Cleveland Heights-University Heights City Schools

Understanding the CHUH Health Insurance Plan

January, 2021

Gallagher

Insurance | Risk Management | Consulting

Health Plan Benefit Overview
Medical Mutual of Ohio – SuperMed Plus Network

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	PPO Plan Jan 2021		PPO Replacement Plan Feb 2021	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Network/Non-Network Integration	Separate – Costs incurred for a non-network provider will only apply to non-network deductible, coinsurance limits, and vice versa		Separate – Costs incurred for a non-network provider will only apply to non-network deductible, coinsurance limits, and vice versa	
Deductible (Single/Family)	$100/$200	$200/$400	$100/$200	$200/$400
Coinsurance (%)	90%	80%	90%	80%
Coinsurance Out-of-Pocket Maximum (Single/Family)	$500/$1,000	Unlimited	$400/$800	Unlimited
Maximum Out-of-Pocket (Single/Family)	$6,850/$13,700	Unlimited	$6,850/$13,700	Unlimited
Preventive Services	100%	100%	100%	100%
Physician Office Visit	$20 Copay	90% after deductible	$15 Copay	90% after deductible
Urgent Care Office Visit	$20 Copay	90% after deductible	$15 Copay	90% after deductible
Surgical Services	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible	90% after deductible	80% after deductible

Health Plan Benefit Overview, continued
Medical Mutual of Ohio – SuperMed Plus Network

	PPO Plan Jan 2021		PPO Replacement Plan Feb 2021	
	In-Network	**Out-of-Network**	In-Network	Out-of-Network
Emergency Room (Emergency Use)	$75 copay, then 100%	$75 copay, then 100%	$25 copay, then 100%	$25 copay, then 100%
Emergency Room (Non-Emergency Use)	$100 copay, then 100%	$100 copay, then 100%	$100 copay, then 100%	$100 copay, then 100%
Durable Medical Equip.	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Organ Transplant	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Ambulance Services	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Inpatient Semi-Private Room & Board	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Inpatient Maternity	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Inpatient & Outpatient Mental Health & Substance Abuse	Benefits paid based upon corresponding medical benefits/type of services.			

Health Plan Benefit Overview, continued
Medical Mutual of Ohio / Express Scripts

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	PPO Plan Jan 2021		PPO Replacement Plan Feb 2021	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUG BENEFITS				
Retail up to a 34-day supply				
Generic	$5 Copay	Not Covered	$5 Copay	Not Covered
Single Source Brand	$15 Copay	Not Covered	$15 Copay	Not Covered
Multi-Source Brand	$50 Copay	Not Covered	$50 Copay	Not Covered
Mail Order up to a 90-day supply				
Generic	$10 Copay	Not Covered	$10 Copay	Not Covered
Single Source Brand	$30 Copay	Not Covered	$30 Copay	Not Covered
Multi-Source Brand	$100 Copay	Not Covered	$100 Copay	Not Covered
Other Rx Drug Changes	Generic Mandate: Members who continue to fill a brand name prescription when a generic is available pay the generic copay plus the difference in cost between the generic and brand drug regardless of dispense as written (DAW). Sexual Dysfunction: drugs excluded.		Effective 2/1/21, the generic mandate and exclusion of sexual dysfunction drugs are removed from the plan	
	MMO's Basic Plus Formulary Coverage Management Programs Apply Prior Authorization, Quantity Duration Limits and Step Therapy for certain drugs.		MMO's Basic Plus Formulary Coverage Management Programs Apply Prior Authorization, Quantity Duration Limits and Step Therapy for certain drugs.	

Where to Find Care

When it comes to taking care of yourself or your loved ones, you want to get the best care as quickly and affordability as possible. When you are ill, injured or feel like you need immediate care, always call your primary care physician (PCP) first. If you can't reach your PCP or don't have time for an office visit, you have options.

Nurse Line: **free call-in service** offered by Medical Mutual, provides 24/7 access to registered nurses for answers to health-related questions. Call 888-912-0636.

Telemedicine: **Cleveland Clinic's Express Care Online** is available 24/7, and is a telephone/online video service providing access to board-certified physicians. Wait times are typically less than 10 minutes after you register. **CHUH health plan members have $0 copay.**

Convenience Clinic: A walk-in clinic located in some drug and grocery stores, staff by a physician's assistant or nurse practitioner. Convenience clinics don't require an appointment and have shorter average wait times. **Office visit copay applies.**

Urgent Care: A walk-in clinic that saves time and money compared to an emergency room. Many are open evenings and weekends. Urgent care facilities don't require an appointment and have average wait times. **Urgent care copay applies.**

Emergency Room (ER): A facility typically found in a hospital, providing 24/7 care in case of emergencies and acute care without prior appointment. ER visits for non-emergency symptoms may result in extremely long wait times and significant higher costs compared to visiting a non-emergency location. **ER Copay applies**

Emergency vs. Non-Emergency Use of the ER

Emergency Use of the Emergency Room:

Emergency Medical Condition – a medical condition characterized by the sudden onset and symptoms of severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.
- Some examples of medical emergencies include but are not limited to:
  - Stroke
  - Heart Attack
  - Loss of Consciousness
  - Shock
  - Poisoning
  - Difficulty Breathing

MMO uses the primary diagnosis code on the claim to determine emergency vs. non-emergency.

Non-Emergency Use of the Emergency Room:

Some examples of conditions which are not typically considered medical emergencies:

- Allergies/Asthma
- Back Pain
- Bronchitis
- Ear Infection
- Cold/Flu
- Urinary Tract Infection

Appropriate care options for non-emergency conditions include urgent care, convenience clinics, your primary care physician, and telemedicine.

Emergency Room visits for non-emergency conditions result in long wait times and significantly higher costs

You will have higher out-of-pocket costs if you use the Emergency Room for a non-emergency condition.

Understanding Preventive Care vs. Diagnostic Care

Preventive Care: You don't have signs of a problem or your doctor wants to make sure everything is okay. Preventive care includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

Diagnostic Care: You have symptoms and your doctor wants to find the cause, or your doctor wants to check on an ongoing problem. Diagnostic medical care includes treatment or diagnosing a problem you're having by monitoring existing problems, checking out new symptoms or following up on abnormal test results.

CHUH Health Plan:

- Preventive Services: covered at 100% for eligible services, in accordance with the Affordable Care Act
  Diagnostic Services: covered subject to deductible, coinsurance and/or copays for eligible services

Understanding Insurance Terminology

DEDUCTIBLE: is the amount you pay for covered health care services before the plan begins to pay. Deductibles start over each January 1st.

For family coverage, no one person in the family will have a greater Deductible than an individual with single coverage. All family members combined will pay no more than the family deductible, even if no family member meets the single deductible. This means the family deductible could be met by any combination of family members.

COINSURANCE: is your share of the costs of a health care service. After you have met your deductible, you and your plan share some of your medical costs. For example, the plan pays 90% and you pay 10%.

COPAY: is flat dollar amount you pay for certain health care services, usually collected at the time you receive the service. The amount varies depending on the type of service. For services that have a copay, deductible and coinsurance do not apply.

Understanding Insurance Terminology

COINSURANCE MAXIMUM : is the most you have to pay for covered services that have coinsurance; for example, when the plan pays 90% and you pay 10%. Once you meet the coinsurance maximum amount for the year, the plan pays 100% for certain services. The coinsurance maximum does not include your deductible amount.

For family coverage, no one person in the family will have a greater Coinsurance Maximum than an individual with single coverage. The Coinsurance Maximum for all family members accumulate toward the family. All family members combined will not pay more than the family coinsurance maximum, even if no family member meets the single coinsurance maximum. This means the family coinsurance maximum could be met by any combination of family members.

MAXIMUM OUT-OF-POCKET: is the most you have to pay for covered health care services during a calendar year, overall. The maximum out-of-pocket includes your deductible + coinsurance + medical and prescription drug copays. Once this maximum is met, the plan pays 100% for all covered services for the rest of the year.

For family coverage, no one person in the family will have a greater Maximum Out-of-Pocket than an individual with single coverage. The Maximum Out-of-Pocket for all family members accumulate toward the family. All family members combined will not pay more than the family Maximum Out-of-Pocket, even if no family member meets the single Maximum Out-of-Pocket. This means the family Maximum Out-of-Pocket could be met by any combination of family members. After the maximum is met, the plan begins paying all covered services at 100%.

Understanding Insurance Terminology

- **Prescription Drug Coverage Management Programs:** pharmacy programs to ensure you get the right drug for the right condition at the right cost. The programs include prior authorization, step therapy, and quantity limits.

Prior authorization (PA) rules check if a drug is prescribed appropriately and proven effective and safe for your condition. If you do not get prior authorization before filling your prescription, your plan may not cover the medication and you will have to pay full price.

Step therapy (ST) rules promote the use of lower-cost generic drugs and preferred brand-name alternatives in place of more costly medications. For example, if Medication A, a generic drug, and Medication B, a brand-name drug, both treat your condition, the plan may not cover Medication B unless you try Medication A first. If Medication A does not work for you, the plan will cover Medication B. Please note: Some medications may be covered if your demographic or medical history meets certain qualifications.

Quantity limit (QL) rules define the amount of the medication your plan will cover. Your plan may only cover a certain quantity per fill (such as six tablets at a time), or a certain quantity over a specific time (for example, 30 tablets within a 90-day period). These limits are determined by FDA-approved dosing. Additional quantities may be allowed if proven medically necessary and safe.

These programs are in place for the CHUH plan effective February 1, 2021. If you took a medication in 2020 that falls under one of these programs, you should receive a letter from Express Scripts identifying the affected medication(s), alternatives medications, and steps to take.

How do I find out what drugs are included in these programs?

Log into My Health Plan at **MedMutual.com/Member**, click Prescription Drug Benefits under the Benefits & Coverage tab, then follow instructions to sign into Express Scripts website. Or, call **1-800-417-1961**.

What to do if your medication requires PA, ST, or QL?

You, your doctor or pharmacist can call **1-800-753-2851** to begin the review process. After contacting Express Scripts (ESI), your doctor will receive a form to complete and fax back to ESI. ESI will send you and your doctor a letter confirming if coverage has been approved.

A coverage management flier is available on the District's benefits website or you may request from HR

Putting it All Together

Here's an example of how it works. Example #1

Let's say you need a CT (CAT) Scan. This is your first claim of the new year which takes place in February, and the total cost is $4,100. This is a diagnostic service, and is subject to deductible and coinsurance.

Cost of CT Scan	$4,100
Your Deductible	$100
Balance	$4,000
Plan Pays (90% of the remaining $4,000)	$3,600
Your Coinsurance (10% of the remaining $4,000)	$400
Total You Owe (Deductible + Coinsurance)	$500

In this example, you are responsible for the **$100 deductible** and **$400 coinsurance**, for a **total of $500.**

Your individual deductible and coinsurance out-of-pocket maximum is met for the remainder of the calendar year, and the plan will begin paying certain services at 100%. You will continue to pay for services that have copays, like office visits, emergency room, and prescriptions, until the **maximum out-of-pocket** is met.

Note: this example assumes that services are provided by in-network providers. Your costs will be higher if using non-network providers.

Putting it All Together

Here's an example of how it works. Example #2

For example 2, you have already met your individual deductible and individual coinsurance out-of-pocket maximum, but have not yet met the overall maximum out-of-pocket for the calendar year, which means you will continue to pay copays for certain services. For example:

- **Services received in January, 2021**
  - **Office Visits**: You pay **$20 copay** per visit
  - **Emergency Room**: You pay **$75 copay** per visit

    (you will pay a higher copay of $100 for non-emergency use of the ER)

- **Services received February 1st and after**
  - **Office Visits**: You Pay **$15 copay** per visit
  - **Emergency Room**: You Pay **$25 copay** per visit

    (you will pay a higher copay of $100 for non-emergency use of the ER)

You will continue to pay copays for office visits, urgent care, emergency room, and prescription drugs until the overall maximum-out-of-pocket is met for the calendar year.

This example assumes that you all services are provided by in-network providers. If you use non-network providers, your out-of-pocket costs will be higher.

MMO Health Plan Enrollees will receive:

- **New MMO ID Cards:**
  - You should have received a set of ID cards for the PPO Plan Jan 2021
    - Cards were mailed on or about 12/31/20
  - You will receive another set of ID cards for the PPO Replacement Plan Feb 2021
    - Cards will be mailed mid-to-late January
    - When you receive cards for the Replacement Plan, discard the previous cards

- **MMO Summary of Benefits & Coverage ("SBC")**
  - SBC's for the PPO Plan Jan 2021 can be found on the District's benefits website or you may request from the HR Department
  - SBC for the PPO Replacement Plan Feb 2021 will be available prior to 2/1

- **MMO Certificate of Coverage** (Benefit Booklet)
  - Certificates of coverage provide detailed information about the health plan
  - Certificates will be mailed to each covered employees home in the near future

Medical Mutual's Member Website: My Health Plan

- Accessible 24/7
- Understand your out-of-pocket costs with real-time deductible an coinsurance information
- Search for network providers
- Estimate costs
- Access to electronic copies of your:
  - ID Cards
  - Explanation of Benefit Statements (EOB's)
  - Certificate Books
- Access via computer, tablet, or mobile app
- Register at **Med.Mutual.com/Member**

Enrollment Changes / Life Events

It's important to remember that your health plan elections (medical, prescription drug, dental, vision, FSA) made during open enrollment remain in effect until the next open enrollment, unless you experience a **qualifying life event, or "change in status".** The election change must be consistent with the change in status, whether requesting to add or drop coverage.

Examples of **life events** include but are not limited to:

- Marriage
- Divorce
- Death of a Spouse
- Change in number of dependents: birth, adoption
- Involuntary Loss of Other Coverage

*If you experience a qualifying life event and wish to make changes to your elections, you must request the change within **30-days** of the event, or you will have to wait until the next open enrollment period to make a change. Please be sure to timely report life events to Denise Toney in benefits.*

Questions?

If you have questions about the health insurance plan, please contact:

- Medical Mutual Customer Service: 1-800-521-6492
- Denise Toney in Benefits
- Your Union leadership

Thank you!

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This summary is an outline of the coverage. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language.
This summary is not a contract of insurance.

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