Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility Treatment
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.382.5729. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 800.382.5729.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for sample medical situations, see the next page

WYANDOT CRAWFORD CONSORTIUM : Plan 11

Coverage Examples

Coverage for: Single or Family | **Plan Type:** PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan Pays $6,330**
- **Patient Pays $1,210**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$300
Copays	$10
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,210**

These 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. For more information about your HRA or FSA, please contact your employer group.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan Pays $4,960**
- **Patient Pays $440**

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedure	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$100
Copays	$300
Coinsurance	$0
Limits or exclusions	$40
Total	**$440**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.382.5729.

Questions: Call 800.382.5729 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.382.5729 to request a copy.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box on each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

WYANDOT CRAWFORD CONSORTIUM : Plan 12 B

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at MedMutual.com/SBC or by calling 800.382.5729.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750/single,$1,500/family Network $1,500/single,$3,000/family Non-Network Doesn't apply to coinsurance, copays and network preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes,N/A/single,N/A/family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Cost sharing for prescription drugs, premiums, balance-billed 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**.
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.
Does this plan use a network of providers?	Yes, See MedMutual.com/SBC or call 800.382.5729 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

71

Questions: Call 800.382.5729 or visit us at MedMutual.com/SBC.
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WYANDOT CRAWFORD CONSORTIUM : Plan 12

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	-------none-------
	Specialist visit	$40 copay/visit	40% coinsurance	-------none-------
	Other practitioner office visit (Chiropractic)	20% coinsurance	40% coinsurance	-------none-------
	Other practitioner office visit (Acupuncture)	Not Covered		Excluded Service
	Preventive care/ screening/ immunization	No charge	40% coinsurance	-------none-------
If you have a test	Diagnostic test (x-ray)	20% coinsurance	40% coinsurance	-------none-------
	Diagnostic test (blood work)	20% coinsurance	40% coinsurance	-------none-------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	-------none-------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail /Rx	$5	Does Not Apply	Covers up to a 30-day supply
	Generic copay - home delivery /Rx	$10	Does Not Apply	Covers up to a 90-day supply
	Formulary copay - retail /Rx	$25	Does Not Apply	Covers up to a 30-day supply
	Formulary copay - home delivery /Rx	$62.50	Does Not Apply	Covers up to a 90-day supply
	Non-Formulary copay - retail /Rx	$40	Does Not Apply	Covers up to a 30-day supply
	Non-Formulary copay - home delivery /Rx	$100	Does Not Apply	Covers up to a 90-day supply

Questions: Call 800.382.5729 or visit us at MedMutual.com/SBC.
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WYANDOT CRAWFORD CONSORTIUM : Plan 12

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-------none-------
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance	-------none-------
If you need immediate medical attention	Emergency room services	$150 copay/visit		-------none-------
	Emergency medical transportation	20% coinsurance	40% coinsurance	-------none-------
	Urgent care	$50 copay/visit	40% coinsurance	-------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-------none-------
	Physician/ surgeon fee (inpatient)	20% coinsurance	40% coinsurance	-------none-------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		-------none-------
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-------none-------
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits		-------none-------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	-------none-------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	-------none-------

73

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WYANDOT CRAWFORD CONSORTIUM : Plan 12

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	-------none-------
	Rehabilitation services (Physical Therapy)	20% coinsurance	40% coinsurance	-------none-------
	Habilitation services (Occupational Therapy)	20% coinsurance	40% coinsurance	-------none-------
	Habilitation services (Speech Therapy)	20% coinsurance	40% coinsurance	-------none-------
	Skilled nursing care	20% coinsurance	40% coinsurance	-------none-------
	Durable medical equipment	20% coinsurance	40% coinsurance	-------none-------
	Hospice service	20% coinsurance	40% coinsurance	-------none-------
If your child needs dental or eye care	Eye exam (Child)	No charge	40% coinsurance	-------none-------
	Glasses	Not Covered		Excluded Service
	Dental check-up (Child)	Not Covered		Excluded Service

74

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility Treatment
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.382.5729. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov.

Questions: Call 800.382.5729 or visit us at MedMutual.com/SBC.
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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 800.382.5729.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for sample medical situations, see the next page

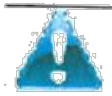
WYANDOT CRAWFORD CONSORTIUM : Plan 12

Coverage Examples

Coverage for: Single or Family | **Plan Type:** PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan Pays $5,230**
- **Patient Pays $2,310**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$800
Copays	$10
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,310**

These 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. For more information about your HRA or FSA, please contact your employer group.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan Pays $4,860**
- **Patient Pays $540**

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedure	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$100
Copays	$400
Coinsurance	$0
Limits or exclusions	$40
Total	**$540**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.382.5729.

77

Questions: Call 800.382.5729 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.382.5729 to request a copy.

Wyandot Crawford Consortium : Plan 13 C

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at MedMutual.com/SBC or by calling 800.540.2583.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,600/single, $5,200/family Network $2,600/single, $5,200/family Non-Network Doesn't apply to coinsurance and network preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, $3,850/single, $7,700/family Network $4,350/single, $8,200/family Non-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.
Does this plan use a network of providers?	Yes, See MedMutual.com/SBC or call 800.540.2583 for list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

78

Questions: Call 800.540.2583 or visit us at MedMutual.com/SBC.
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Wyandot Crawford Consortium : Plan 13

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	40% coinsurance	------none------
	Specialist visit	No charge after deductible	40% coinsurance	------none------
	Other practitioner office visit (Chiropractic)	No charge after deductible	40% coinsurance	------none------
	Other practitioner office visit (Acupuncture)	Not Covered		Excluded Service
	Preventive care/ screening/ immunization	No charge	40% coinsurance	------none------
If you have a test	Diagnostic test (x-ray)	No charge after deductible	40% coinsurance	------none------
	Diagnostic test (blood work)	No charge after deductible	40% coinsurance	------none------
	Imaging (CT/PET scans, MRIs)	No charge after deductible	40% coinsurance	------none------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Retail Generic copay /Rx	$5 after deductible	Does Not Apply	Covers up to a 30-day supply.
	Home delivery Generic copay /Rx	$10 after deductible	Does Not Apply	Covers up to a 90-day supply.
	Retail - Formulary copay /Rx	$25 after deductible	Does Not Apply	Covers up to a 30-day supply.
	Home delivery - Formulary copay /Rx	$62.50 after deductible	Does Not Apply	Covers up to a 90-day supply.
	Retail - Non-Formulary copay /Rx	$40 after deductible	Does Not Apply	Covers up to a 30-day supply.
	Home delivery - Non-Formulary copay /Rx	$100 after deductible	Does Not Apply	Covers up to a 90-day supply.

Questions: Call 800.540.2583 or visit us at MedMutual.com/SBC.
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Wyandot Crawford Consortium : Plan 13

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	40% coinsurance	------none------
	Physician/surgeon fees (Outpatient)	No charge after deductible	40% coinsurance	------none------
If you need immediate medical attention	Emergency room services	No charge after deductible		------none------
	Emergency medical transportation	No charge after deductible	40% coinsurance	------none------
	Urgent care	No charge after deductible	40% coinsurance	------none------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% coinsurance	------none------
	Physician/ surgeon fee (inpatient)	No charge after deductible	40% coinsurance	------none------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		------none------
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		------none------
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		------none------
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits		------none------
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		------none------
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits		------none------
If you are pregnant	Prenatal and postnatal care	No charge after deductible	40% coinsurance	------none------
	Delivery and all inpatient services	No charge after deductible	40% coinsurance	------none------

80

Wyandot Crawford Consortium : Plan 13

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Single or Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations and Exceptions
If you need help recovering or have other special health needs	Home health care	No charge after deductible	40% coinsurance	------none------
	Rehabilitation services (Physical Therapy)	No charge after deductible	40% coinsurance	------none------
	Habilitation services (Occupational Therapy)	No charge after deductible	40% coinsurance	------none------
	Habilitation services (Speech Therapy)	No charge after deductible	40% coinsurance	------none------
	Skilled nursing care	No charge after deductible	40% coinsurance	------none------
	Durable medical equipment	No charge after deductible	40% coinsurance	------none------
	Hospice service	No charge after deductible	40% coinsurance	------none------
If your child needs dental or eye care	Eye exam (Child)	No charge	40% coinsurance	------none------
	Glasses	Not Covered		Excluded Service
	Dental check-up (Child)	Not Covered		Excluded Service

81

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility Treatment
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.540.2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 800.540.2583.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

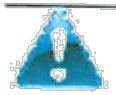
To see examples of how this plan might cover costs for sample medical situations, see the next page

Wyandot Crawford Consortium : Plan 13
Coverage Examples

Coverage for: Single or Family | **Plan Type:** PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan Pays $4,730**
- **Patient Pays $2,810**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$2,600
Copays	$10
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,810**

These 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. For more information about your HRA or FSA, please contact your employer group.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan Pays $2,680**
- **Patient Pays $2,720**

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedure	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$2,600
Copays	$80
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,720**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.540.2583.

Questions: Call 800.540.2583 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.540.2583 to request a copy.

MEDICAL MUTUAL

10/1/2008

Galion City Schools
Traditional Dental
With Orthodontia

TraditionalDental

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	23 Dependent/25 Student Removal upon Birthdate
Benefit Period Maximum (per member)	$1,500
Benefit Period Deductible (per member)[1]	$25/$50
Orthodontic Lifetime Maximum (covered for adults)	$1,500
Preventive Services	
Oral Exams – two per benefit period	100% UCR
Bite Wing X-Rays – two sets per benefit period	100% UCR
Prophylaxis (cleaning) – two per benefit period	100% UCR
Fluoride Treatment – one treatment per benefit period (covered for adults)	100% UCR
Sealants – one every rolling 36 months per tooth	100% UCR
Space Maintainers (covered for adults)	100% UCR
Diagnostic X-Rays – including Full Mouth/Panorex, which are limited to one every 36 consecutive months	100% UCR
Emergency Palliative Treatment – includes emergency oral exam	100% UCR
Essential Services	
Consultations and Other Exams by Specialist	80% UCR after deductible
Minor Restorative Services	80% UCR after deductible
Endodontics/Pulp Services	80% UCR after deductible
Periodontal Services	80% UCR after deductible
Repairs, Relines & Adjustments of Prosthetics	80% UCR after deductible
Simple Extractions	80% UCR after deductible
Impactions	80% UCR after deductible
Minor Oral Surgery Services	80% UCR after deductible
General Anesthesia	80% UCR after deductible
Complex Services	
Gold Foil Restoration	70% UCR after deductible
Inlays, Onlays – one (per area) every five years	70% UCR after deductible
Crowns – one (per tooth) every five years	70% UCR after deductible
Bridgework (Pontics & Abutments) – one (per area) every five years	70% UCR after deductible
Partial and Complete Dentures – one every five years	70% UCR after deductible

Benefits	
Orthodontic Services (covered for adults)	
Orthodontic Diagnostic Services	60%
Minor Treatment for Tooth Guidance	60%
Minor Treatment for Harmful Habits	60%
Interceptive Orthodontic Treatment	60%
Comprehensive Orthodontic Treatment	60%

Note: Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

[1]Maximum deductible per member.

VSP
Vision care for life

Your Vision Benefits Summary

Get the best in eyecare and eyewear with Wyandot Crawford Schools Consortium and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  The decision is yours to make—choose a VSP provider or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195.**
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com.**

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more!. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Coverage Effective Date: 12/01/2014
VSP Provider Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 12 months	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam.....up to $50	Lined Trifocal Lenses.....up to $100
Frame.....up to $70	Progressive Lenses.....up to $75
Single Vision Lenses.....up to $50	Contacts.....up to $105
Lined Bifocal Lenses.....up to $75	

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

†Brands/Promotion subject to change.