Benefit Package

Non-Union Personnel
Revised BOE Meeting 09-11-23

Effective August 1, 2023 to July 31, 2026

Certificated/Licensed Administrators

Effective July 1, 2023 to June 30, 2026

Classified Administrators, Central Office Support Staff

CLEARVIEW SCHOOLS
Administrative, Supervisory, and Central Office Compensation Plan

Benefits Provisions

The following benefit provisions apply to all individuals by the Board of Education who are classified as an administrator, supervisor, and/or central office employee.

I. Administrators/Supervisors

One of the primary goals with regard to salaries is to remain competitive with area school districts. In turn, this will enable the district to retain its personnel and maintain stability in its operations.

Educational Growth Stipend

Just as teachers receive additional pay on the negotiated salary schedule for obtaining graduate semester credit hours, masters, certified/licensed administrators will also receive a stipend for additional coursework. According to the following scale, administrators will receive the corresponding stipend to be paid in December of each year. The graduate hours earned for placement on the scale must be certified by October 1st of each year.

Degree and Graduate Hours	Stipend
M.A. + 9 – Semester Hours	$1,000
M.A. + 18 – Semester Hours	$1,250
M.A. + 27 – Semester Hours	$1,500
M.A. + 36 – Semester Hours	$1,750
M.A. + 45 – Semester Hours	$2,000
M.A. + 54	$2,250
Ph.D./Ed.D/Ed.S	$2,500

In addition, administrators will be reimbursed for the cost of graduate hours taken at a maximum of $2,750 per year.

II. Central Office Classified Employee Salaries

The Central Office Classified Employee Salary Schedule is based upon a comparison of internal job classifications and responsibilities. Just as the high school secretary position carries an increased number of work days and wage scale over other building secretaries, so too do the central office staff positions demand different responsibilities beyond the high school secretary.

As such, the development of the salary schedule is based on the wage of the high school secretary. Each year, the salary schedule will be modified to coincide with the OAPSE negotiated scale for the high school secretary.

Placement on the salary schedule is not necessarily a reflection of years of service. Particularly for current employees, their placement was determined, in part, based on their present salary. For new employees, placement on the salary schedule will be determined by the Superintendent and/or Treasurer in conjunction with Board approval. Consideration should be given for experience in similar positions.

III. Administrators/Supervisors/Central Office – Other Benefits

A. Medical/Vision/Dental Coverage:
Administrators, Supervisors, Central Office

- See description of Medical Plan Design detailed below.

B. Life Insurance
Administrators, Supervisors, Central Office

- Twice their annual salary

C. Mileage Reimbursement
Administrators, Supervisors, Central Office

- At the IRS-approved per mile rate for use of a privately owned car for official school business.

D. Professional Meeting Reimbursement
Administrators, Supervisors, Central Office

- Appropriate reimbursement for lodging, travel, registration, food, and related expenses for approved meetings

E. Sick Leave
Administrators, Supervisors, Central Office

- Fifteen (15) days per year accumulative

F. Personal Business Leave
Administrators, Supervisors, Central Office

- Four (4) days per year – non-cumulative

G. Bereavement Leave
Administrators, Supervisors, Central Office

- Five (5) days per year – non-cumulative for death of immediate family member

H. Retirement
Administrators, Supervisors, Central Office

- Full Board-paid Employee share with pick-up in the appropriate STRS or SERS retirement plan
- Effective 7/1/2012, all current classified office staff will be grandfathered in regards to pick-up on the pick-up.

I. Holidays
All 260-day Administrators, Supervisors, Central Office:

- Eight (9) legal holidays [New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Juneteenth, July 4th, Labor Day, Thanksgiving Day, Christmas Day] plus (6) designated vacation holidays including Good Friday, the day before and after Thanksgiving, the day before and after Christmas, and the day before New Year's.

J. Vacation

All 260 day Administrators, Supervisors, Central Office as per the following schedule:

Central Office Staff

- Less than one year of service / 5 days per year
- 1 - 6 years of service / 10 days per year
- 7 – 13 years of service / 15 days per year
- 14+ years of service / 20 days per year

Central Office Administration

- Less than one year of service / 10 days per year
- 2+ years of service / 20 days per year

Maintenance Supervisor

- Less than one year of service / 8 days per year
- 1 – 10 years of service / 15 days per year
- 11+ years of service / 20 days per year

All employees – vacation time earned shall be cumulative for up to two (2) years or they may request to receive compensation or lose it.

K. Longevity Benefit

Classified Central Office Employee

After Years of Service		Annual Increment
• 10 years	additional	$ 300.00
• 15 years	additional	$ 400.00
• 20 years	additional	$ 500.00
• 25 years	additional	$ 600.00
• 30 years	additional	$ 800.00
• 35 years	additional	$1,000.00

- Superintendent and Treasurer = $500.00 per years of service to the District

L. Annuity

Administrators, Masters, Certified/License

- The administrator contracts $500 per year accumulative after two (2) years of service in the Clearview Schools

M. Severance

Administrators, Supervisors, Central Office

- Payment upon retirement, for one fourth (1/4) of accumulated sick leave with the following limits:
- Building Administrators, Supervisors, Central Office, maximum days equal to 100 days
    - Treasurer – 175 days
    - Superintendent – 175 days

Upon retirement from the District into the SERS or STRS an employee with ten (10) or more years of experience in the Clearview Local School District shall be paid severance by the Board as set forth herein.

An employee shall be paid by the Board for one-fourth (1/4) of his/her accumulated sick leave up to a maximum of seventy-five (75) days [the Superintendent and Treasurer are paid to a maximum of one hundred fifty (150) days]. Payment shall be at the daily rate in effect at the last

day of actual employment. Full severance pay will be paid at the time of death if the employee was eligible to retire and had worked for the District for ten (10) or more years. At the time of death, if an employee is not eligible to retire and has ten (10) years of service or more, his/her estate will receive half of his/her severance pay.

Employees shall receive their severance pay in three (3) equal installments beginning in February of the calendar year following the date of retirement and the following two Februarys thereafter. The payments will be made within a week of the District receiving its County funds but under no circumstances later than the end of February. Employees may elect to have their triennial severance payments deposited into a 457 Ohio Deferred Compensation Plan and/or with a District approved 403b provider.

N. Retirement Incentive
- See Section M and Severance Pay Section

O. Association Memberships - Annual Board paid dues for the following:
- Superintendent – BASA dues
- Treasurer – OASBO dues
- Building Administrators – OASSA, OAMSA, OAESA, LCAAA, OAPSA dues
- Any other professional dues as approved by the Superintendent of Schools

P. Any other benefits provided to the Superintendent and/or Treasurer, as negotiated with the Board, will be included with their signed contracts.

Q. Any modifications, deletions, or additions to these outlined benefits for individual employees will be included with their signed contract.

HOSPITALIZATION – HEALTH MAINTENANCE

1. All Regular Employees working thirty (30) hours or more per work shall be entitled to the Hospitalization-Medical-Vision plan described below.

2. All Regular Employees who work at least fifteen (15) hours per week (but less than thirty (30) hours per week) for at least thirty-six (36) weeks shall be entitled to the Hospitalization-Medical-Vision plan described below, but the Board shall only provide one-half of single or family coverage to which the employee is entitled.

Hospitalization / Dental Coverage

A. The Board shall provide hospitalization / major medical and dental coverage. Each employee may annually select one of the offered Health Benefit Plans (e.g., *Premium*; *Standard*; *Minimum Value*).

B. Board Contribution to Coverage:

The Board shall pay ninety percent (90%) of the cost of the *Premium* and *Standard* coverages for full-time employees, and, for part-time employees, the Board shall pay ninety percent (90%) of that part of the total cost proportionate to the workload. The Board shall pay one hundred percent (100%) of the cost of the *Minimum Value* coverage for full-time employees.

C. Working Spouse Mandatory Enrollment Rule

Any spouse that has single medical/prescription drug insurance coverage available through his/her employer, business, organization or retirement plan, that costs the spouse no more than 50% of the premium cost for the lowest cost plan, must enroll in that coverage and the Clearview Local School District's Health Plan will coordinate as secondary payer for any and all services provided.

It is the employee's responsibility to advise the Treasurer or designee immediately (i.e., within thirty (30) days after any change in eligibility) if the employee's spouse becomes eligible to participate in group medical/prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan, or if the contribution for single coverage changes. Upon becoming eligible, the employee's spouse must enroll in single coverage under any group medical/prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan unless he/she is exempt from this requirement because the spouse's cost for single coverage under the lowest cost plan is more than 50% of the premium cost.

Any spouse who fails to enroll in any group medical/prescription drug insurance coverage sponsored by his/her employer, business, organization, or any retirement plan, as required by this rule, shall be ineligible for benefits under such group insurance coverage sponsored by the Clearview Local School District.

Every employee whose spouse participates under the Clearview Local School District's medical/prescription drug insurance coverage shall complete and submit to the Treasurer or designee, upon request, a written certification verifying whether his/her spouse is eligible to participate in group medical/prescription drug insurance coverage sponsored by the spouse's employer, business, organization, or any retirement plan. If any employee fails to complete and submit the certification form by the required date, such employee's spouse will be removed immediately from all group medical/prescription drug insurance coverage sponsored by the Clearview Local School District. Additional documentation may be required.

If an employee knowingly or recklessly submits false information, or fails to promptly (i.e., within thirty (30) days after any change in eligibility) advise the Treasurer or designee of a change in his/her spouse's eligibility for employer (or business, organization, or retirement plan) sponsored group medical/prescription drug insurance, and such false information or such failure by the employee results in the District's Health Plan providing benefits to which the employee's spouse is not entitled, the employee will be personally liable to the District's Health Plan for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Plan. Any amount to be reimbursed by the employee may be deducted from the benefits to which the employee would

otherwise be entitled. In addition, the employee's spouse will be terminated immediately from group medical/prescription drug insurance coverage under the Plan. If any employee submits false information, he/she may be subject to disciplinary action, up to and including termination of employment.

Vision Care Plan

Vision Care benefits apply when a covered person incurs vision care charges for services recommended and approved by a Physician or Optometrist.

Vision Care charges are limited to the vision services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts in accordance with the Schedule of Benefits.

Vision examinations are covered regardless of medical necessity. An exam includes the
following:

1. Case History;
2. External examination of the eye and adnexa;
3. Opthalmoscopic examination;
4. Determination of refractive status;
5. Binocular balance testing;
6. Tonometry, as needed;
7. Gross visual fields;
8. Color vision testing;
9. Summary findings; and
10. Recommendations including prescribing lenses.

Prescribed lenses and frames are covered in accordance with the Schedule of Benefits.

Coverage allows for the following services only when they are done to obtain the prescribed lenses and frames:

1. Facial measurements and determination of interpupillary distance;
2. Assistance in choosing frames;
3. Verification of lenses as prescribed; and
4. After-care for a reasonable period for fitting and adjustment.

Prescribed contact lenses as shown in the Schedule of Benefits.

Treatment for diseases involving the eye (glaucoma, cataracts, etc.) are covered under the medical portion of the Medical Plans.

LIMITATIONS AND EXCLUSIONS

The Plan does not cover the following services, supplies, or charges:

1. Services that are not received from a provider acting within the scope of his/her license.
2. Diagnostic services and drugs or medications not a part of a vision examination.
3. Services that, to any extent, are payable under the medical expenses benefits of the Medical Plans.
4. Services that the Plan determines are special or unusual, such as orthoptics, vision training, and low vision aids.
5. For the replacement of lenses and frames except as shown under the limitation of frequency in the Schedule of Benefits.
6. For any lenses that are not prescribed.
7. For safety glasses and safety goggles.
8. For any services or supplies for which benefits are payable under any worker's compensation law or under any governmental program.
9. For eye examinations that occurred before the covered person's effective date of employment.
10. For examinations or services incurred or received after the covered person's effective termination date.
11. For those services, supplies, or charges that are not specified under this Plan.

DEPENDENT AGE LIMIT

Coverage stops on the 26th birthday.

Section 125 Plan

A. The Board shall provide a Section 125 Plan that is designed to allow employees who must make employee contributions for health care coverage to elect to do so on a pre-tax basis.

B. The Section 125 Plan will be designed to meet the requirements of Internal Revenue Code ("IRC") Section 125 and applicable regulations. Accordingly, each employee will have an opportunity on an annual basis to enroll in the Plan. The election to participate must be submitted to the Treasurer during the month of September. Each newly hired employee may enroll in the Section 125 Plan within his/her first thirty (30) days of his/her contractual start date during his/her first year of employment only. The newly hired employee's Section 125 Plan year will begin the first of the month following the employee's election to participate and will end upon notification from the employee of his/her intent to no longer participate as may be submitted during the following September. The Section 125 Plan may not be revoked during the current plan year unless there is a change in the employee's circumstances that, in accordance with I.R.C. Section 125, permits the employee to change his/her election under the plan

(e.g., divorce, death of spouse, change in employment status including employment status affecting a spouse or dependent, birth or adoption of a child, a child losing eligibility for coverage, a court order requiring coverage, or other enrollment rights consistent with federal law). Details of the Section 125 Plan will be provided on an annual basis at the time of enrollment and will also be available through the Treasurer's office.

MEDICAL PLAN DESIGN

Annually, each bargaining unit member may select one of the following Health Benefit Plans.

The annual per person dental maximum shall be $1,500.

In-Network	*Premium*	*Standard*	*Min. Value Based Design for ACA*
Deductible (In-network)	$750/$1,500	$1,000/$2,000	$4,000/$8,000
- Earned Incentive Award	($250)/($500)	($250)/($500)	($250/$500)
Deductible (In-network)	$500/$1,000	$750/$1,500	$3,750/$7,500
Coinsurance	90%	80%	70%
Coinsurance Out-of-Pocket Max (does not include deductible)	$1,500/$3,000	$2,000/$4,000	$6,250/$12,500
Total Out-of-Pocket Max includes deductible and coinsurance) with wellness incentive	$2,000/$4,000	$2,750/$5,500	$10,000/$20,000
Total Out-of-Pocket Max includes deductible and coinsurance) without wellness incentive	$2,250/$4,500	$3,000/$6.000	$10,250/$20,500
Out-of-Network			
Deductible (Out-of-network)	$1,500/$3,000	$2,000/$4,000	$4,000/$8,000
Coinsurance	60%	60%	50%
Coinsurance Out-of-Pocket Max (does not include deductible)	$3,000/$6,000	$4,000/$8,000	$10,000/$20,000
Total Out-of-Pocket Max includes deductible and coinsurance)	$6,600/$13,200	$6,000/$12,000	$14,000/$28,000
Office and Emergency Visits			
OV Copay	$25	$30	$50
Urgent Care Visit	$40	$45	$100
Specialist Visit	$40	$45	$100

ER Copay - Emergency	$100	$150	$300
ER Copay - Non-Emergency	$200	$200	$300
WELLNESS			
Immunizations	100% In-network	100% In-network	100% In-network
Routine Physical	100% In-network	100% In-network	100% In-network
Routine PSA	100% In-network	100% In-network	100% In-network
Endoscopies	100% In-network	100% In-network	100% In-network
Pap Test Exam	100% In-network	100% In-network	100% In-network
PPACA Expanded Wellness Svcs	100% In-network	100% In-network	100% In-network
Prescription Drug Benefit			
Retail Drug Card	$10/$25/$50	$15/$30/$60	Ded. then $10/$50/$100
Mail Order	$20/$50/$100	$30/$60/$120	Ded. then $20/$100/$200
Specialty Medications	$60	$100	Ded. then $200
Step Therapy	YES	YES	YES
Mandatory Mail Order	YES	YES	YES
Maintenance Choice	YES	YES	YES

MEDICAL MUTUAL OF OHIO®
CAROLINA CARE PLAN | CONSUMERS LIFE

Lake Erie Regional Council
EyeMed Access Network

EyeMed VISION CARE.

Services	EyeMed Access Network	Non-Network[1]
Dependent Age Limit	Determined by District	
Professional Services (One every 12 months) Spectacle Exam	$15 copayment Any amount over spectacle exam	$15 maximum
Contact Lens Fit & Follow-Up Standard Premium	(up to $55) 10% off of Retail	Not Covered Not Covered
Frame (One every 12 months)	$0 copayment (Up to $100)+ 20% off amount over $100	$30 maximum
Lenses (Uncoated plastic) One pair every 12 months Single vision Bifocal Trifocal Lenticular	 $15 copayment $15 copayment $15 copayment $15 copayment	 $10 maximum $20 maximum $30 maximum $40 maximum
Contact Lenses (In lieu of lenses) (One pair every 12 months for Conventional or Medically necessary) Conventional	$15 copayment (up to $100) + 15% off of amount over $100	$40 maximum
Disposable	$15 copayment (up to $100)	$40 maximum
Medically necessary	$15 copayment (up to $200)	$75 maximum

Listed below are additional ways to save through the EyeMed Vision program.

Lens Options: Members also received fixed, discount prices on the lens options listed below when an EyeMed provider is used

Lens options	Discounted price	Lens options	Discounted price
Standard Progressive (no-line bifocal)	$65 plus bifocal copay	Standard Anti-reflective coating	$45
Polycarbonate	$40	Solid tint or Gradient tint	$15
Scratch-resistant coating	$15	Photochromic	20% off retail price
Ultraviolet coating	$15	Glass	20% off retail price
Other Add-Ons	20% off retail price		

Contact Lenses by Mail: After initial purchases, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Additional Savings on Eyeglasses and Conventional Contact Lenses: After the funded benefit has been used, members save 40% off retail on complete pairs of eyeglasses and 15% off conventional contact lenses at an unlimited frequency.

Laser Vision Correction: Members also receive a 15% discount off regular price or 5% off the promotion price for LASIK or PRK from the US Laser Network, owned and Operated by LCA Vision.

The discounts listed above are available through the EyeMed Access network of providers only and are subject to change by EyeMed Vision Care.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than 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. Benefit allowances provide no remaining balance for future use within the same benefit frequency. There are certain brand name Vision Materials in which the manufacturer imposes a no-discount practice. Limitations and exclusions apply.

[1] The non-network maximum is the amount a member receives for covered vision services received from a non-network provider.

L8799 SMV [EyeMed] – revised 03/28/12
LERC Eyemed 07/01/13
09/13/13

SEVERANCE PAY
Administrators, Supervisors, Central Office

Upon retirement into STRS or SERS, as applicable), an employee with ten (10) or more continuous years of work experience in the Clearview Local School District shall be paid severance as set forth herein. Employees who elect to retire and meet the requirements of the applicable Retirement System shall be paid for one-fourth (1/4) of his/her accumulated sick leave up to a maximum of seventy-five (75) days [the Superintendent and Treasurer are paid to a maximum of one hundred fifty (150) days]. Payment shall be at the employee's daily rate in effect at the last day of actual employment, exclusive of overtime or supplemental pay.

The employee shall receive his/her severance pay in a lump sum payment in February of the calendar year following the date of retirement. The employee may elect to have his/her severance payment deposited into a 457 Ohio Deferred Compensation Plan and/or a 403b Tax Sheltered Annuity of the employee's choice from the pre-approved list of providers.

Payment of sick leave on this basis shall be considered to eliminate all sick leave credit accrued by the employee. Such payment shall be made only once to any employee.

In the event of an employee's death, his/her spouse or child will receive the severance pay. The deceased employee must have been eligible for retirement/severance benefits, as determined by the Retirement System, at the time of death.

RETIREMENT INCENTIVE – CLASSIFIED CENTRAL SUPPORT PERSONNEL

1. Statement of Retirement Incentive Plan

   The following Retirement Incentive Plan is effective July 1 and expires June 30. Participation in the plan is voluntary.

2. Eligibility for Benefits

   A. The employee:

      1. Shall become eligible between July 1 and June 30, for retirement by virtue of meeting all eligibility requirements under the Ohio School Employees Retirement System (S.E.R.S.).

      2. Must have at least ten (10) or more full and continuous years of service with the Clearview Local School District.

      3. Must submit an application for retirement benefits to the S.E.R.S. during his/her first year of eligibility for receipt of retirement benefits under the statutes and rules governing the S.E.R.S. An employee who does not apply for this buyout in his/her first year of eligibility, shall not be eligible for and will not be granted this buyout at any other time. Although, he/she may do so, any employee who meets the S.E.R.S. requirement of 25/55 or 25/60 (as applicable) is not obligated to retire to collect the retirement incentive at such time. Said employee remains eligible to collect the retirement incentive if he/she retires at the 30-years of service level.

4. Only employees who first become eligible for retirement under the rules and regulations of the S.E.R.S. during the school year may apply for this Retirement Incentive if they retire effective July 1.

B. This Plan does not apply to:

1. Those applying for and/or receiving disability retirement.

2. Those terminated by the Board for cause or whose contracts are otherwise discontinued or suspended involuntarily (e.g., pursuant to a reduction in force).

3. Those whose contracts are non-renewed.

4. Those who do not submit an application for retirement to the S.E.R.S. in his/her (1st) year of eligibility for receipt of retirement benefits under the statute and rules governing the S.E.R.S.

3. Application for Retirement

A. Those employees who seek to participate in the Retirement Incentive shall submit a letter of intent to the Board to retire on or before July 1 of the year they are eligible and intend to retire under the statue and the rules governing the S.E.R.S. Such letter must be submitted to the Board no later than March 1 of the calendar year of retirement.

B. After receipt of the letter to retire from the employee seeking this Retirement Incentive, the Board will verify that the applicant meets all of the requirements of the plan and issue such notice within thirty (30) calendar days of application. Neither the Board nor the employee may withdraw from this action after the Board notifies the employee that he/she has met the requirements for this Retirement Incentive.

4. Payment Schedule

A. The employee's payment under the Retirement Incentive Plan shall be made in one lump-sum payment in the second payroll of February of the calendar year following the date of retirement. Payments made under this plan shall not be incorporated into the calculation of employee salary and/or benefits for purposes of the School Employees Retirement System.

B. Eligible employees whose requests for retirement between the aforementioned dates are approved by the Board shall receive a lump sum payment of 15% of their compensation that was received over the (12) months immediately preceding the effective date of their retirement.

RETIREMENT INCENTIVE – CERTIFICATED/LICENSED ADMINISTRATORS, TREASURER

1. Statement of Retirement Incentive Plan

The following Retirement Incentive is effective August 1 and expires July 31. Participation in the plan is voluntary.

2. Eligibility for Benefits

A. The Certificated/Licensed Employee:

1. Shall become eligible between August 1 and July 31 for retirement by virtue of meeting all eligibility requirements under the Ohio State Teachers Retirement System (STRS) and State Employees Retirement System (SERS).

2. Must have at least ten (10) or more full and continuous years of service with the Clearview Local School District.

3. Must submit an application for retirement benefits to the STRS/SERS during his/her first year of eligibility for receipt of retirement benefits under the statues and rules governing the STRS/SERS. An employee who does not apply for this incentive in his/her first year of eligibility, shall not be eligible for and will not be granted this incentive at any other time. Although he/she may do so, any teacher who meets the STRS/SERS requirement of 26/55 is not obligated to retire to collect the retirement incentive at such time. Said teacher remains eligible to collect the retirement incentive if he/she retires at the 35 years of service level.

4. All Administrators who first become eligible for retirement under the rules and regulations of the STRS/SERS during the school year may apply for this Retirement Incentive if they retire effective August 1.

B. This plan does not apply to:

1. Those applying for and/or receiving disability retirement.

2. Those terminated by the Board for cause or whose contracts are otherwise discontinued or suspended involuntarily (e.g., pursuant to a reduction in force).

3. Those whose contracts are non-renewed.

4. Those who do not submit an application for retirement to the STRS in his/her first (1st) year of eligibility for receipt of retirement benefits under the statute and rules governing the STRS/SERS.

3. Application for Retirement

A. Those employees who seek to participate in the Retirement Incentive shall submit a letter of intent to the Board to retire effective August 1 of the year they are eligible and intend to retire under the statute and the rules governing the STRS. Such letter must be submitted to the Board no later than March 1 of the calendar year of retirement.

B. After receipt of the letter of intent to retire from the certificated/licensed employee seeking this Retirement Incentive, the Board will verify that the applicant meets all of the requirements of the Plan and issue such notice within thirty (30) calendar days of application. Neither the Board nor the certificated/licensed employee may withdraw from this action after the Board notifies the employee that he/she has met the requirements for this Retirement Incentive.

4. Payment Schedule

A. The employee's payment under the Retirement Incentive shall be made in three (3) equal lump-sum payments beginning in February of the calendar year following the date of retirement and the following two Februarys thereafter.

Payments made under this Plan shall not be incorporated into the calculation of employee salary and/or benefits for purposes of the STRS/SERS.

B. Eligible employees whose requests for retirement between the aforementioned dates are approved by the Board shall receive seven hundred ($1000.00) for each year of STRS/SERS service to a maximum of thirty (35) years ($25,000.00).

C. Administrators may elect to have their triennial Retirement Incentive payments deposited into a 457 Ohio Deferred Compensation Plan and/or a 403b Tax Sheltered Annuity of the employee's choice from the pre-approved list of providers.

Clearview Local Schools

ADMINISTRATIVE SALARY SCHEDULE

Certificated Schedule - HS Principals/260-day Directors & Supervisors

09-11-23

		71400					
	BA	MA	MA+10	MA+20	MA+30	MA+40	PhD/EdD
0	67430	**71400**	75370	79333	81910	84980	88593
	0.9444	1.0000	1.0556	1.1111	1.1472	1.1902	1.2408
1	69458	73542	77626	81717	84366	87536	91256
	0.9728	1.0300	1.0872	1.1445	1.1816	1.2260	1.2781
2	71543	75748	79961	84166	86901	90157	93991
	1.0020	1.0609	1.1199	1.1788	1.2171	1.2627	1.3164
3	73685	78019	82353	86694	89507	92863	96811
	1.0320	1.0927	1.1534	1.2142	1.2536	1.3006	1.3559
4	75898	80361	84830	89293	92192	95647	99717
	1.0630	1.1255	1.1881	1.2506	1.2912	1.3396	1.3966
5	78176	82774	87372	91970	94955	98518	102709
	1.0949	1.1593	1.2237	1.2881	1.3299	1.3798	1.4385
6	80518	85259	89993	94726	97811	101474	105786
	1.1277	1.1941	1.2604	1.3267	1.3699	1.4212	1.4816
7	87329	87815	92691	97568	100745	104522	108964
	1.2231	1.2299	1.2982	1.3665	1.4110	1.4639	1.5261
8	85423	90450	95476	100496	103766	107657	112234
	1.1964	1.2668	1.3372	1.4075	1.4533	1.5078	1.5719
9	87986	93163	98339	103516	106879	110884	115597
	1.2323	1.3048	1.3773	1.4498	1.4969	1.5530	1.6190
10	90628	95954	101288	106614	110085	114211	119067
	1.2693	1.3439	1.4186	1.4932	1.5418	1.5996	1.6676

Clearview Local Schools

ADMINISTRATIVE SALARY SCHEDULE

Certificated Schedule – Elementary & Middle School Principals

09-11-23

		64500					
	BA	MA	MA+10	MA+20	MA+30	MA+40	PhD/EdD
0	60914	**64500**	68086	71666	73994	76768	80032
	0.9444	1.0000	1.0556	1.1111	1.1472	1.1902	1.2408
1	62746	66435	70124	73820	76213	79077	82437
	0.9728	1.0300	1.0872	1.1445	1.1816	1.2260	1.2781
2	64629	68428	72234	76033	78503	81444	84908
	1.0020	1.0609	1.1199	1.1788	1.2171	1.2627	1.3164
3	66564	70479	74394	78316	80857	83889	87456
	1.0320	1.0927	1.1534	1.2142	1.2536	1.3006	1.3559
4	68564	72595	76632	80664	83282	86404	90081
	1.0630	1.1255	1.1881	1.2506	1.2912	1.3396	1.3966
5	70621	74775	78929	83082	85779	88997	92783
	1.0949	1.1593	1.2237	1.2881	1.3299	1.3798	1.4385
6	72737	77019	81296	85572	88359	91667	95563
	1.1277	1.1941	1.2604	1.3267	1.3699	1.4212	1.4816
7	78890	79329	83734	88139	91010	94422	98433
	1.2231	1.2299	1.2982	1.3665	1.4110	1.4639	1.5261
8	77168	81709	86249	90784	93738	97253	101388
	1.1964	1.2668	1.3372	1.4075	1.4533	1.5078	1.5719
9	79483	84160	88836	93512	96550	100169	104426
	1.2323	1.3048	1.3773	1.4498	1.4969	1.5530	1.6190
10	81870	86682	91500	96311	99446	103174	107560
	1.2693	1.3439	1.4186	1.4932	1.5418	1.5996	1.6676

Clearview Local Schools

ADMINISTRATIVE SALARY SCHEDULE

Certificated Schedule – Directors & Supervisors

09-11-23

		54632					
	BA	MA	MA+10	MA+20	MA+30	MA+40	PhD/EdD
0	51594	**54632**	57670	60702	62674	65023	67787
	0.9444	1.0000	1.0556	1.1111	1.1472	1.1902	1.2408
1	53146	56271	59396	62526	64553	66979	69825
	0.9728	1.0300	1.0872	1.1445	1.1816	1.2260	1.2781
2	54741	57959	61182	64400	66493	68984	71918
	1.0020	1.0609	1.1199	1.1788	1.2171	1.2627	1.3164
3	56380	59696	63013	66334	68487	71054	74076
	1.0320	1.0927	1.1534	1.2142	1.2536	1.3006	1.3559
4	58074	61488	64908	68323	70541	73185	76299
	1.0630	1.1255	1.1881	1.2506	1.2912	1.3396	1.3966
5	59817	63335	66853	70371	72655	75381	78588
	1.0949	1.1593	1.2237	1.2881	1.3299	1.3798	1.4385
6	61609	65236	68858	72480	74840	77643	80943
	1.1277	1.1941	1.2604	1.3267	1.3699	1.4212	1.4816
7	66820	67192	70923	74655	77086	79976	83374
	1.2231	1.2299	1.2982	1.3665	1.4110	1.4639	1.5261
8	65362	69208	73054	76895	79397	82374	85876
	1.1964	1.2668	1.3372	1.4075	1.4533	1.5078	1.5719
9	67323	71284	75245	79205	81779	84843	88449
	1.2323	1.3048	1.3773	1.4498	1.4969	1.5530	1.6190
10	69344	73420	77501	81577	84232	87389	91104
	1.2693	1.3439	1.4186	1.4932	1.5418	1.5996	1.6676

Clearview Local Schools
ADMINISTRATIVE SALARY SCHEDULE
Classified Schedule – Food Service Supervisor

09-11-23

		44498					
	<BA	BA	MA	MA+10	MA+20	MA+30	PhD/EdD
0	42024	**44498**	46972	49442	51048	52962	55213
	0.9444	1.0000	1.0556	1.1111	1.1472	1.1902	1.2408
1	43288	45833	48378	50928	52579	54555	56873
	0.9728	1.0300	1.0872	1.1445	1.1816	1.2260	1.2781
2	44587	47208	49833	52454	54159	56188	58577
	1.0020	1.0609	1.1199	1.1788	1.2171	1.2627	1.3164
3	45922	48623	51324	54029	55783	57874	60335
	1.0320	1.0927	1.1534	1.2142	1.2536	1.3006	1.3559
4	47301	50082	52868	55649	57456	59610	62146
	1.0630	1.1255	1.1881	1.2506	1.2912	1.3396	1.3966
5	48721	51587	54452	57318	59178	61398	64010
	1.0949	1.1593	1.2237	1.2881	1.3299	1.3798	1.4385
6	50180	53135	56085	59035	60958	63241	65928
	1.1277	1.1941	1.2604	1.3267	1.3699	1.4212	1.4816
7	54426	54728	57767	60807	62787	65141	67908
	1.2231	1.2299	1.2982	1.3665	1.4110	1.4639	1.5261
8	53237	56370	59503	62631	64669	67094	69946
	1.1964	1.2668	1.3372	1.4075	1.4533	1.5078	1.5719
9	54835	58061	61287	64513	66609	69105	72042
	1.2323	1.3048	1.3773	1.4498	1.4969	1.5530	1.6190
10	56481	59801	63125	66444	68607	71179	74205
	1.2693	1.3439	1.4186	1.4932	1.5418	1.5996	1.6676

Clearview Local Schools

ADMINISTRATIVE SALARY SCHEDULE

Classified Schedule - Transportation Supervisor

09-11-23

	Base	**44609** Salary
0	42129	**44609**
	0.9444	1.0000
1	43396	45947
	0.9728	1.0300
2	44698	47326
	1.0020	1.0609
3	46036	48744
	1.0320	1.0927
4	47419	50207
	1.0630	1.1255
5	48842	51715
	1.0949	1.1593
6	50306	53268
	1.1277	1.1941
7	51813	54865
	1.1615	1.2299
8	53370	56511
	1.1964	1.2668
9	54972	58206
	1.2323	1.3048
10	56622	59950
	1.2693	1.3439

Clearview Local Schools

ADMINISTRATIVE SALARY SCHEDULE

Classified Schedule - Maintenance Supervisor

09-11-23

		50306
	Base	Salary
0	47509	**50306**
	0.9444	1.0000
1	48938	51815
	0.9728	1.0300
2	50407	53370
	1.0020	1.0609
3	51916	54969
	1.0320	1.0927
4	53475	56619
	1.0630	1.1255
5	55080	58320
	1.0949	1.1593
6	56730	60070
	1.1277	1.1941
7	58430	61871
	1.1615	1.2299
8	60186	63728
	1.1964	1.2668
9	61992	65639
	1.2323	1.3048
10	63853	67606
	1.2693	1.3439

CENTRAL OFFICE CLASSIFIED EMPLOYEE SALARY SCHEDULE

2023-2024 09-11-23

Step	Administrative Secretarial Assistant	EMIS Coordinator	Financial Analyst Registrar Secretary	Payroll Manager	Assistant to the Treasurer	Superintendent Secretary
0	18.93					
1	19.50					
2	20.08	20.08	20.08			
3	20.84	20.84	20.84			
4	21.65	21.65	21.65	21.65	21.65	21.65
5	22.16	22.16	22.16	22.16	22.16	22.16
6	23.17	23.17	23.17	23.17	23.17	23.17
7	23.96	23.96	23.96	23.96	23.96	23.96
8	24.77	24.77	24.77	24.77	24.77	24.77
9	25.63	25.63	25.63	25.63	25.63	25.63
10	26.54	26.54	26.54	26.54	26.54	26.54
11		27.47	27.47	27.47	27.47	27.47
12				28.45	28.45	28.45
13				29.40	29.40	29.40
14						30.46

CENTRAL OFFICE CLASSIFIED EMPLOYEE SALARY SCHEDULE

2024-2025 09-11-23

Step	Administrative Secretarial Assistant	EMIS Coordinator	Financial Analyst Registrar Secretary	Payroll Manager	Assistant to the Treasurer	Superintendent Secretary
0	19.50					
1	20.08					
2	20.68	20.68	20.68			
3	21.47	21.47	21.47			
4	22.30	22.30	22.30	22.30	22.30	22.30
5	22.83	22.83	22.83	22.83	22.83	22.83
6	23.87	23.87	23.87	23.87	23.87	23.87
7	24.68	24.68	24.68	24.68	24.68	24.68
8	25.51	25.51	25.51	25.51	25.51	25.51
9	26.40	26.40	26.40	26.40	26.40	26.40
10	27.34	27.34	27.34	27.34	27.34	27.34
11		28.30	28.30	28.30	28.30	28.30
12				29.30	29.30	29.30
13				30.29	30.29	30.29
14						31.37

CENTRAL OFFICE CLASSIFIED EMPLOYEE SALARY SCHEDULE

2025-2026 09-11-23

Step	Administrative Secretarial Assistant	EMIS Coordinator	Financial Analyst Registrar Secretary	Payroll Manager	Assistant to the Treasurer	Superintendent Secretary
0	20.09					
1	20.69					
2	21.30	21.30	21.30			
3	22.11	22.11	22.11			
4	22.97	22.97	22.97	22.97	22.97	22.97
5	23.51	23.51	23.51	23.51	23.51	23.51
6	24.58	24.58	24.58	24.58	24.58	24.58
7	25.42	25.42	25.42	25.42	25.42	25.42
8	26.28	26.28	26.28	26.28	26.28	26.28
9	27.19	27.19	27.19	27.19	27.19	27.19
10	28.16	28.16	28.16	28.16	28.16	28.16
11		29.15	29.15	29.15	29.15	29.15
12				30.18	30.18	30.18
13				31.20	31.20	31.20
14						32.31

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
LERC: Premium with Wellness

Coverage Period: 07/01/2023- 06/30/2024
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 800-540-2583. 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 MedMutual.com/SBC or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500/single,$1,000/family Network $1,500/single,$3,000/family Non-Network**	Generally, you must pay all of 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 and all services with copayments are 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. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance Limit:** **$1,500/single,$3,000/family Network** **$3,000/single,$6,000/family Non-Network** **Out-of-pocket Limit:** **$6,600/single,$13,200/family Network** **Unlimited/single,Unlimited/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?	**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 network provider?	Yes. See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's 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.**

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Network Provider (You will pay the least)			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	$25 copay/visit	40% coinsurance	None
	Specialist visit	$40 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your 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)	10% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	10% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic copay – retail Tier 1	$10	Does Not Apply	Not all Prescriptions are covered. To determine if a drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. You are required to use the Mail Order service after 2 retail refills
	Generic copay – home delivery Tier 1	$20	Does Not Apply	
	Preferred brand copay – retail Tier 2	$25	Does Not Apply	
	Preferred brand copay – home delivery Tier 2	$50	Does Not Apply	
	Non-Preferred brand copay – retail Tier 3	$50	Does Not Apply	
	Non-Preferred brand copay – home delivery Tier 3	$100	Does Not Apply	
	Specialty drugs	$60	Does Not Apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	10% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit		None
	Emergency medical transportation	10% coinsurance	40% coinsurance	None
	Urgent care	$40 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	None
	Physician/ surgeon fee (inpatient)	10% coinsurance	40% coinsurance	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		None
If you are pregnant	Office visits	No charge	50% coinsurance	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	10% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	(40 visits per benefit period)
	Rehabilitation services (Physical Therapy)	10% coinsurance	40% coinsurance	None
	Habilitation services (Occupational Therapy)	10% coinsurance	40% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional; combined with Chiropractic and Physical Therapy)I
	Habilitation services (Speech Therapy)	10% coinsurance	40% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional; combined with Chiropractic and Occupational Therapy)U
	Skilled nursing care	10% coinsurance	40% coinsurance	None
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	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 or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more 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 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 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 your plan at 800-540-2583.

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 sample medical situations, see the next section

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

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	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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)*

Total Example Cost	
Specialist visit *(anesthesia)*	**$12,700**

In this example, Peg would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,770**
Deductibles	$500
Copayments	$0
Coinsurance	$1,200

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs

Total Example Cost	
Durable medical equipment *(glucose meter)*	**$5,600**

In this example, Joe would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**
Deductibles	$100
Copayments	$200
Coinsurance	$0

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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**

In this example, Mia would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$810**
Deductibles	$500
Copayments	$200
Coinsurance	$100

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: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL

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 1-800-382-5729 (TTY: 711).

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 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

كلرفلوتةوغلاكعلسملاتلدخنلبسةظلاركتلحتشكلاقظوطم).711 مك يلاو مصلاقاهمقر 1-800-382-5729 مقوربلصتانلجلاي)

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

BHk1MAHk1E: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hÓlǫ ´ , kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

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。1-800-382-5729 (TTY: 711)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 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви мо)Кете звернутися до безкоштовної слу)Кби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENT,IE: Dacă vorbit,i limba română, vă stau la dispozit,ie servicii de asistent,ă lingvistică, gratuit. Sunat,i la 1-800-382-5729 (TTY: 711).

Tagalog

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Nondiscrimination Notice

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If you need these services or if you believe Medical Mutual 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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
LERC: Standard with Wellness

Coverage Period: 07/01/2023- 06/30/2024
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 800-540-2583. 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 MedMutual.com/SBC or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750**/single,**$1,500**/family Network **$2,000**/single,**$4,000**/family Non-Network	Generally, you must pay all of 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 and all services with copayments are 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. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance Limit:** **$2,000**/single,**$4,000**/family Network **$4,000**/single,**$8,000**/family Non-Network **Out-of-pocket Limit:** **$6,600**/single,**$13,200**/family Network **Unlimited**/single,**Unlimited**/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?	**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 network provider?	Yes. See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's 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.**

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$30 copay/visit	40% coinsurance	None
	Specialist visit	$45 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your 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)	20% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic copay – retail Tier 1	$15	Does Not Apply	Not all Prescriptions are covered. To determine if a drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. You are required to use the Mail Order service after 2 retail refills
	Generic copay – home delivery Tier 1	$30	Does Not Apply	
	Preferred brand copay – retail Tier 2	$30	Does Not Apply	
	Preferred brand copay – home delivery Tier 2	$60	Does Not Apply	
	Non-Preferred brand copay – retail Tier 3	$60	Does Not Apply	
	Non-Preferred brand copay – home delivery Tier 3	$120	Does Not Apply	
	Specialty drugs	$100	Does Not Apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit		None
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	$45 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/ surgeon fee (inpatient)	20% coinsurance	40% coinsurance	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		None
If you are pregnant	Office visits	No charge	50% coinsurance	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	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	(40 visits per benefit period)
	Rehabilitation services (Physical Therapy)	20% coinsurance	40% coinsurance	(10 visits then Medical Review - Professional; unlimited - Institutional)combined with Occupational Therapy and Chiropractic)
	Habilitation services (Occupational Therapy)	20% coinsurance	40% coinsurance	(10 visits then Medical Review - Professional; unlimited - Institutional)combined with Physical Therapy and Chiropractic)
	Habilitation services (Speech Therapy)	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	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 or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more 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 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 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 your plan at 800-540-2583.

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 sample medical situations, see the next section* ----------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

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	$750
Specialist copay	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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)*

Total Example Cost	
Specialist visit *(anesthesia)*	$12,700

In this example, Peg would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,820**
Deductibles	$750
Copayments	$0
Coinsurance	$2,000

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copay	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs

Total Example Cost	
Durable medical equipment *(glucose meter)*	$5,600

In this example, Joe would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**
Deductibles	$100
Copayments	$200
Coinsurance	$0

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copay	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

In this example, Mia would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,160**
Deductibles	$750
Copayments	$200
Coinsurance	$200

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: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

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 1-800-382-5729 (TTY: 711).

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 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

711.(ملحوظة: إذا كنت تتحدث بلغة تقدم خدمات المساعدة اللغوية مجانًا. اتصل برقم 1-800-382-5729 (رقم الهاتف النصي: 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНКІМАНКІЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

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Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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- 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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
LERC: ACA with Wellness

Coverage Period: 07/01/2023- 06/30/2024
Coverage for: Single or Family | **Plan Type:** PPO

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,750**/single,**$7,500**/family Network **$4,000**/single,**$8,000**/family Non-Network	Generally, you must pay all of 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 and all services with copayments are 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. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance Limit:** **$2,250**/single,**$4,500**/family Network **$10,000**/single,**$20,000**/family Non-Network **Out-of-pocket Limit:** **$6,600**/single,**$13,200**/family Network **$14,000**/single,**$28,000**/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?	**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 network provider?	Yes. See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's 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.**

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$50 copay/visit	50% coinsurance	None
	Specialist visit	$100 copay/visit	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your 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)	30% coinsurance	50% coinsurance	None
	Diagnostic test (blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic copay – retail Tier 1	$10 after deductible	Does Not Apply	Not all Prescriptions are covered. To determine if a drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. You are required to use the Mail Order service after 2 retail refills
	Generic copay – home delivery Tier 1	$20 after deductible	Does Not Apply	
	Preferred brand copay – retail Tier 2	$50 after deductible	Does Not Apply	
	Preferred brand copay – home delivery Tier 2	$100 after deductible	Does Not Apply	
	Non-Preferred brand copay – retail Tier 3	$100 after deductible	Does Not Apply	
	Non-Preferred brand copay – home delivery Tier 3	$200 after deductible	Does Not Apply	
	Specialty drugs	$200 after deductible	Does Not Apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees (Outpatient)	30% coinsurance	50% coinsurance	None

Common Medical Event Network Provider (You will pay the least)	Services You May Need	What You Will Pay	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$300 copay/visit		None
	Emergency medical transportation	30% coinsurance	50% coinsurance	None
	Urgent care	$100 copay	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	None
	Physician/ surgeon fee (inpatient)	30% coinsurance	50% coinsurance	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		None
If you are pregnant	Office visits	No charge	50% coinsurance	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	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None

Common Medical Event Network Provider (You will pay the least)	Services You May Need	What You Will Pay	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	(40 visits per benefit period)
	Rehabilitation services (Physical Therapy)	30% coinsurance	50% coinsurance	None
	Habilitation services (Occupational Therapy)	30% coinsurance	50% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional; combined with Chiropractic and Physical Therapy)[I
	Habilitation services (Speech Therapy)	30% coinsurance	50% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional; combined with Chiropractic and Physical Therapy)[I
	Skilled nursing care	30% coinsurance	50% coinsurance	None
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	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 or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more 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 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 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 your plan at 800-540-2583.

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 sample medical situations, see the next section* ----------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

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	$3,750
Specialist copay	$100
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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)*

Total Example Cost	
Specialist visit *(anesthesia)*	$12,700

In this example, Peg would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$6,070**
Deductibles	$3,750
Copayments	$0
Coinsurance	$2,250

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,750
Specialist copay	$100
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs

Total Example Cost	
Durable medical equipment *(glucose meter)*	$5,600

In this example, Joe would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,800**
Deductibles	$100
Copayments	$400
Coinsurance	$0

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,750
Specialist copay	$100
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

In this example, Mia would pay:

Cost Sharing	
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,310**
Deductibles	$1,800
Copayments	$500
Coinsurance	$0

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: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

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 1-800-382-5729 (TTY: 711).

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 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

711.(ملكن لاو مصلاقاهمقر 1-800-382-5729 مقرب لصتانلجلاي)

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНкIМАНкIЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hÓlǫ́ ́, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

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。1-800-382-5729 (TTY: 711) 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 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви мо)кете звернутися до безкоштовної слу)Кби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENT,IE: Dacă vorbit,i limba română, vă stau la dispozit,ie servicii de asistent,ă lingvistică, gratuit. Sunat,i la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio 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. Medical Mutual 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.

- Medical Mutual 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.).
- Medical Mutual 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 Medical Mutual 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