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, visit www.ualocal94benefits.org or call 1-800-540-2583 (medical) & 1-330-779-8874 (vision/dental). 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/SBC or call 1-800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual/**$1,000** Family Non-Network: :**$1,000** Individual/**$2,000** 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Office visits, prescription drugs, physical exams for individuals age 21 and over, flu shots, network well-child care, routine mammogram, routine pap test, prostate specific antigen test, colonoscopy, telemedicine, services for which a copayment is charged, and emergency room care for medical emergencies 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 a copayment or 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?	Network: **$4,500** Individual/**$9,000** Family Non-Network: **$9,000** Individual/**$18,000** Family Prescription drugs: **$5,650** Individual/**$11,300** Family (Network)	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance billing is prohibited), dental care, vision care, 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?	Yes. See MedMutual.com/SBC or call1-800-540-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be

		aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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
		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	$15 copayment/visit. Deductible does not apply.	$15 copayment/visit, then 20% coinsurance	Telemedicine available through the Cleveland Clinic; $15 copayment/visit and the deductible does not apply.
	Specialist visit	$15 copayment/visit. Deductible does not apply.	$15 copayment/visit, then 20% coinsurance	Chiropractic services limited to 24 visits per person per calendar year.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs/caremark.com.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance (retail)	Retail: 30-day supply; Mail order: 90-day supply. Maintenance medications may only be filled at non-CVS/Caremark retailers up to 3 fills then only available through CVS/Caremark mail order. Cost-sharing for insulin is capped at $35 per purchase. Your cost sharing does not count toward the deductible. Prescription drug out-of-pocket limit: **$5,650** Individual/**$11,300** Family (Network) No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Brand drugs (no generic substitute available)	20% coinsurance (retail and mail order)	20% coinsurance (retail)	
	Brand drugs (generic substitute available)	30% coinsurance (retail and mail order)	30% coinsurance (retail)	
	Specialty drugs	Same cost sharing as generic, brand (no generic substitute available), and brand (generic substitute available) drugs, depending on the type of specialty drug.	Same cost sharing as generic, brand (no generic substitute available), and brand (generic substitute available) drugs, depending on the type of specialty drug.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance;	None
	Emergency medical transportation	20% coinsurance	40% coinsurance, except 20% for air ambulance services	None
	Urgent care	$15 copayment/visit. Deductible does not apply.	40% coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Limited to semi-private room rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $15 copayment/visit. Deductible does not apply; Other outpatient services: 20% coinsurance	Office visit: $15 copayment/visit, then 20% coinsurance; Other outpatient services: 40% coinsurance	Telemedicine available through the Cleveland Clinic; $15 copayment/visit and the deductible does not apply.
	Inpatient services	20% coinsurance	40% coinsurance	Limited to semi-private room rate.
If you are pregnant	Office visits	$15 copayment/visit. Deductible does not apply.	, 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	Occupational therapy and physical therapy subject to combined limit of 64 visits per person per calendar year. Speech therapy limited to 40 visits per person per calendar year. These visit limits do not apply to or restrict these services needed for treatment of Autism.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 90 days per person per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None

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 your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	Individuals under age 19 not subject to the $2,000 per family combined vision and dental maximum. Please contact your Health Care Office at 330-779-8874 if you have any questions. Your cost sharing does not count toward the out-of-pocket limit.
	Children's glasses	20% coinsurance	20% coinsurance	
	Children's dental check-up	20% coinsurance	20% coinsurance	Individuals under age 19 not subject to the $2,000 per family combined vision and dental maximum. Please contact your Health Care Office at 330-779-8874 if you have any questions. Your cost sharing does not count toward the out-of-pocket limit.

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.)

- Acupuncture
- Cosmetic surgery (except to improve a body function, to treat a scar caused by an injury or surgery, to correct a birth defect, or reconstructive surgery following mastectomy)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Bariatric surgery (if medically necessary)
- Chiropractic care (up to 24 visits per person per calendar year)
- Dental care (Adult) ($2,000 family maximum combined with vision care per calendar year; individuals under age 19 not subject to the $2,000 per family combined vision and dental maximum.)
- Private-duty nursing
- Routine eye care (Adult) ($2,000 family maximum combined with dental care per calendar year; individuals under age 19 not subject to the $2,000 per family combined vision and dental maximum.)

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 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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 plan at 1-800-540-2583 for medical and 1-330-779-8874 for dental and vision. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 the 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 1-800-540-2583.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-540-2583 uff.

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 network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$15
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$2,130
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,710**

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

The plan's overall deductible	$500
Specialist copayment	$15
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$530
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,160**

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

The plan's overall deductible	$500
Specialist copayment	$15
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$940**

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