Lorain Mercy SEIU RNs PPO Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at mercy.healthspanproviders.org or by calling HealthSpan at **1-800-686-7100**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Domestic Tier 1A & Affiliated Tier 1B= **$150** individual/**$300** family In-Network Tier 2= **$300** individual/$**600** family Out-of-Network Tier 3 = **$350** individual/**$800** family Not subject to deductible: Tier 1 preventive care and Tier 2 preventive physical exams and routine well child care; Tier 1/Tier 2 office visits (including at urgent care facilities); all Tiers emergency treatment and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Domestic Tier 1A providers = **$300** individual/**$600** family. Affiliated Tier 1B providers = **$1,650** individual/**$3,300** family. In-Network Tier 2 providers = **$2,800** individual/**$5,600** family. Out-of-Network Tier 3 providers = **$6,350** individual/**$12,800** family. Your prescription drug out-of-pocket maximums for all Tiers are **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	All Tiers: Premiums, penalties, balance-billed charges, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. For a list of **plan providers** see **mercy.healthspanproviders.org**; For a list of **participating providers** see **mercy.healthspanproviders.com**; or call **1-800-686-7100**.	If you use an in-network doctor or other health care **provider**, this plan pay some or all of the costs of covered services. Be aware, your in-netwo doctor or hospital may use an out-of-network **provider** for some servic Plans use the term in-network, preferred, or **participating** for **provider** their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this pla
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **exclud services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if th plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allow amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowe amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a				Limitations & Exceptions
		Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$15	$30 copay per visit then 40% coinsurance	$50 copay per visit then 50% coinsurance	Services that **are** available at Mercy Regional M Center (MRMC) or Mercy Allen Hospital (MA but done at a Tier 1B provider will be paid at 6 However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%.
	Specialist visit	No charge	$30	$45 per visit then 40% coinsurance	$60 per visit/ then 50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%.
	Other practitioner office visits (including chiropractic care subject to limits)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%. Chiropractic care: limited to 12 visits in a calen year.12 Visits per Benefit Period
	Preventive care (routine physical exams)	No charge	$15	$15 copay per visit	$20 copay per visit/then 50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%.
	Preventive care (immunizations)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	
	Preventive care (routine tests)	No charge	0% coinsurance	40% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MA done at a Tier 1B provider will be paid a However, if services **are not** available at MR MAH but done at a Tier 1B provider, they paid at 100%.

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **mercy.healthspanproviders.org**	Generic drugs	34-day supply Retail pharmacy or In-house pharmacy: Initial filling and first two refills: $10 copay After third fill: $15 copay 90-day supply Mail order pharmacy or In-house pharmacy: $15 copay				Preventive drugs mandated by PPACA=No Cl Women's preventive care medications are cove Request for brand medication when generic is available will require you to pay the applicable copay plus the difference in cost between gene brand. The Rx out-of-pocket maximum is $1,600 individual/$3,200 family. This does not includ excluded, limited, and not covered drugs. Multi-Source Copay (By request): $20+ differe
	Formulary brand drugs	34-day supply Retail pharmacy or In-house pharmacy: Initial filling and first two refills: $25 copay After third fill: $45 copay 90-day supply Mail order pharmacy or In-house pharmacy: $45 copay				
	Non-Formulary brand drugs	34-day supply Retail pharmacy or In-house pharmacy: Initial filling and first two refills: $45 copay After third fill: $85 copay 90-day supply Mail order pharmacy or In-house pharmacy: $85 copay				
	Specialty drugs	Paid as stated above, based on type of drug.				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
	Physician/surgeon fees	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	MAH but done at a Tier 1B provider, they will paid at 100%.
If you need immediate medical attention	Emergency room services	No Charge				----------None----------
	Emergency medical transportation	No Charge				----------None----------
	Urgent care	$50 copay	$50 copay	$50 copay then 20% coinsurance	$50 copay then 50% coinsurance	Tiers 2, & 3: Not subject to the overall deducti
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Precertification is required for Inpatient confinements (including Skilled Nursing Facili Rehabilitation, Mental Health and Substance A with the exception of childbirth admissions of than 48 hours for vaginal delivery or 96 hours cesarean delivery Failure to comply with precertification requirem may result in a financial penalty (not considered expense nor applied to your deductible or out-o pocket maximum).
	Physician/surgeon fee	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or	Mental/Behavioral health outpatient services	No charge	$15	$30 copay per visit then 40% coinsurance	$50 copay per visit then 50% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
substance abuse needs	Mental/Behavioral health inpatient services	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Precertification is required for Inpatient confinements (including Skilled Nursing Facili Rehabilitation, Mental Health and Substance A Failure to comply with precertification requirem may result in a financial penalty (not considered expense nor applied to your deductible or out-o pocket maximum).
	Substance use disorder outpatient services	No charge	$15	$30 copay per visit then 40% coinsurance	$50 copay per visit then 50% coinsurance	----------None----------
	Substance use disorder inpatient services	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Precertification is required for Inpatient confinements (including Skilled Nursing Facili Rehabilitation, Mental Health and Substance A Failure to comply with precertification requirem may result in a financial penalty (not considered expense nor applied to your deductible or out-o pocket maximum).
If you are pregnant	Prenatal and postnatal care	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	----------None----------
	Delivery and all inpatient services	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Precertification provision does not apply to childbirth admissions of less than 48 hours for vaginal delivery or 96 hours for cesarean delive
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%. Limit of 30 days per benefit period

Common Medical Event	Services You May Need	Your cost if you use a				Limitations & Exceptions
		Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	
	Rehabilitation services	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%. Limit of 40 visits per benefit period combined Physical/Occupational Therapy per benefit pe Limit of 36 visits per benefit period for Cardia Rehabilitation Limit of 120 days per benefit period for Inpati Physical Medicine and Rehabilitation

Common Medical Event	Services You May Need	Your cost if you use a Domestic Network Tier 1A Provider	Affiliated Network Tier 1B Provider	Network Tier 2 Provider	Non-Network Tier 3 Provider	Limitations & Exceptions
	Habilitation services	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Services that **are** available at MRMC or MAH done at a Tier 1B provider will be paid at 60%. However, if services **are not** available at MRM MAH but done at a Tier 1B provider, they will paid at 100%. Combined limit of 40 visits per benefit period Occupational/Physical Therapy Limit of 20 visits per benefit period for Speech Therapy
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	50% coinsurance	Precertification is required for Inpatient confinements (including Skilled Nursing Facili Rehabilitation, Mental Health and Substance A Failure to comply with precertification requirem may result in a financial penalty (not considered expense nor applied to your deductible or out-o pocket maximum). Limit of 30 days per benefit period
	Durable medical equipment	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	----------None----------
	Hospice service	0% coinsurance	0% coinsurance	40% coinsurance	50% coinsurance	Limit of 180 days per benefit period
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Not Covered	----------None----------
	Glasses	Not Covered	Not Covered	Not Covered	Not Covered	No coverage for glasses
	Dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	No coverage for dental check ups

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic Surgery • Dental Check-up (Child)	• Glasses • Hearing Aids • Long-Term/Custodial Nursing Home Care • Non-Emergency Care when Traveling Outside the U.S.	• Private-Duty Nursing • Routine Dental Services (Adult) • Routine Foot Care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery	• Chiropractic Services	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep healtl coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-686-7100. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: HealthSpan at 1-800-686-7100, online at **mercy.healthspanproviders.org**, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-686-7100 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Chinese (**中文**): **如果需要中文的帮助**，请拨打这个号码1-800-757-7585 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-686-7100 or TTY/TDD Akron: 1-330-633-1161 Cleveland: 1-800-676-6677 Medicare Eligible: 1-216-479-5003

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. This example applies to Tier 1 only.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,740
- **Patient pays** $800

Sample care costs:

Hospital Charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$600
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,060
- **Patient pays** $340

Sample care costs:

Prescriptions	$1,50
Medical Equipment and Supplies	$1,30
Office Visits and Procedures	$73
Education	$29
Laboratory tests	$14
Vaccines, other preventive	$14
Total	**$5,40**

Patient pays:

Deductibles	$10
Copays	$20
Coinsurance	$
Limits or exclusions	$4
Total	**$34**

Total amounts above are based on subscriber only coverage

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For eMAH treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** Charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in eMAH example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.