CLE Care HSA 5,000 w/PD Rx**

Illustrative Summary of Benefits

Health Savings Account Compatible

Effective 5/1/2020

Benefits	Network
Benefit Period	January 1st through December 31st
Dependent Age Limit	26 - Removal upon End of the Month
Deductible (Single / Family)	$5,000 / $10,000
Coinsurance Max. Out-of-Pocket (excl. ded) (Single / Family)	N/A
Maximum Out-of-Pocket (Single / Family)[1]	$6,900 / $13,800
Coinsurance (member cost)	0%
Physician/Office Services	
Physician Office Visit	coinsurance after deductible
Specialist Office Visit	coinsurance after deductible
Urgent Care Office Visit	coinsurance after deductible
Emergency Services	
Emergency Use of an Emergency Room	coinsurance after network deductible
Emergency Services (expenses other than Emergency Room)	coinsurance after network deductible
Non-Emergency Use of an Emergency Room	Not Covered
Routine/Preventive Services[2]	
Health Care Reform Benefits	0%
Health Care Reform Benefits for Women	0%
All Immunizations	0%
Routine Physical Exam (age 21 and over)	0%
Routine Mammogram (one per benefit period)	0%
Routine Pap Test (one per benefit period)	0%
Routine Lab, Medical Tests, and X-rays	0%
Routine Endoscopic Services	0%
Well Child Care (to age 21)	
Well Child Care Exams, Immunizations and Labs	0%
Hearing Exams	0%
Vision Exams	0%
Lenses	Not Covered
Frames	Not Covered
Contacts	Not Covered
Outpatient Services	
Allergy Testing and Treatments	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period/combined)	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible
Cardiac Rehabilitation (36 visits per benefit period)	coinsurance after deductible
Surgical Services	coinsurance after deductible
Diagnostic Lab, Medical Tests, and X-rays	coinsurance after deductible
Diagnostic Imaging	coinsurance after deductible
Diagnostic Endoscopic Services	0%
Institutional Services	coinsurance after deductible
Maternity	coinsurance after deductible
Skilled Nursing Facility (90 days per benefit period)	coinsurance after deductible

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Benefits	Network
Additional Services	
Ambulance	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits
Durable Medical Equipment	coinsurance after deductible
DME - Wigs	Not Covered
Home Health Care (100 visits per benefit period)	coinsurance after deductible
Hospice	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible
Organ Transplant Services (includes travel, meals, lodging and transportation)	coinsurance after deductible
Private Duty Nursing	coinsurance after deductible
Sterilization	coinsurance after deductible
Mental Health & Substance Abuse - Federal Mental Health Parity	
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits
Outpatient Mental Health and Substance Abuse Services	

Prescription Drug Benefits[3]			
ESI National Plus Network		MetroHealth Pharmacies	
Retail only:	Mail:	Retail:	Mail:
(up to 30-day supply) Generic: $15 copay; Preferred Brand: $45 copay; Non-Preferred Brand: $75 copay; Specialty High-Cost Drugs*: 50% up to max of $200	Not applicable Must use MetroHealth Pharmacy	(up to 30-day supply): Generic: $7.50 copay; Preferred Brand: $22.50 copay; Non-Preferred Brand: $37.50 copay; Specialty High-Cost Drugs*: 50% up to max of $200	(up to 90-day supply) Generic: $22.50 copay; Preferred Brand: $67.50 copay; Non-Preferred Brand: $112.50 copay;

[1]Network level Out-of-Pocket includes deductible, coinsurance and flat dollar copayments.

[2]Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

[3]**Generic Incentive:** If a brand-name drug is requested when a generic equivalent exists, the member pays the brand-name copay plus the difference between the cost of the generic drug and the brand-name drug.
***Specialty High-Cost Drugs** Must be filled by MetroHealth, Accredo or Gentry.
**The HSA plan has post-deductible drug copays. Amounts apply only after the deductible is met.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

Benefits will be administered by Medical Mutual of Ohio. Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures. This document is only a partial listing of benefits. This is not a contract of insurance. Only an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.