LICKING COUNTY EDUCATIONAL SERVICE CENT : Plan 3

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage Period: 09/01/2016 - 08/31/2017

Coverage for: Single or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at MedMutual.com/SBC or by calling 800.525.5957.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/single,**$1,000**/family Network **$1,000**/single,**$2,000**/family Non-Network Doesn't apply to coinsurance, copays and network preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes, Coinsurance Limit:** **$1,500**/single,**$3,000**/family Network **$3,000**/single,**$6,000**/family Non-Network **Out-of-pocket Limit:** **$6,600**/single,**$13,200**/family Network **Unlimited**/single,**Unlimited**/family Non-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The coinsurance limit is included in the **out-of-pocket limit**.
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**.
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.
Does this plan use a network of providers?	Yes, See MedMutual.com/SBC or call 800.525.5957 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 800.525.5957 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.525.5957 to request a copy.

Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	40% coinsurance	-------none-------
	Specialist visit	$15 copay/visit	40% coinsurance	-------none-------
	Other practitioner office visit (Chiropractic)	$15 copay/visit	40% coinsurance	(12 visits per benefit period)
	Other practitioner office visit (Acupuncture)	Not Covered		Excluded Service
	Preventive care/ screening/ immunization	No charge	40% coinsurance	-------none-------
If you have a test	Diagnostic test (x-ray)	No charge	40% coinsurance	-------none-------
	Diagnostic test (blood work)	No charge	40% coinsurance	-------none-------
	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	-------none-------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail /Rx	$10	Does Not Apply	Covers up to a 30-day supply
	Generic copay - home delivery /Rx	$20	Does Not Apply	Covers up to a 90-day supply
	Preferred Brand copay - retail /Rx	$30	Does Not Apply	Covers up to a 30-day supply
	Preferred Brand copay - home delivery /Rx	$60	Does Not Apply	Covers up to a 90-day supply
	Non-Preferred Brand copay - retail /Rx	$50	Does Not Apply	Covers up to a 30-day supply
	Non-Preferred Brand copay - home delivery /Rx	$100	Does Not Apply	Covers up to a 90-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-------none-------
	Physician/surgeon fees (Outpatient)	$15 copay/visit at Physician; 20% coinsurance for all other places after deductible	40% coinsurance	-------none-------
If you need immediate medical attention	Emergency room services	$100 copay/visit		-------none-------
	Emergency medical transportation	20% coinsurance	30% coinsurance	-------none-------
	Urgent care	$35 copay/visit	40% coinsurance	-------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-------none-------
	Physician/ surgeon fee (inpatient)	20% coinsurance	40% coinsurance	-------none-------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		-------none-------
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits		-------none-------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	(Prenatal Visits are covered at no charge with in-network providers)
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	-------none-------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	-------none-------
	Rehabilitation services (Physical Therapy)	$15 copay/visit at Physician; 20% coinsurance at Facility after deductible	40% coinsurance	(40 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	$15 copay/visit at Physician; 20% coinsurance at Facility after deductible	40% coinsurance	(40 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	$15 copay/visit at Physician; 20% coinsurance at Facility after deductible	40% coinsurance	(20 visits per benefit period)
	Skilled nursing care	20% coinsurance	40% coinsurance	(180 days per benefit period)
	Durable medical equipment	20% coinsurance	40% coinsurance	-------none-------
	Hospice service	20% coinsurance	40% coinsurance	(180 days per benefit period)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If your child needs dental or eye care	Eye exam (Child)	No charge	40% coinsurance	-------none-------
	Glasses	Not Covered		Excluded Service
	Dental check-up (Child)	Not Covered		Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.525.5957. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 800.525.5957.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan Pays $5,620**
- **Patient Pays $1,920**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$1,920**

These 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 your HRA or FSA, please contact your employer group.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan Pays $4,860**
- **Patient Pays $540**

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedure	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$40
Total	**$540**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.525.5957.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**,and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

× **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

× **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box on each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف 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 yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', 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

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

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- 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