

Cleveland Clinic/Akron General Employee Health Plans

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

Coverage Period: 01/01/2017 - 12/31/2017

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 MutualHealthServices.com/SBC or by calling 800.451.7929.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	N/A/single, N/A/family Preferred \$500 /single, \$1,500 /family Network N/A/single, N/A/family Non-Network Does not apply to copays, co-insurance and 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 <u>deductibles</u> for specific services?	Yes, \$100/single, \$300/family network for prescription drugs	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, \$1,500 /single, \$3,000 /family Preferred N/A/single, N/A/family Network N/A/single, N/A/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 <u>not included</u> in the <u>out-of-pocket limit</u>?	Drug copays, deductibles, 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 <u>annual limit</u> 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 <u>network of providers</u>?	Yes, See MutualHealthServices.com/SBC or call 800.451.7929 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 <u>specialist</u>?	No	You can see the specialist you choose without permission from this plan.

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Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services .
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- **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 Preferred Provider	Your Cost if You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Deductible, \$25 copay/visit	Not Covered	-----none-----
	Specialist visit	\$35 copay/visit	Deductible, \$50 copay/visit	Not Covered	-----none-----
	Other practitioner office visit (Chiropractic)	\$35 copay/visit for the first 10 visits/benefit period, then 50% coinsurance for the next 10 visits	Not Covered	Not Covered	Prior authorization is required under age 16; 20 visits per benefit period
	Other practitioner office visit (Acupuncture)	50% coinsurance	Not Covered	Not Covered	10 visits per benefit period
	Preventive care/ screening/ immunization	No charge	Not Covered	Not Covered	-----none-----

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If you have a test	Diagnostic test (x-ray)	No charge	30% coinsurance	Not Covered	-----none-----
	Diagnostic test (blood work)	No charge	30% coinsurance	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$35 copay/visit	Deductible, \$50 copay, 30% coinsurance	Not Covered	Prior authorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage refer to EHP Total Care Prescription Benefit & Formulary Handbook for required prior authorizations, non-covered drugs, and quantity level limits available on our website at: www.clevelandclinic.org/healthplan	Drug Out of Pocket Limit - Single	\$1,500	Does Not Apply		-----none-----
	Drug Out of Pocket Limit - Family	\$4,500	Does Not Apply		-----none-----
	Generic copayment – home delivery up to 90 day supply /Rx	15%	Does Not Apply		Cleveland Clinic Pharmacies
	Generic copayment – retail 30 day supply /Rx	20%	Does Not Apply		CVS Caremark Retail Network Pharmacies
	Preferred brand copayment – home delivery up to 90 day supply /Rx	25%	Does Not Apply		Cleveland Clinic Pharmacies
	Preferred brand copayment - 30 day supply /Rx	30%	Does Not Apply		CVS Caremark Retail Network Retail Pharmacies
	Non-preferred brand copay home delivery up to 90 day supply /Rx	45%	Does Not Apply		Cleveland Clinic Pharmacies
	Non-preferred brand copayment – retail 30 day supply /Rx	50%	Does Not Apply		CVS Caremark Retail Network Retail Pharmacies
	Specialty drugs – up to 90 day supply/RX	20%	Does Not Apply		Only at: Cleveland Clinic Pharmacies, Home Delivery, CVS Caremark Retail Network Pharmacies

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Not Covered	-----none-----
	Physician/surgeon fees (Outpatient)	No charge	30% coinsurance	Not Covered	-----none-----
If you need immediate medical attention	Emergency room services	\$150 copay/visit Copay waived if admitted			Prior authorization required for Non Cleveland Clinic Hospital ER admits.
	Emergency medical transportation	No charge			-----none-----
	Urgent care	\$50 copay/visit			-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay	Ded/ \$150copay/ 30% coinsurance		Prior authorization required
	Physician/ surgeon fee (inpatient)	No charge	30% coinsurance	Not Covered	

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits			
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits			
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits			
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits			
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits			Prior authorization required
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits			Prior authorization required
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Not Covered	-----none-----
	Delivery and all inpatient services	\$150 copay	Deductible, \$150 copay/ 30% coinsurance	Not Covered	-----none-----

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If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Not Covered	60 visits per calendar year; prior authorization is required
	Rehabilitation services (Physical Therapy)	\$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Deductible, then \$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Not Covered	(35 visits per benefit period)
	Habilitation services (Occupational Therapy)	\$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Deductible, then \$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Not Covered	(35 visits per benefit period)
	Habilitation services (Speech Therapy)	\$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Deductible, then \$10 copay/visit for the first 20 visits/benefit period, then 50% coinsurance for the next 15 visits	Not Covered	(35 visits per benefit period)
	Skilled nursing care	No charge	30% coinsurance	Not Covered	(60 days per benefit period; prior authorization required)
	Durable medical equipment	20% coinsurance	20% coinsurance	Not Covered	-----none-----
	Hospice service	No charge	No charge	Not Covered	Respite care 10 days per benefit year

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If your child needs dental or eye care	Eye exam (Child)	\$35 copay/visit	Not Covered	Not Covered	-----none-----
	Glasses		Not Covered		Excluded Service
	Dental check-up (Child)		Not Covered		Excluded Service

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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.)

- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)

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 800.451.7929. 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.

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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 800.451.7929. You may also contact the Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3273) or www.dol.gov/ebsa/healthreform.

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.**

Language Access Services

Para obtener asistencia en Español, llame al
如果 需要 蝶菡 请拨打这个号码

800.451.7929

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne'

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

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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)

- n Amount owed to providers: **\$7,540**
- n Plan Pays **\$7,120**
- n Patient Pays **\$420**

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	\$20
Copays	\$200
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$420

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)

- n Amount owed to providers: **\$5,400**
- n Plan Pays **\$4,690**
- n Patient Pays **\$710**

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	\$70
Coinsurance	\$500
Limits or exclusions	\$40
Total	\$710

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: 800.451.7929.

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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.

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Cleveland Clinic and Akron Employee Plan: Coverage Examples

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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 1-800-451-7929.

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 1-800-451-7929。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-451-7929

Arabic

المساعدة خدمات ف إن، اللغة اذكر تتحدث كذت ذا إملحوظة
800-451-7929- والبك م الص م ه اتف رقم 1 لك تتواف رة اللغ و
ب رقم اتصل ل بالمج ان 7929

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-800-451-7929.

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Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-451-7929.

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-451-7929.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-451-7929.

Navajo

Díí baa akó nínízin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'dé' ę', t'áá jiik'eh, éí ná hóló', kojí' hódíílnih 1-800-451-7929

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-451-7929.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-451-7929 번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-451-7929.

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。1-800-451-7929 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 1-800-451-7929.

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-451-7929.

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-451-7929.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-451-7929.

Cleveland Clinic and Akron Employee Plan:

Coverage Examples

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QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-451-7929.

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

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

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