Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Cleveland Clinic Employee Health Plan: Employee

Coverage Period: 01/01/2019- 12/31/2019
Coverage for: Single or Family | **Plan Type:** PPO

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, 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 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. There is no deductible in the preferred network.	You must pay all the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services. When using the non-preferred network for covered services the deductible applies.
What is the out-of-pocket limit for this plan?	**$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 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 preferred network provider?	Yes, See MutualHealthServices.com/SBC or call 800-451-7929 for a listing of participating providers	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's** preferred **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)	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	Deductible, $25 copay/visit	Not Covered	None
	Specialist visit	$35 copay/visit	Deductible, $50 copay/visit	Deductible, $50 copay/visit	Not Covered	None
	Preventative care/ screening/ immunization	No charge	Not Covered	Not Covered	Not Covered	You may have to pay for services that aren't preventive. Ask you 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	20% coinsurance	30% coinsurance	Not Covered	None
	Diagnostic test (blood work)	No charge	20% coinsurance	30% coinsurance	Not Covered	None
	Imaging (CT/PET scan, MRIs)	$50 copay/visit	$50 copay/visit, deductible; 20% coinsurance	$50 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)	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 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.clevelandclinicorg/healthplan**	Drug Out of Pocket Limit-Single	$1,500	Does Not Apply	Does Not Apply	Does Not Apply	None
	Drug Out of Pocket Limit-Family	$4,500	Does Not Apply	Does Not Apply	Does Not Apply	None
	Generic copayment - retail 30 day supply Tier 1	20%	Does Not Apply	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	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	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	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	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	Does Not Apply	Includes Cleveland Clinic Pharmacies Refer to note below
	Specialty drugs	20%	Does Not Apply	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	20% coinsurance	30% coinsurance	Not covered	None
	Physician's surgeon fees (Outpatient)	No charge	20% coinsurance	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)	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)	$250 copay/admission	Deductible, $250 copay/admission, 20% coinsurance	Deductible,$250 copay/admission, 30% coinsurance	Not Covered	None
	Physician's surgeon fee (inpatient)	No charge	20% coinsurance	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				
If you are pregnant	Office visits	No charge	20% coinsurance	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	20% coinsurance	30% coinsurance	Not Covered	None
	Childbirth/delivery facility services	$250 copay/admission	Deductible, $250 copay/admission, 20% coinsurance	Deductible, $250 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)	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	20% coinsurance	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	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	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	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	$250 copay/admission	Deductible, $250 copay/admission, 20% coinsurance	Deductible, $250 copay/admission, 30% coinsurance	Not Covered	None
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	Not Covered	None
	Hospice services	No charge	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	Not Covered	1 per calendar year
	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 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.
- 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 ccio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For 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 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 meet Minimum Value Standards? 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 exception 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 assistance en Español, llame al

Kung kailangan ninyo ang tulong sa Tagalong tumawag sa

如果需要中文的帮助，请拨打这个号码

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*----------

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*	$0
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$470**

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*	$0
Copayments	$70
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
Total Joe would pay is	**$1,330**

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 tests (*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
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.

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
ملحوظة: إذا كنت تتحدث اذكر
1رقم هاتف الصم والبكم -0(

Pennsylvania Dutch
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ru f 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 số1 -800-451-7929.

Navajo
Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dę´ ę´', 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
ATENT, IE: Dacă vorbit,i 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.

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Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company.

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