



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, www.HealthReformPlanSBC.com or by calling 1-833-414-2331. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-833-414-2331 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	Cleveland Clinic Quality Alliance: Individual (IND) \$250/ Family (FAM) \$500. Aetna Network: IND \$500/ FAM \$1,500.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
<u>Are there services covered before you meet your deductible?</u>	Yes. Emergency care; plus Cleveland Clinic in-network generic <u>prescription drugs</u> , office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
<u>Are there other deductibles for specific services?</u>	Yes. For <u>prescription drugs</u> : IND \$200 / FAM \$400. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<u>What is the out-of-pocket limit for this plan?</u>	Cleveland Clinic Quality Alliance: IND \$3,950 / FAM \$7,900. Aetna Network: IND \$4,750 / FAM \$9,500. RX: IND \$3,950 / FAM \$7,900.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges, bariatric surgery <u>copay</u> * Autism school & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See Main_CampusResidents_and_Fellows">https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=directInklogo&planValue=CCUSW>Main_CampusResidents_and_Fellows or call 1-833-414-2331 for a list of Cleveland Clinic Quality Alliance.	You pay the least if you use a <u>provider</u> in Cleveland Clinic Quality Alliance. You pay more if you use a <u>provider</u> in Aetna <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cleveland Clinic Quality Alliance (You will pay the least)	Aetna Network (You will pay more)	Out-of-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	30% <u>coinsurance</u> after \$25 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after \$50 <u>copay</u> /visit	Not covered	None
	<u>Preventive care /screening</u> /immunization	No charge	Not covered	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit	30% <u>coinsurance</u> after \$75 <u>copay</u> /visit	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan .
If you need drugs to treat your illness or condition	Preferred non-specialty generic drugs (tier 1)	Not applicable	See <u>Summary Plan Description</u>	Not covered	
	Preferred non-specialty brand drugs (tier 2)	Not applicable	See <u>Summary Plan Description</u>	Not covered	See <u>Summary Plan Description</u> .
	Non-preferred brand & generic drugs (tier 3)	Not applicable	See <u>Summary Plan Description</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Cleveland Clinic Quality Alliance (You will pay the least)	Aetna Network (You will pay more)	Out-of-Network Provider (You will pay the most)	
<u>Prescription drug coverage</u> is administered by CVS Caremark					
	More information about <u>prescription drug coverage</u> is available at www.Clevelandclinic.org/healthplan	Specialty brand & generic drugs (tier 4)	Not applicable	See Summary Plan Description	See Summary Plan Description.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, hospital and hospital outpatient locations)	\$75 <u>copay</u> /visit	30% <u>coinsurance</u> after \$75 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network.
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <u>copay</u> /stay	30% <u>coinsurance</u> after \$350 <u>copay</u> /stay	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan .
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	<p>Outpatient services</p> <p>Inpatient services</p>	<p>Cleveland Clinic Quality Alliance (You will pay the least)</p> <p>Office: \$35 <u>copay/visit</u>, <u>deductible</u> doesn't apply; other outpatient services: 0% <u>coinsurance</u></p>	<p>Aetna Network (You will pay more)</p> <p>Office: 30% <u>coinsurance</u> after \$50 <u>copay/visit</u>; other outpatient services: 0% <u>coinsurance</u></p>	<p>Out-of-Network Provider (You will pay the most)</p> <p>Not covered</p>	<p>None</p> <p>Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.</p>
If you are pregnant	<p>Office visits</p> <p>Childbirth/delivery professional services</p> <p>Childbirth/delivery facility services</p>	<p>No charge</p> <p>0% <u>coinsurance</u></p> <p>\$350 <u>copay/stay</u></p>	<p>No charge</p> <p>30% <u>coinsurance</u></p> <p>30% <u>coinsurance</u> after \$350 <u>copay/stay</u></p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Copay</u> waived on newborn facility <u>claim</u> if baby discharged with mother. Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.</p>
If you need help recovering or have other special health needs	<p><u>Home health care</u></p> <p><u>Rehabilitation services</u></p> <p><u>Habilitation services</u></p>	<p>0% <u>coinsurance</u></p> <p>\$20 <u>copay/visit</u>, <u>deductible</u> doesn't apply</p> <p>No charge</p>	<p>30% <u>coinsurance</u></p> <p>Not covered</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>	<p>60 visits/calender year. Precertification required.</p> <p>30 visits/calender year for each physical, occupational, and speech therapy, including outpatient hospital services</p> <p>Habilitative physical, occupational, and speech therapy for Apraxia, Autism, Autism Spectrum Disorder, Cerebral Palsy, Developmental Delay, Spina Bifida. No visit limit for Autism/Autism Spectrum Disorder.</p>

Common Medical Event	Services You May Need	Cleveland Clinic Quality Alliance (You will pay the least)	What You Will Pay Aetna Network (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Skilled nursing care</u>	\$350 <u>copay/stay</u>	30% <u>coinsurance</u> after \$350 <u>copay/stay</u>	Not covered	60 days/calendar year. Precertification required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	0% <u>coinsurance</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Not covered	2 routine eye exams/calender year up to age 18 and 1 routine eye exam/calender after 18.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - 10 visits/calender year for disease, injury & chronic pain.
- Bariatric surgery - For Cleveland Clinic Quality Alliance providers only.
- Chiropractic care - 10 visits/calender year.
- Hearing aids - 50% of charge up to \$3,500 per ear/every 3 years for Cleveland Clinic Quality Alliance providers only.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Long-term care
- Routine eye care (Adult) - 2 routine eye exams/calender year up to age 18 and 1 routine eye exam/calender after 18.

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 more information on your rights to continue coverage, contact the plan at 1-833-414-2331.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, 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 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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-833-414-2331. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at:
<http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>

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 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.

To see examples of how this plan might cover costs for a sample medical situation, 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 <u>plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$350
■ <u>Other coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$300
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$760

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$350
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$300
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,490

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$350
■ <u>Other coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$300
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-833-414-2331.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

English -	To access language services at no cost to you, call 1-833-414-2331.
Amharic -	የችንች አገልግሎቶችን የለከፍም ለማግኘት፡ በ 1-833-414-2331 ይደውሉ፡፡
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال على الرقم 1-833-414-2331.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-833-414-2331 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-414-2331.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-833-414-2331.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-833-414-2331.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-833-414-2331.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-833-414-2331.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-833-414-2331.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-833-414-2331 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-833-414-2331.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોર માટે, કોણ કરોર 1-833-414-2331.
Hindi -	आपकेलिए बिना ककसी कीमत के भाषा सेवाओंका उपयोग करनेकेलिए, 1-833-414-2331 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-833-414-2331.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-833-414-2331.
Japanese -	言語サービスを無料でご利用いただくには、1-833-414-2331 までお電話ください。
Karen -	လာတ်ကမန်ကိုယ်အတ်မစာအတ်ပံ့တ်မတော်လာတအိုဒီးအပ္ပါယာကဘုံဟုံအိုဂိုံဘုံနှင့် ကို 1-833-414-2331 စောက့်။
Korean -	무료 언어 서비스를 이용하려면 1-833-414-2331 번으로 전화해 주십시오.
Laotian -	ເຜົ່າຂົ້ນໃຈ້ກ້ານບໍລິການພາກາໄດ້ລັບໜ່າຍຄ່າກໍາທ່ານ, ໃຫ້ໃຫ້ທາງເປີ 1-833-414-2331.
Mon-Khmer, Cambodian -	ເដືອນໂຈ້ງຂ້າຍພາສາ ເພື່ອສະໜັບສະໜັດ ແລ້ວສະໜັດ ແລ້ວສະໜັດ 1-833-414-2331 ၅

Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqh ílínígóó koji' hólne' 1-833-414-2331.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-833-414-2331.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-833-414-2331 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-833-414-2331.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-833-414-2331.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-833-414-2331 'ਤੇ ਫੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-833-414-2331.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-833-414-2331.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-833-414-2331.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-833-414-2331.
Syriac-Assyrian -	جَلْ بِلْجِيَّةَ حَلَقَنْتَهُ، ۱-۸۳۳-۴۱۴-۲۳۳۱.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-833-414-2331.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-833-414-2331.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-833-414-2331.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-833-414-2331.