PLAN YEAR 2019

Cleveland Clinic (CC)/Akron General (AG) EHP Employee (Print) _____ **ID Card EHP No.:** _____

SSN: _____ **Date of Birth:** _____ **LETTER CODE: 700**

Do (did) you or your participating dependents have other Medical, Pharmacy, Dental, Vision, Medicare or Medicaid coverage in **2018 and/or 2019?** ☐ YES ☐ NO

Please complete the form and refer to the letter for submission instructions.

OTHER INSURANCE INFORMATION (NON MEDICARE) ***Please enclose a copy of the other insurance ID cards.***

Policyholder's Name _____ Relationship to CC/AG Employee _____

Policyholder's Date of Birth ___/___/_____ ID No. _____ Group No. _____

Original Effective Date ___/___/_____ Policy Term Date (*if applicable **) ___/___/_____ ***Please provide a copy of Creditable Coverage Letter(s).***

Policy Obtained Through: ☐ Group Employment ☐ Individual Purchase ☐ Student ☐ Medicaid ☐ Other_____

Policy Status: ☐ Active Benefits ☐ Retiree Benefits ☐ COBRA **Policy Covers**: ☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision

Policy Type: ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family ☐ Other _____

Name of Other Insurance Company _____ Customer Service Telephone No. _____

Name of Employer _____

Please complete columns below for those covered under the other insurance policy listed above. Use additional COB forms if necessary.

Last Name	First Name	Date of Birth	Relationship	Effective Date	Term Date

Is there legal documentation stating who is responsible for carrying the healthcare coverage for you or your dependents?
☐ YES ☐ NO ***If yes, legal documents must accompany the form stating who is responsible for carrying healthcare coverage.***

Name of Custodial Parent _____

_____

MEDICARE INSURANCE INFORMATION ***Please enclose a copy of your Medicare card.***

Medicare ID No. _____

Medicare Recipient Name _____

Effective Date: Part A ___/___/___ Part B ___/___/___

Medicare Coverage is the result of:

☐ Age (65 years)

☐ Disability _____/_____/_____ Date Approved for Medicare Benefits

☐ End-Stage Renal Disease

If yes, please check one of the following:

☐ Transplant _____/_____/_____ Date of Transplant

☐ Dialysis _____/_____/_____ Date of First Dialysis

Please check one: ☐ Home Dialysis ☐ Facility Dialysis

Medicare ID No. _____

Medicare Recipient Name _____

Effective Date: Part A ___/___/___ Part B ___/___/___

Medicare Coverage is the result of:

☐ Age (65 years)

☐ Disability _____/_____/_____ Date Approved for Medicare Benefits

☐ End-Stage Renal Disease

If yes, please check one of the following:

☐ Transplant _____/_____/_____ Date of Transplant

☐ Dialysis _____/_____/_____ Date of First Dialysis

Please check one: ☐ Home Dialysis ☐ Facility Dialysis

CC/AG Employee Signature _____ **Date**___/___/_____

Ohio Revised Code Section 3999.21 – Insurance Fraud Warning "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

CLEVELAND CLINIC/AKRON GENERAL EMPLOYEE HEALTH PLAN COORDINATION OF BENEFITS (COB) FORM

Coordination of Benefits (COB) is the process used to pay healthcare insurance policy expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare or Medicaid. If you/your dependents are covered by more than one healthcare insurance policy, Mutual Health Services (MHS), the Cleveland Clinic Employee Health Plan (EHP) Third-Party Administrator (TPA), follows rules established by Ohio law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). The combined payments of all healthcare insurance policies will not exceed the actual amount of your bills.

All members are required to complete the COB process each year in January.

The following three options are available for submitting your COB information to MHS:

1. **Cleveland Clinic:** Complete the online COB form via the MHS website as follows: https://chn.mutualhealthservices.com. **OR** You can access the website via the ONE HR Workday and Portal. Once you log in, click "ONE HR Portal," then "ONE HR." From the "My Health" drop down, click on "Overview Claims, COB and more", then click the "Coordination of Benefits" tab. Click on "Mutual Health Services". Sign in, and then click on "Health Plan Claims – Cleveland Employees Only." Click on "Continue." You will see the COB tab at the top.
   Akron General: Complete the online COB form via the MHS website as follows: https://chn.mutualhealthservices.com. **OR** Contact your HR Representative for assistance.

   Please note: If you have legal documentation stating who is responsible for providing healthcare for the dependent children covered on your health plan, and/or you have other insurance in the current or prior plan year, then you may not *submit* your COB information via the web site. You may enter your COB information via the web site and then print and send it, along with your legal document, via mail or fax to MHS.

2. Complete the form, where applicable, then sign the bottom of the COB form, and return to MHS via Fax or U.S. mail.

   Fax Number: Mutual Health Services
   Administrative Service Department: 440-878-5488

   Mailing Address: Mutual Health Services
   Administrative Service Department
   15885 West Sprague Road
   Strongsville, OH 44136-1772

   Remember to include the following information (if applicable) for all parties on your EHP with your completed COB form:
   - **Attach a *copy* of the other healthcare insurance ID card(s)**
   - **Attach a *copy* of the Medicare card(s)**
   - **Attach a *copy* of the certificate of creditable coverage for each person terminated on another healthcare insurance policy**

3. If no other insurance existed in the plan year being updated or the prior plan year, Call MHS Customer Service at 1-800-451-7929. The interactive voice response (IVR) system is available 24/7 to accept COB updates. A live, Customer Service Representative is available to personally assist you during regular business hours (Monday-Friday, 8am-5pm)

NOTE: Be advised that if you have other insurance and there is legal documentation regarding who is responsible for providing healthcare coverage for the dependent children on your health plan, then the legal documentation must accompany your COB information.

NOTE: If you fail to complete the COB process, all claims payments will be delayed and/or denied. Forms that are incomplete could be sent back for additional information and will delay the processing of your claim(s).

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

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

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل برقم 1-800-451-7929.

Pennsylvania Dutch

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

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 yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dę́ ę́', t'áá jiik'eh, éí ná hóló, kojį' 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

ATENŢ IE: Dacă vorbiţi limba română, vă stau la dispozit,ie servicii de asistent,ă lingvistică, gratuit. Sunat,i 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.

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

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