

**Pinnacle Care Providers**  
**2024 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICES**

**Medicare Part D Rx Requirements**

- Notice of Creditable Coverage

**General Notice & HIPAA Notice Requirements**

- HIPAA Notice of Privacy Practices
- Uses and Disclosures of Protected Health Information (PHI)
- HIPAA Plan Special Enrollment Notice
- Genetics Information Notice
- Mental Health/Substance Use Disorder Parity
- Newborns' and New Mothers Care Disclosure
- Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

**ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!**

## Notice of Creditable Coverage

Your prescription drug coverage provided under Pinnacle Care Providers is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as “creditable coverage”.

### Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pinnacle Care Providers has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>. However, if you lose your current creditable coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Pinnacle Care Providers coverage may or may not be affected as well as dependent coverage. Additional guidance is available at <https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/> which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage**

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pinnacle Care Providers changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Human Resources  
Address: 4580 Stephens Circle, Suite 202, Canton, OH 44718  
Phone Number: (330) 597-2815

**For More Information Regarding Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

1. Visit [www.medicare.gov](http://www.medicare.gov)
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

## HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

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## Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

**Treatment Purposes.** The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

**Payment Purposes.** The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

**Health Care Operations.** The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

**To a Business Associate of the Health Plan.** The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

**To the Health Plan Sponsor.** The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

**Required by Law or Requested as Part of a Regulatory or Legal Proceeding.** The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

**Public Health Activities or to Avert a Serious Threat to Health or Safety.** The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

**Law Enforcement or Specific Government Functions.** The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

### **An Individual's Rights Regarding PHI**

An individual has the following rights with respect to their PHI:

**Right to Inspect and Copy PHI.** An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

**Right to Request Restrictions).** An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

**Right to Receive Confidential Communications of PHI).** An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

**Right to Request an Amendment.** An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

**Right to Accounting of Disclosures.** An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

**Breach Notification.** An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

*Optional if covered entity engages in underwriting* **Genetic Information** An individual's genetic information will not be used for under writing except for long term care plans.

**Right to Paper Copy.** An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

#### **The Health Plan's Responsibilities Regarding an Individual's PHI**

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

**Department of Health and Human Services  
The Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201**

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## **HIPAA Plan Special Enrollment Notice**

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

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## **Genetics Information Notice**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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## **Mental Health/Substance Use Disorder Parity**

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

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## **Newborns' and New Mothers Care Disclosure**

This Plan generally does not, consistent with applicable Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, consistent with that same Federal law, this Plan generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan does not, in accordance with Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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## **Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice**

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

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## **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).



If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA - Medicaid	Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447
ALASKA - Medicaid	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>
ARKANSAS - Medicaid	Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid	Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO - Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
FLORIDA - Medicaid	Website: <a href="https://www.flmedicaidtprrecovery.com/flmedicaidtprrecovery.com/hipp/index.html">https://www.flmedicaidtprrecovery.com/flmedicaidtprrecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
GEORGIA - Medicaid	Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131
INDIANA - Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562
KANSAS - Medicaid	Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884
KENTUCKY - Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a> KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>
LOUISIANA - Medicaid	Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid	Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: -800-977-6740 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a> Phone: 1-800-862-4840
MINNESOTA - Medicaid	Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739

MISSOURI - Medicaid	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
MONTANA - Medicaid	Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
NEBRASKA - Medicaid	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY - Medicaid and CHIP	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
NEW YORK - Medicaid	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100
NORTH DAKOTA - Medicaid	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742
OREGON - Medicaid	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a> Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA - Medicaid	Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
TEXAS - Medicaid	Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669 Phone: 1-877-543-7669
VERMONT - Medicaid	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
WYOMING - Medicaid	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either: U.S. Department of Labor, U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa) 1-866-444-EBSA (3272) [www.cms.hhs.gov](http://www.cms.hhs.gov) 1-877-267-2323, Menu Option 4, Ext. 61565



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 800-367-3762. 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 [MutualHealthServices.com/SBC](https://MutualHealthServices.com/SBC) or call 800-367-3762 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000/single,\$4,000/family Network \$4,000/single,\$8,000/family Non-Network	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 deductible?	Yes. Certain <u>preventive care</u> and <u>all services with 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.
Are there other deductibles 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> ?	\$5,000/single,\$10,000/family Network \$11,000/single,\$22,000/family Non-Network	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> , balance-billed 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 <a href="https://MutualHealthServices.com/SBC">MutualHealthServices.com/SBC</a> or call 800-367-3762 for a list of participating providers.	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)	Non-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	\$25 copay/visit	40% <u>coinsurance</u>	(Physician exam only)
	Specialist visit	\$50 copay/visit	40% <u>coinsurance</u>	(Physician exam only)
	Preventive care/ <u>screening</u> / immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services you need are <u>preventive</u> . Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (X-ray)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Diagnostic test</u> (blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Generic copay - retail Tier 1	\$10	Does Not Apply	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	\$30	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	\$30	Does Not Apply	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	\$90	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	\$60	Does Not Apply	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	\$180	Does Not Apply	Covers up to a 90-day supply.
If you have outpatient surgery	<u>Specialty drugs</u>	50% up to \$200	Does Not Apply	Covers up to a 30-day supply.
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

[For more information about limitations and exceptions, see the plan or policy document at [MutualHealthServices.com/SBC](http://MutualHealthServices.com/SBC).]

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>		\$350 copay/visit		Copay waived if admitted
	<u>Emergency medical transportation</u>		\$50 copay/visit		None
	<u>Urgent care</u>		\$75 copay/visit	40% coinsurance	(includes facility)
If you have a hospital stay	Facility fee (e.g., hospital room)		20% coinsurance	40% coinsurance	Pre-certification is required
	Physician/ surgeon fee (inpatient)		20% coinsurance	40% 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
If you are pregnant	Office visits		No charge	40% coinsurance	Cost sharing 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% coinsurance	40% coinsurance	Covered for subscriber and spouse only, benefits paid are based on corresponding medical benefits, prenatal visits are covered at no charge with <u>in-network providers</u> .
	Childbirth/delivery facility services		20% coinsurance	40% coinsurance	Covered for subscriber and spouse only, benefits paid are based on corresponding medical benefits, prenatal visits are covered at no charge with <u>in-network providers</u> .

[ For more information about limitations and exceptions, see the [plan or policy document at MutualHealthServices.com/SBC.](http://plan.or.policy.document.at.MutualHealthServices.com/SBC.)]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(100 days per benefit period)
	Rehabilitation services (Physical Therapy)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(20 visits per benefit period)
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(90 days per benefit period)
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Children's eye exam	No charge	40% <u>coinsurance</u>	None
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

[For more information about limitations and exceptions, see the [plan](#) or policy document at [MutualHealthServices.com/SBC](http://MutualHealthServices.com/SBC).]

## Excluded Services & Other Covered Services:

<p><b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b></p> <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Children's dental check-up</li><li>• Children's glasses</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li><li>• Hearing Aids</li><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
<p><b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b></p> <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Private-Duty Nursing</li></ul>

**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 Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [ccio.cms.gov](http://ccio.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](http://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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) or your plan at 800-367-3762.

### 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-----

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 \$2,000
- Specialist copay \$50
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,170</b>

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

- The plan's overall deductible \$2,000
- Specialist copay \$50
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$100
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$820</b>

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

- The plan's overall deductible \$2,000
- Specialist copay \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$800
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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: 800-367-3762.

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

[For more information about limitations and exceptions, see the plan or policy document at MutualHealthServices.com/SBC.]



# Multi-Language Interpreter Services & Nondiscrimination Notice



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 1-800-367-3762.

## 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 1-800-367-3762。

## German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

## Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-367-3762 رقم هاتف الصم والبكم

## Pennsylvania Dutch

Wann du Deitsch schwetzscht, kansch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff. Call 1-800-367-3762.

## Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

## French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

## Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

## Navajo

Díí baa akó nínízin: Díí saad bee yánífti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojí' hódílnih 1-800-367-3762.

## Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

## Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

## Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

## 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。1-800-367-3762 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 1-800-367-3762.

## Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

## Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.

## Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762.

**QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.**

**Nondiscrimination Notice**

Mutual Health Services 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. Mutual Health Services 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.

Mutual Health Services 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.).

Mutual Health Services 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 Mutual Health Services 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](mailto: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](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf)

■ By mail at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SV 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](http://hhs.gov/ocr/office/file/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.



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 800-367-3762. 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 [MutualHealthServices.com/SBC](https://MutualHealthServices.com/SBC) or call 800-367-3762 to request a copy.

Important Questions		Answers	Why This Matters:
What is the overall deductible?	\$3,200/single,\$6,400/family Network \$6,000/single,\$12,000/family Non-Network	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 deductible?	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.	
Are there other deductibles 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> ?	\$6,450/single,\$12,900/family Network \$11,000/single,\$22,000/family Non-Network	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> , balance-billed 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 <a href="https://MutualHealthServices.com/SBC">MutualHealthServices.com/SBC</a> or call 800-367-3762 for a list of participating providers.	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)	Non-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	No charge after <u>deductible</u>	40% <u>coinsurance</u>	(Physician exam only)
	Specialist visit	No charge after <u>deductible</u>	40% <u>coinsurance</u>	(Physician exam only)
	Preventive care/ screening/ immunization	No charge	40% <u>coinsurance</u>	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 plan will pay for.
If you have a test	Diagnostic test (x-ray)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	None
	Diagnostic test (blood work)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	None
	Generic copay - retail Tier 1	\$10 copay after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
If you need drugs to treat your illness or condition	Generic copay - home delivery Tier 1	\$30 copay after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	\$30 copay after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	\$90 copay after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	\$60 copay after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	\$180 copay after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
If you have outpatient surgery	Specialty drugs	50% up to \$200	Does Not Apply	Covers up to a 30-day supply.
	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	None

[For more information about limitations and exceptions, see the plan or policy document at [MutualHealthServices.com/SBC](http://MutualHealthServices.com/SBC).]

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	No charge after <b>deductible</b>	No charge after <b>deductible</b>	None	
	<u>Emergency medical transportation</u>	No charge after <b>deductible</b>	No charge after <b>deductible</b>	None	
	<u>Urgent care</u>	No charge after <b>deductible</b>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	(includes facility)
	Facility fee (e.g., hospital room)	No charge after <b>deductible</b>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification is required
If you have a hospital stay	Physician/ surgeon fee (inpatient)	No charge after <b>deductible</b>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	None	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	None	None
	Office visits	No charge	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copay</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	No charge after <b>deductible</b>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Covered for subscriber and spouse only, benefits paid are based on corresponding medical benefits, prenatal visits are covered at no charge with <u>in-network providers</u> .
	Childbirth/delivery facility services	No charge after <b>deductible</b>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	(covered for subscriber and spouse only)

[ For more information about limitations and exceptions, see the plan or policy document at [MutualHealthServices.com/SBC](https://MutualHealthServices.com/SBC).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	40% coinsurance	(100 days per benefit period)
	Rehabilitation services (Physical Therapy)	No charge after deductible	40% coinsurance	(40 visits per benefit period, combined with Occupational Therapy)
	Habilitation services (Occupational Therapy)	No charge after deductible	40% coinsurance	(40 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	No charge after deductible	40% coinsurance	(20 visits per benefit period)
	Skilled nursing care	No charge after deductible	40% coinsurance	(90 days per benefit period)
	Durable medical equipment	No charge after deductible	40% coinsurance	None
	Hospice services	No charge after deductible	40% coinsurance	None
	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

[For more information about limitations and exceptions, see the [plan](#) or [policy](#) document at [MutualHealthServices.com/SBC](http://MutualHealthServices.com/SBC).]

## Excluded Services & Other Covered Services:

<p><b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b></p> <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Children's dental check-up</li><li>• Children's glasses</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li><li>• Hearing Aids</li><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
<p><b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b></p> <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Private-Duty Nursing</li></ul>

**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 Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [ccio.cms.gov](http://ccio.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](http://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 the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) or your plan at 800-367-3762.

### 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 -----

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 \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,270</b>

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

- The plan's overall deductible \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,420</b>

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

- The plan's overall deductible \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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: 800-367-3762.

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

[For more information about limitations and exceptions, see the plan or policy document at [MutualHealthServices.com/SBC](http://MutualHealthServices.com/SBC).]



# Multi-Language Interpreter Services & Nondiscrimination Notice



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 1-800-367-3762.

## 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 1-800-367-3762。

## German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

## Arabic

ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-367-3762 رقم هاتف الصم والبكم

## Pennsylvania Dutch

Wann du Deitsch schwetzscht, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff. Call 1-800-367-3762.

## Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

## French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

## Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

## Navajo

Díí baa akó nínizin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' hódíílnih 1-800-367-3762.

## Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

## Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

## Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

## 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。1-800-367-3762 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 1-800-367-3762.

## Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

## Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.

## Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762.

**QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.**

**Nondiscrimination Notice**

Mutual Health Services 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. Mutual Health Services 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.

■ Mutual Health Services 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.).

■ Mutual Health Services 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 Mutual Health Services 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](mailto: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](http://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](http://hhs.gov/ocr/office/file/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.