



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 City of Akron Employee Benefits Office at (330)375-2700. 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](https://www.medicare.gov/coverage/preventive-care-benefits/) or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$150 /single or \$300 /family Network \$300 /single or \$600 /family Non-Network	Generally, you must pay all of the costs from <u>providers</u> 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> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> 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 a <u>copayment</u> or <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>?	For <u>network providers</u> \$1,500/single, \$3,000/family; for <u>out-of-network providers</u> \$3,000/single, \$6,000/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>?	<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>?	Yes, See MedMutual.com or call 877-328-6664 for a list of participating providers. See Caremark.com or call 888-202-1654 for a list of participating pharmacies.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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 **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
		Network Provider (You will pay the least)	Out-of-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	\$15 copay/visit	30% after deductible	None
	<u>Specialist</u> visit	\$40 copay/visit	30% after deductible	None
	<u>Preventive care/ screening/ immunization</u>	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray)	20% after deductible	30% after deductible	None
	<u>Diagnostic test</u> (blood work)	20% after deductible	30% after deductible	None
	Imaging (CT/PET scans, MRIs)	20% after deductible	30% after deductible	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Caremark.com or by calling 888-202-1654.	Generic copay – retail Tier 1	\$10	Does Not Apply	Covers up to a 34-day supply.
	Generic copay – home delivery or CVS retail 90 – Tier 1	\$20	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand copay – retail – Tier 2	\$20	Does Not Apply	Covers up to a 34-day supply.
	Preferred brand copay – home delivery or CVS retail 90 – Tier 2	\$40	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay – retail – Tier 3	\$40	Does Not Apply	Covers up to a 34-day supply.
	Non-preferred brand name copay – home delivery or CVS retail 90 – Tier 3	\$80	Does Not Apply	Covers up to a 90-day supply.
	Specialty copay – Retail Non-Preferred ED Drugs: Retail Nexium – Retail Nexium – Home Delivery or CVS retail 90	\$50 \$50 \$100 \$200	Does Not Apply Does Not Apply Does Not Apply Does Not Apply	Covers up to a 34-day supply. Covers 10 pills per 30-day supply. Covers up to a 34-day supply. Covers up to a 90-day supply.

Questions: Call Medical Mutual at 1-877-328-6664 or visit www.medmutual.com or call Employee Benefits at 330-375-2700. If you are not clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.medmutual.com/SBC or call 1-800-540-2583 to request a copy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	30% after deductible	None
	Physician/surgeon fees (Outpatient)	20% after deductible	30% after deductible	None
If you need immediate medical attention	<u>Emergency room care (Facility and Physician Services)</u>	\$125 copay/visit		Copay waived if admitted
	<u>Emergency medical transportation</u>	20% after deductible	30% after deductible	None
	Emergency room care(Non-Emergency)(Facility and Physician Services)	\$200 copay/visit, then 20%	\$200 copay/visit, then 30%	Copay waived if admitted
	<u>Urgent care</u>	\$45 copay/visit	30% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	30% after deductible	None
	Physician/ surgeon fee (inpatient)	20% after deductible	30% after deductible	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

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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	30% after deductible	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% after deductible	30% after deductible	Preauthorization Required
	Childbirth/delivery facility services	20% after deductible	30% after deductible	Preauthorization Required
If you need help recovering or have other special health needs	<u>Home health care</u>	20% after deductible	30% after deductible	100 visits per benefit period
	<u>Rehabilitation services</u> (Physical Therapy)	20% after deductible	30% after deductible	Combined benefit of 25 visits, then Medical Review - Professional; unlimited - Institutional; combined with Physical Therapy)
	<u>Habilitation services</u> (Occupational Therapy)	20% after deductible	30% after deductible	
	<u>Habilitation services</u> (Speech Therapy)	20% after deductible	30% after deductible	
	<u>Skilled nursing care</u>	20% after deductible	30% after deductible	100 days per benefit period
	<u>Durable medical equipment</u>	20% after deductible	30% after deductible	(Wigs - <u>Medically Necessary</u>)
	<u>Hospice services</u>	20% after deductible	30% after deductible	None
	<u>Chiropractic services</u>	20% after deductible	30% after deductible	25 visits, then Medical Review
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered – See Dental Plan		Excluded Service

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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.)

- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Private-duty nursing
- Routine Foot Care
- Routine Eye Care (Adult)

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Weight Loss Programs

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: your state insurance department at 800-686-1526 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 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 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 sample medical situations, 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 \$150
- Specialist copay \$40
- 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*)

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$150
- Specialist copay \$40
- 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*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$150
- Specialist copay \$40
- 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	\$12,700
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Total Example Cost	\$5,600
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Total Example Cost	\$2,800
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<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,350
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$1,570

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$260

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$165
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$615

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