

Stark County Schools Council of Governments: Traditional Plan

Coverage for: Individual/Family | PlanType: PPO

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 Medical Mutual at 1-800-228-6472 or go to www.medmutual.com. 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 www.medmutual.com or 1-800-228-6472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$250 Individual / \$500 Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,000 Individual /\$2,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Not applicable	This <u>plan</u> does not use a provider <u>network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	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% <u>coinsurance</u>	None
	<u>Specialist visit</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Coverage for routine mammograms, prostate screening or pap test is limited to one per calendar year. Routine physicals are limited to one per calendar year. Routine gynecological exams are limited to two per calendar year.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com or call a Customer Care Representative toll free at 1-888-202-1654.	Generic drugs / Brand drugs	20% <u>coinsurance</u>	Mandatory generic drugs where available (unless doctor specifies dispense as written). Mail order is required for long term prescription drugs, limited to 1 st fill and one refill at retail pharmacy. All subsequent prescription drugs must be filled by mail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Penalty of \$200 may apply for failure to get <u>preauthorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Penalty of \$200 may apply for failure to get <u>preauthorization</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of service, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (ie: ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Penalty of \$200 may apply for failure to get <u>preauthorization</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for ongoing services.
	<u>Habilitation services</u>	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No charge	Coverage is provided for vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	

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**.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (adult)
- Habilitation Services
- Hearing Aids
- 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
- Infertility Treatment
- 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: for non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

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: for non-federal governmental group health plans, contact Medical Mutual at 1-800-228-6472 or call the Ohio Department of Insurance 1-800-686-1526.

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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-228-6472

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-228-6472

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-228-6472

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-228-6472

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

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](#) **\$250**
- [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 **\$12,800**

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,020

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

- The [plan's overall deductible](#) **\$250**
- [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 **\$7,400**

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,060

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

- The [plan's overall deductible](#) **\$250**
- [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 **\$1,900**

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$390
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$640

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company.