The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-451-7929. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MutualHealthServices.com/SBC or call 800-451-7929 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/single$0/family Preferred $500/single, $1,500/family Network N/A/single, N/A/family Non-Network	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, 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.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is covered and paid by the plan 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.
Are there other deductibles for specific services?	Yes, $200/single, $400/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.
What is the out-of-pocket limit for this plan?	$3,950 /single $7,900/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 in a 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?	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.
Will you pay less if you use a network provider?	Yes, See MutualHealthServices.com/SBC or call 800-451-7929 for a list of participating 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Deductible, $25 copay/visit	Not Covered	None
	Specialist visit	$35 copay/visit	Deductible, $50 copay/visit	Not Covered	None
	Preventive care/ screening/ immunization	No charge	Not Covered	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
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)	$75 copay/visit	$75 copay/visit, deductible; 30% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	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 MutualHealthServices.com/SBC	Drug Out of Pocket Limit - Single	$3,950	Does Not Apply	Does Not Apply	None
	Drug Out of Pocket Limit - Family	$7,900	Does Not Apply	Does Not Apply	None
	Generic copayment - retail 30 day supply Tier 1	20%	Does Not Apply	Does Not Apply	CVS Caremark Retail Refer to note below
	Generic copayment - home delivery 90 day supply Tier 1	15%	Does Not Apply	Does Not Apply	Includes Cleveland Clinic Pharmacies Refer to note below
	Preferred brand copayment - 30 day supply Tier 2	30%	Does Not Apply	Does Not Apply	CVS Caremark Retail Refer to note below
	Preferred brand copayment - home delivery 90 day supply Tier 2	25%	Does Not Apply	Does Not Apply	Includes Cleveland Clinic Pharmacies Refer to note below
	Non-preferred brand copayment - retail 30 day supply Tier 3	50%	Does Not Apply	Does Not Apply	CVS Caremark Retail Refer to note below
	Non-preferred brand copayment - home delivery 90 day supply Tier 3	45%	Does Not Apply	Does Not Apply	Includes Cleveland Clinic Pharmacies Refer to note below
	Specialty drugs	20%	Does Not Apply	Does Not Apply	Refer to EHP Total Care Rx Benefit & Formulary Handbook for required prior authorizations, non-covered drugs, and quantity level limits available on our website at www.clevelandclinic.org/healthplan
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 care	$250 copay/visit			None
	Emergency medical transportation	No charge			None
	Urgent care	$50 copay/visit			None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/admission	Deductible, $350 copay/admission, 30% coinsurance	Not Covered	None
	Physician/ surgeon fee (inpatient)	No charge	30% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits			None
	Inpatient services	Benefits paid based on corresponding medical benefits			None
If you are pregnant	Office visits	No charge	30% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	Not Covered	None
	Childbirth/delivery facility services	$350 copay/admission	Deductible, $350 copay/admission, 30% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
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 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	$350 copay/admission	Deductible, $350 copay/admission, 30% coinsurance	Not Covered	(60 days per benefit period; prior authorization required)
	Durable medical equipment	20% coinsurance	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	Not Covered	Not Covered	None
	Children's glasses	Not Covered			Excluded Service
	Children's dental check-up	Not Covered			Excluded Service

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.)

- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform or your plan at 800-451-7929.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services **800-451-7929**

Para obtener asistencia en Español, llame al

如果需要中文的帮助，请拨打这个号码

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

About these Coverage Examples:

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

Peg is having a baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist copay $35
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$40
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$400

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

- The plan's overall deductible $0
- Specialist copay $35
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$70
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,530

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

- The plan's overall deductible $0
- Specialist copay $35
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$450

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-451-7929.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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