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 deductible?	$250 Individual / $500 Family	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 services covered before you meet your deductible?	Yes. Certain Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But 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?	$1,000 Individual /$2,000 Family	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?	Penalties, premiums, balance-billing 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?	Not applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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% coinsurance	None
	Specialist visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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	Diagnostic test (x-ray, blood work)	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call a Customer Care Representative toll free at 1-888-202-1654.	Generic drugs / Brand drugs	20% coinsurance	Mandatory generic drugs where available (unless doctor specifies dispense as written). Mail order is required for long term prescription drugs, limited to 1st 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% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	None
	Urgent care	20% coinsurance	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% coinsurance	Preauthorization is required. Penalty of $200 may apply for failure to get preauthorization.
	Physician/surgeon fees	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	None
	Inpatient services	20% coinsurance	Preauthorization is required. Penalty of $200 may apply for failure to get preauthorization.
If you are pregnant	Office visits	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of service, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (ie: ultrasound).
	Childbirth/delivery professional services	20% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	Preauthorization is required. Penalty of $200 may apply for failure to get preauthorization.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	Preauthorization may be required for ongoing services.
	Habilitation services	Not covered	
	Skilled nursing care	20% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	Preauthorization is required for certain DME services.
	Hospice services	20% coinsurance	Preauthorization 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, kwiijigo 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:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$750
What isn't covered	
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:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$750
What isn't covered	
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:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$390
What isn't covered	
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.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

7KLV GRFXPHQW QRWL¿HV LQGLYLGXDOV RI KRZ WR VHHN DVVLVWDQFH LI WKH\ VSHDN D ODQJXDJH RWKHU WKDQ (QJOLVK.

Spanish

$7(1&,Ï1: 6L KDEOD HVSDxRO, WLHQH D VX GLVSRVLFLyQ VHUYLFLRV JUDWXLWRV GH DVLVWHQFLD OLQJ• tVWLFD. /ODPH DO 1-800-382-5729 (77<: 711).

Chinese

疢km ʚ揣ᄿ▮趣僐浣ᗑ羲,ᄿ ⌧ v ⌧彊蠆㈦崭岏壼ᅩ㦬ᅭ𝔬ᆩ嵚哋榊 1-800-382-5729 (77<: 711)𝔬ᆩ

German

$&+781*: :HQQ 6LH 'HXWVFK VSUHFKHQ, VWHKHQ ,KQHQ NRVWHQORV VSUDFKOLFKH +LOIVGLHQVWOHLVWXQJHQ]XU 9HUI• JXQJ. 5XIHQ 6LH 1-800-382-5729 (77<: 711).

Arabic

[illegible] .(711 [illegible] 1-800-382-5729 [illegible]

Pennsylvania Dutch

:DQQ GX 'HLWVFK VFKZHWVFKW, NDQQVFKW GX PLWDXV .RVFKWH HEEHU JULFNH, DVV GLU KHOIW PLW GLH HQJOLVFK 6FKSURRFK. 5XI VHOO 1XPPHU XII: &DOO 1-800-382-5729 (77<: 711).

Russian

ȼɇɂɆȺɇɂȿ: ȿɫɥɢ ɜɵ ɝɨɜɨɪɢɬɟ ɧɚ ɪɭɫɫɤɨɦ ɹɡɵɤɟ, ɬɨ ɜɚɦ ɞɨɫɬɭɩɧɵ ɛɟɫɩɥɚɬɧɵɟ ɭɫɥɭɝɢ ɩɟɪɟɜɨɞɚ. Ɂɜɨɧɢɬɟ 1-800-382-5729 (ɬɟɥɟɬɚɣɩ: 711).

French

$77(17,21: 6L YRXV SDUOH] IUDQoDLV, GHV VHUYLFHV G¶DLGH OLQJXLVWLTXH YRXV VRQW SURSRVpV JUDWXLWHPHQW. $SSHOH] OH 1-800-382-5729 ($76: 711).

Vietnamese

&+Ò é: 1ӃX EҥQ QyL 7LӃQJ 9LӋW, Fy FiF GӏFK Yө Kӛ WUӧ QJ{Q QJӳ PLӉQ SKt GjQK FKR EҥQ. *ӑL Vӕ 1-800-382-5729 (77<: 711).

Navajo

'tt EDD DNy QtQt]LQ: 'tt VDDG EHH \iQtáWL¶ JR 'LQp %L]DDG, VDDG EHH iNi¶iQtGD¶iZR¶Gé¶, W¶ii MLLN¶HK, pt Qi Kóót, NRMħǫ KμGtt ÓQLK 1-800-382-5729 (77< 711 .

Oromo

;,<<(())$11$$: $IDDQ GXEEDWWX 2URRPLIID, WDMDDMLOD JDUJDDUVD DIDDQLL, NDQIDOWLLGKDDQ DOD, QL DUJDPD. %LELODD 1-800-382-5729 (77<: 711).

Korean

늱넍 뻙霡꽶 끞뾇갫 陲끲, 꾉꽶 뎃낌 ⌧갡 넧끞뾇겥 넵갥 . 1-800-382-5729 (77<: 711)⌧냀 봙뾍뾇 늱겟갫꿳.

Italian

$77(1=,21(: ,Q FDVR OD OLQJXD SDUODWD VLD O¶LWDOLDQR, VRQR GLVSRQLELOL VHUYL]L GL DVVLVWHQ]D OLQJXLVWLFD JUDWXLWL. &KLDPDUH LO QXPHUR 1-800-382-5729 (77<: 711).

Japanese

疢km㊥檔 应戳崭ᄎ貴ᄉᄋᄌᄍ ᆩ 糤嶙ᄏ岏崭岹壼ᄎ ᄑⓒ 趣ᄒᄓᄔᄕᄖᄗᆩ1-800-382-5729 (77<: 711) ᄖ ᄘᆩᄙ榊 貴⌧⌧ᄑ抲俐ᄚᄔᄗᄒᆩ

Dutch

$$1'$&+7: $OV X QHGHUODQGV VSUHHNW, NXQW X JUDWLV JHEUXLNPDNHQ YDQ GH WDDONXQGLJH GLHQVWHQ. %HO 1-800-382-5729 (77<: 711).

Ukrainian

ɍȼȺȽȺ! əɤɳɨ ɜɢ ɪɨɡɦɨɜɥɹɽɬɟ ɭɤɪɚʀɧɫɶɤɨɸ ɦɨɜɨɸ, ɜɢ ɦɨɠɟɬɟ ɡɜɟɪɧɭɬɢɫɹ ɞɨ ɛɟɡɤɨɲɬɨɜɧɨʀ ɫɥɭɠɛɢ ɦɨɜɧɨʀ ɩɿɞɬɪɢɦɤɢ. Ɍɟɥɟɮɨɧɭɣɬɟ ɡɚ ɧɨɦɟɪɨɦ 1-800-382-5729 (ɬɟɥɟɬɚɣɩ: 711).

Romanian

$7(17,(: 'DFă YRUELĠL OLPED URPkQă, Yă VWDX OD GLVSR]LĠLH VHUYLFLL GH DVLVWHQĠă OLQJYLVWLFă, JUDWXLW. 6XQDĠL OD 1-800-382-5729 (77<: 711).

Tagalog

3$81$:$: .XQJ QDJVDVDOLWD NDQJ 7DJDORJ, PDDDUL NDQJ JXPDPLW QJ PJD VHUELV\R QJ WXORQJ VD ZLND QDQJ ZDODQJ ED\DG. 7XPDZDJ VD 1-800-382-5729 (77<: 711).

Order Number: Z8188-MCA R11/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTEDTO 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 quali)ed 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 quali)ed 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 bene.ts 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)le a civil rights complaint with the U.S. Department of Health and Human Services, Of)ce for Civil Rights.

- Electronically through the Of)ce 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/of)ce/)le/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.