Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Stark County Schools Council of Governments: PPO Plan

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, contact AultCare at 1-800-344-8858 / www.aultcare.com or Medical Mutual at 1-800-228-6472 / www.medmutual.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.aultcare.com, www.medmutual.com, or by calling AultCare 1-800-344-8848 or Medical Mutual 1-800-228-6472 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For network providers $250 Individual / $500 Family For out-of-network providers $500 Individual / $1,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
<td></td>
</tr>
</tbody>
</table>

| Are there services covered before you meet your deductible? | Yes. Network preventive care is 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? | For network providers $1,000 Individual / $2,000 Family For out-of-network providers $2,000 Individual / $4,000 Family | The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |

| What is not included in the out-of-pocket limit? | Penalties, Premiums, balance-billing charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

| Will you pay less if you use a network provider? | Yes. For a list of network providers: AultCare: see www.aultcare.com or call 1-800-344-8858; Medical Mutual: see www.medmutual.com or call 1-800-228-6472. | 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 **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Coverage for routine physicals, routine mammograms, prostate screening or pap test is limited to one per calendar year. Routine gynecological exams are limited to two per calendar year.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>Preauthorization may be required for certain imaging services.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs / Brand drugs</td>
<td>20% coinsurance</td>
<td>Mandatory generic drugs where available (unless doctor specifies Dispense as Written). Mail order is required for long term prescription drugs, limited to first fill and one refill at retail pharmacy. All subsequent prescription drugs must be filled by mail.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>Preauthorization may be required for certain surgery services.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>Network deductible will apply.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Network deductible will apply.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>Preauthorization is required. Penalty of $200 may apply for failure to obtain preauthorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services Benefits based upon the corresponding medical benefit.</td>
<td>Benefits based upon the corresponding medical benefit.</td>
<td>Services for Mental Health, Behavioral Health, or Substance Abuse are payable on the same basis as any other illness.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>Preauthorization is required. Penalty of $200 may apply for failure to obtain preauthorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits Benefits based upon the corresponding medical benefit.</td>
<td>Benefits based upon the corresponding medical benefit.</td>
<td>Cost sharing does not apply to certain preventive services. Depending on the type of service, deductible or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>Preauthorization is required. Penalty of $200 may apply for failure to obtain preauthorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 10% coinsurance 20% coinsurance</td>
<td>Preauthorization is required.</td>
<td>Preauthorization may be required for ongoing services.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services 10% coinsurance 20% coinsurance</td>
<td>Preauthorization is required.</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care 10% coinsurance 20% coinsurance</td>
<td>Preauthorization is required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 10% coinsurance 20% coinsurance</td>
<td>Preauthorization is required for certain DME services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services 10% coinsurance 20% coinsurance</td>
<td>Preauthorization is required.</td>
<td></td>
</tr>
</tbody>
</table>

[* For more information about limitations and exceptions, see the plan or policy document at www.aultcare.com or www.medmutual.com.]*
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

- **Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.):
  - Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
  - Acupuncture
  - Bariatric Surgery
  - Cosmetic Surgery
  - Dental Care (adult)
  - Habilitation Services
  - Hearing Aids
  - Long Term Care
  - Non-Emergency care when traveling outside the U.S.
  - Routine Eye Care (adult)
  - Routine Foot Care
  - Weight Loss Programs

- **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**
  - Chiropractic Care
  - Infertility Treatment
  - Private Duty Nursing

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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for group health coverage subject to ERISA, contact Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); for non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for group health coverage subject to ERISA, contact Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call the Ohio Department of Insurance 1-800-686-1526; for non-federal governmental group health plans and church plans that are group health plans, contact AultCare at 1-800-344-8858, Medical Mutual at 1-800-228-6472, or call the Ohio Department of Insurance 1-800-686-1526.

**Does this plan provide Minimum Essential Coverage?** Yes

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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.aultcare.com](http://www.aultcare.com) or [www.medmutual.com](http://www.medmutual.com).]
Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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[* For more information about limitations and exceptions, see the plan or policy document at www.aultcare.com or www.medmutual.com.]
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)
- The plan’s overall deductible: $250
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250</td>
<td>$0</td>
<td>$800</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is: $1,060

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

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
- The plan’s overall deductible: $250
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250</td>
<td>$0</td>
<td>$500</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $20 |

The total Joe would pay is: $770

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)
- The plan’s overall deductible: $250
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250</td>
<td>$0</td>
<td>$300</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is: $550

The plan would be responsible for the other costs of these EXAMPLE covered services.
AultCare/Aultra Notice Tag Lines for the State of Ohio

English
This Notice has Important Information. This notice has important information about your application or coverage through AultCare/Aultra. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Local: 330.363.6560 Outside Stark County: 1.800.344.8858 TTY Local: 711 Outside Stark County: 711

Spanish
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través AultCare/Aultra. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al Local: 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 711 Fuera del condado de Stark : 711

Chinese
本通知有重要的訊息。本通知有關於您透過 AultCare/Aultra 保險公司 提交的申請或保險的重要訊息，請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 本地：330.363.6360 斯塔克縣外：711

German

Arabic
يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة عن الحصول على التغطية من خلال شركة التأمين AultCare/Aultra. تبحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لإتخاذ إجراءة في تواريخ معينة للحفاظ على تغطية الصحة أو المساعدة في دفع التكاليف. الفحص في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. تصل بالعنوان 330.363.6360 خارج مقاطعة ستارك: 1.800.344.8858 TTY محل المحلي: 711 خارج مقاطعة ستارك: 711

Pennsylvania Dutch
Deutsch

Russian
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Страховую компанию AultCare/Aultra. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 711 Вне Старка County: 711

French

Vietnamese
Việt Nam
Cushite-Oromo

Korean
한국어

Italian
Italiano

Japanese
日本語
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Dutch
Nederlands

Ukrainian
український
Це повідомлення містить важливу інформацію про Ваше звернення до страхової компанії AultCare/Aultra. Відповідайте на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону Місцевий: 330.363.6360 Поза Старка County: 1.800.344.8858 TTY лінія Місцевий: 711 Поза Старка County: 711.

Romanian
Română

Non-Discrimination Notice:
AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra 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, other formats). AultCare/Aultra 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 that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.


AultCare/Aultra Notice Taglines Revised 6/2021 (TTY)
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 1-800-382-5729 (TTY: 711).

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 1-800-382-5729 (TTY: 711)。

German

Arabic
ملحوظة: إذا كنت تتحدث اللغة，则您可以免费获得语言援助服务。拨打号码 1-800-382-5729 (TTY: 711)。

Pennsylvania Dutch

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телефон: 711).

French
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo
Dii baa akó niniziní: Dii saab bede yánííti’i go Diné Bizaad, saab bede áká’ánída’áwó’déé’, t'áá jiik’eh, éí ná hóló, kojji hódíílníih 1-800-382-5729 (TTY: 711).

Order Number: Z8188-MCA R11/16
Dept of Ins. Filing Number: Z8188-MCA R9/16
Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care 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

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
- 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