan Prescription Drug Summary for further information.** | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees (outpatient) | 30% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit | | None |
| | Emergency medical transportation | 30% coinsurance | 50% coinsurance | None |
| | Urgent care | $100 copay/visit | $100 copay/visit, 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees (inpatient) | 30% coinsurance | 50% 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 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | No charge | 50% 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 | 30% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | None |
| | Rehabilitation services (Physical Therapy) | 30% coinsurance | 50% coinsurance | (40 visits per benefit period, combined with Occupational Therapy) |
| | Habilitation services (Occupational Therapy) | 30% coinsurance | 50% coinsurance | (40 visits per benefit period, combined with Physical Therapy) |
| | Habilitation services (Speech Therapy) | 30% coinsurance | 50% coinsurance | (20 visits per benefit period) |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | None |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | None |
| | Hospice services | 30% coinsurance | 50% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | $50 copay/visit, 50% coinsurance | None |
| | Children's glasses | Not Covered | | Excluded Service |
| | Children's dental check-up | Not Covered | | Excluded Service |

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

**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 the 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 a sample medical situation, see the next section.***

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

## About these Coverage Examples:

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

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

- **The plan's overall deductible** **$3,750**
- **Specialist copay** **$100**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$12,800** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $3,750 |
| Copayments | $0 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$6,350** |

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

- **The plan's overall deductible** **$3,750**
- **Specialist copay** **$100**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$7,400** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $6,000 |
| **The total Joe would pay is** | **$6,500** |

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

- **The plan's overall deductible** **$3,750**
- **Specialist copay** **$100**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$1,900** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,100 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

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.

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

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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