Cleveland Clinic

Employee Health Plan –

Summary Plan Description for Martin Health Retirees Under 65

Calendar Year 2025

Your Guide to Quality Healthcare Services and Healthier Living

Welcome to the Cleveland Clinic Residents and Fellows Employee Health Plan, hereafter referred to as the "Health Benefit Program" (HBP). As a Health Benefit Program member, you have access to some of the very best healthcare services in the world. This *Summary Plan Description (SPD)* was developed to help you understand the healthcare services and benefits available to you. It is updated as necessary and is also available on our website at **employeehealthplan.clevelandclinic.org**. *My EHP Health Connection* newsletters are also sent to members informing them of any health plan updates throughout the year.

The *Summary Plan Description* is the health benefit program document. There are no other documents to reference when determining health plan coverage. We encourage you to read it carefully.

Begin with Section One: "Getting Started," and then review the rest of the *SPD* to find helpful information about:

- Medical and behavioral health benefits
- Pharmacy benefit programs
- Network providers
- Medical and behavioral health case management
- Pharmacy Management
- The Third-Party Administrator and coordination of benefits
- The Medicare prescription drug benefit and eligibility
- Administrative and enrollment procedures and
- Customer service.

Refer to the back of this booklet for detailed definitions of the terms used throughout the *SPD*. If you have any questions, refer to the HBP Quick Reference Guide on page 7 in Section One: "Getting Started" for appropriate phone numbers and addresses.

This is your guide to quality healthcare services and healthier living. Quality healthcare is everybody's responsibility. We encourage you to pursue a lifestyle of healthy living. The HBP looks forward to assisting you with your healthcare needs.

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Section One
GETTING STARTED

Cleveland Clinic Health Benefit Program Mission

To manage the Health Benefit Program (HBP) in a manner that is consistently customer-focused, quality-oriented, and fiscally responsible.

This section of the *Summary Plan Description (SPD)* gives a brief overview of your covered health benefits and access to network providers. It also summarizes your responsibilities to the Health Benefit Program.

Review this overview section of the *SPD* to familiarize yourself with the:

- Coordination of Benefits Process
- Two-Tiered Network of Providers
- Medical and Behavioral Health Coverage Summary
- Prescription Drug Benefit Summary

This section also addresses the importance of accurate registration, updating life event changes, claims processing information, and customer service. A Quick Reference Guide is on page 7.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process used to pay healthcare expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare. The HBP is partnered with Aetna, our Third-Party Administrator (TPA), to administer your health plan benefits and provide claims processing for healthcare services.

Aetna – our Third-Party Administrator (TPA) – partners with COB Smart®, and identifies EHP members who have other insurance coverage. Aetna receives weekly files from COB Smart® with those EHP members matching other insurance and will automatically update your record. This means less paperwork for most EHP members. Some smaller insurance companies may not currently participate in COB Smart®. In these instances, you will be asked to complete the COB form. The form is available on our website at **clevelandclinic.org/healthplan** and the instructions for completion are on the form.

Employees have one year to complete the COB process. **After one year, claim payment will become the responsibility of the member.** For more information about Aetna and Coordination of Benefits, see Section Four of the *Summary Plan Description (SPD)*: "Third-Party Administrator (TPA) – Aetna".

Two-Tier Provider Network

The Cleveland Clinic Quality Alliance (QA), including Cleveland Clinic owned and affiliated providers and specialties and the Florida clinically integrated network is the Tier 1 provider network. The Tier 2 provider network consists of providers in the Aetna Select Open Access network. Your EHP Identification (ID) card reflects these relationships. See Section Five: "Administrative Information" for ID card details. As a HBP member, you can use any of the two provider tiers at anytime throughout the year. However, **to receive maximum coverage, you must use Tier 1 providers**. See Section Two: "Tiered Network of Providers" for explanations of both tiers and the benefits of each.

HBP Benefits

The HBP includes medical, behavioral, and prescription drug benefits. This comprehensive healthcare coverage is summarized in the charts on the following pages.

Medical and Behavioral Health Benefit Program

The HBP Benefits Summary chart on pages 3 and 4 summarizes provider coverage for medical and behavioral health services, and includes copay, deductible and out-of-pocket maximum information for each tier. **NOTE:** Copays are the responsibility of the member and are due at the time services are rendered. The Health Benefit Program features include physician office visits, hospital services, diagnostic services and emergency services, to name a few. Behavioral Health features include all services for mental health and substance abuse.

Prescription Drug Benefit Program

The Prescription Drug Benefit Summary chart on page 5 summarizes drug categories, lists prescription drug delivery options, including Cleveland Clinic Pharmacies, and lists annual deductibles and co-insurance amounts.

The HBP Prescription Drug Benefit provides coverage for FDA-approved prescription drugs that are included in the *Cleveland Clinic HBP Prescription Drug Formulary*. Medications are listed in the *Formulary* by both their brand and generic names.

Prescription drugs in the *Formulary* are categorized by Tier 1, Tier 2 and Tier 4 of the Prescription Drug Benefit (Tier 3 are Non-Preferred Brands.) Following is a description of each:

Preferred Generic Medications Non-Specialty; (Tier 1) – The HBP supports and encourages the use of FDA-approved generic equivalents that are as effective and safe as brand name products. Using generic medications delivers the same quality treatment as brand name medications and is cost effective.

Preferred Brands Non-Specialty; (Tier 2) – FDA-approved brand name medications of proven therapeutic effectiveness and safety considered essential for patient care and approved for inclusion in the *Formulary*.

Non-Preferred/Non-Formulary Brand and Generic Medications (Tier 3) – These are FDA-approved brand name medications that are considered non-formulary and are therefore not included in the *Formulary*. Higher co-payments are charged for Non-Preferred Brand and Generic Medication.

Specialty Brand/Generic Drugs (Tier 4) – These medications are only available through the Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Pharmacies or the CVS Specialty Pharmacy. ***Please note***: The member may have higher out-of-pocket expenses if they choose to obtain their specialty medications from CVS Caremark™.

In addition to reviewing the Benefits and Prescription Drug Benefit Summary charts, read Section Three: "Health Benefit Program Coverage" in its entirety so that you have a thorough understanding of your medical, behavioral health, and prescription drug benefits. More detailed information is addressed on HBP services, precertification guidelines, pharmacy programs, and options for filling your prescription medications.

HBP Benefits Summary

Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance and Florida Clinically Integrated Networks	*TIER 2* Aetna Select Open Access Network
Annual Deductible Single Family **Out-of-Pocket Maximum** Single Family	 None None $3.950 $7,900	 $500 $1,500 $4,750 $9,500
Medical Benefit Program Features		
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)	100% of Allowed Amount	$25 copay, then 70% of Allowed Amount (after deductible)
PCP Virtual Visits	100% of Allowed Amount	$25 copay, then 70% of Allowed Amount (after deductible)
Specialist Office Visits	100% of Allowed Amount after $35 copay (no referral required)	$50 copay, then 70% of Allowed Amount (after deductible)
Specialist Virtual Visits	100% of Allowed Amount after $35 copay	$50 copay, then 70% of Allowed Amount (after deductible)
Maternity Care	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Routine (Annual) Physical Exam by Primary Care Physician **Routine (Annual) Eye Exam**	100% of Allowed Amount 100% of Allowed Amount after $35 copay	Not Covered Not Covered
Inpatient Hospital Services[1]	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admissions, then 70% of Allowed Amount (after deductible)
Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent)[1] **Outpatient Surgery/Procedures:** Ambulatory surgery centers, hospital and outpatient hospital locations	100% of Allowed Amount 100% of Allowed Amount $75 copay, then 100% of Allowed Amount $75 copay, then 100% of Allowed Amount	70% of Allowed Amount (after deductible) 70% of Allowed Amount (after deductible) $75 copay, then 70% of Allowed Amount (after deductible) $75 copay, then 70% of Allowed Amount (after deductible)
Laboratory/Diagnostic Tests	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Emergency Department Emergency Services Urgent Care	 100% after $250 copay 100% after $50 copay	 100% after $250 copay 100% after $50 copay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	80% of Allowed Amount (after deductible)
Skilled Nursing Care[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Acute Inpatient Rehab[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Long-Term Acute Care[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Hospice Symptom Management Respite Care	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount
Home Health Care[1] 60 Visits per Benefit Year	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Acupuncture Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after $35 copay	$35 copay, then 70% of Allowed Amount (after deductible)
Chiropractic Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after $35 copay	Not Covered

1. Precertification required.

HBP Benefits Summary (continued)

Medical Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance and Florida Clinically Integrated Networks	*TIER 2* Aetna Select Open Access Network
Therapy Services (Rehabilitative) Occupational/Speech/Physical	100% of Allowed Amount after a $10 copay. 30 Visits per Therapy per Calendar Year	Not Covered
Therapy Services (Habilitative) Physical/Occupational/Speech Apraxia, Autism, Autism Spectrum Disorder, Cerebral Palsy, Developmental Delay and Spina Bifida	100% of Allowed Amount (No visit limitation)	Not Covered
Family Planning (See Coverage Clarifications) Voluntary Abortion	100% of Allowed Amount 100% of Allowed Amount	Not Covered 100% of Allowed Amount
Infertility Treatment[1]	100% of Allowed Amount Lifetime Maximum (LTM): ($15,000 Medical, $6,000 Pharmacy)	Not Covered
Hearing Aids[4]	50% of Charge up to $3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant[1] Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
Behavioral Health Benefit Program Features		
Outpatient Coverage Outpatient (OP Visits)[2]	100% of Allowed Amount	100% of Allowed Amount (after deductible)
Office Visits	$35 copay, then 100% of Allowed Amount	$50 copay, then 70% of Allowed Amount (after deductible)
Psychological and Neuro-Psychological Testing[3]	100% of Allowed Amount	Not Covered
Outpatient Telemedicine/Virtual Consultation	100% of Allowed Amount after $35 copay	$50 copay, then 70% of Allowed Amount (after deductible)
Inpatient Coverage[1]	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Intensive Outpatient (OP)[1]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Residential Treatment[1]	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[1]	100% of Allowed Amount	Not Covered

Copayments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of copayments for bariatric surgery and the Autism School.

1. Precertification required.

2. The Outpatient coverage for the Behavioral Health Benefit Program includes any outpatient services provided by a behavioral health practitioner for chronic pain management, sleep disorder, aftercare groups for substance abuse, and/or pre and post gastric surgery visits. There is no coverage for school meetings by outpatient behavioral health practitioners.

3. Psychological and Neuro Psychological Testing: Up to eight hours testing are automatically covered without precertification. Neuro-Psychological Testing: Testing is covered in Tier 1 only, by trained Behavioral Health Specialists.

4. Hearing aids are only covered when provided by a Cleveland Clinic provider. There is no coverage for any other provider.

Note: Prior authorization, precertification and prior approval are often used interchangeably.

Any *unauthorized* programs, services or visits will not be covered by the HBP under any circumstances and the subsequent charges will be the financial responsibility of the member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency services.

HBP Prescription Drug Benefit

Administered Through CVS Caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2025

Categories	*TIER 1* Preferred Generics (Non-Specialty)	*TIER 2* Preferred Brands (Non-Specialty)	*TIER 3* Non-Preferred Brands and Generics (Non-Formulary)	*TIER 4* Specialty Brand and Drugs (Hi-Tech)	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
Annual Deductible	$200 Individual $400 Family	*(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)*			No	No
Member % Co-insurance Cleveland Clinic Pharmacies: up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Covered by Rx Plan – Use Discount Card
Member % Co-insurance CVS Store Pharmacies: 30-Day Supply **Mail Service Program:** 90-Day Supply	20%	30%	50%	20%	Member Pays 100% of the Discounted Price	Not Covered by Rx Plan – Use Discount Card
Cleveland Clinic Pharmacies including Specialty & Home Delivery: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $3 Minimum/ $50 Maximum per Month Supply	Yes $3 Minimum/ $50 Maximum per Month Supply	No	Yes No Minimum/ $50 Maximum per Month Supply	No	No
Retail Pharmacies: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $5 Minimum/ $50 Maximum per Month Supply	Yes $5 Minimum/ $50 Maximum per Month Supply	No	N/A	No	No
CVS Caremark Mail Service Program: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $15 Minimum/ $150 Maximum 90-Day Supply	Yes $15 Minimum/ $150 Maximum 90-Day Supply	No	Yes No Minimum/ $100 Maximum per Month Supply	No	No
Is there an Annual Out-of-pocket Maximum?	**After Deductible Has Been Met:** $3,950 Individual / $7,900 Family Combined Maximums for Retail, Specialty and Home Delivery				No	No
Components of Each Category			**Brand Name Drugs** See the ***EHP Prescription Drug Formulary***	**Specialty Drugs**[5, 6] See complete list of Specialty Drugs, PrudentRx Solution Specialty Medication, and Medications in the EHP Copay Card Assistance Program in the ***EHP Prescription Drug Formulary***	**Discounted Drugs** See the ***EHP Prescription Drug Formulary***	**Non-Covered and Over-the-Counter Drugs** See the ***EHP Prescription Drug Formulary***
Prior Authorization Required	See the ***EHP Prescription Drug Formulary*** for list of pharmaceuticals requiring prior authorization				No	N/A
Diabetic Supplies[7] **Asthma Delivery Devices**[7] **and Prescription Vitamins**[8]	Co-insurance 20%			No	No	N/A
Pharmacies[9] **in the Retail Network**	CVS store pharmacies (including CVS pharmacies located in Target stores. CVS MinuteClinics are not included.					

Note: Benefit Program includes generic oral contraceptives.

5. Certain specialty medications are included in the Copay Card Assistance Program. Please refer to the *Prescription Drug Formulary Handbook*.

6. There are 3 options for obtaining medications in the category listed above. The options are: *1. Cleveland Clinic Pharmacies, 2. Cleveland Clinic Specialty Pharmacy, and 3. CVS Caremark Specialty Drug Program.* ***Specialty Drug prescription orders (first fill and refills) are limited to a one month supply.***

7. Diabetic Supplies – All diabetic supplies covered, except for most insulin pumps and insulin pump supplies (with the exception of Omnipod Dash, Omnipod 5 G6), continuous glucose monitors (with the exception of FreeStyle Libre products), and continuous glucose monitor supplies (which are covered under the medical benefit). Diabetic supplies covered under the prescription drug benefit include: needles purchased separately, test strips, lancets, glucose meters, syringes, lancing devices, injection pens, FreeStyle Libre products, and Omnipod Dash. Members with type 1 diabetes who are under 18 years of age will have no out-of-pocket expense for their insulins and diabetic supplies covered under the prescription drug benefit. Asthma Delivery Devices – Includes spacers used with asthma inhalers.

8. Refers to vitamins that require a prescription from your healthcare provider.

9. Members can use any Cleveland Clinic pharmacy or any CVS store pharmacy for obtaining acute care medications (e.g. single course of antibiotic therapy) and for the first fill of maintenance medications but must use a Cleveland Clinic Pharmacy or CVS Caremark Mail Service Program for all maintenance medications.

Accurate Registrations

Accurate registration ensures timely claim reimbursement. Make sure that registration information is correct for each family member every time you or any of your dependents receive healthcare services. Make sure the correct ID card is being used, the address information is up-to-date, and the date of birth information is accurate (see Section Five: "Administrative Information").

Claims Information

The HBP allows you, in most instances, to receive care without sending any claims or paperwork to the Third-Party Administrator (TPA). After you receive care, you will receive an Explanation of Benefits (EOB) from the TPA. See Section Four: "Third-Party Administrator – Aetna" for details. Additional information about claim types and benefit determination for claims can be found in Section Six: "HBP Members' Rights and Responsibilities".

Communication and Service

The Cleveland Clinic Health Benefit Program (HBP) continually updates members about new initiatives or changes regarding their health plan coverage. It is our goal to do this through the *My EHP Health Connection* newsletter, and through our website.

EHP Customer Service Unit

EHP Customer Service is open Monday through Friday from 8 a.m. to 4:30 p.m. A trained representative is available to answer health plan questions regarding the Healthy Choice Program and benefits such as medical, behavioral health/substance abuse, and prescription drug coverage. They can also assist you with billing and/or claims issues.

You can contact us by:

Phone: 216.986.1050, Option 1 or toll-free 888.246.6648, Option 1

Fax: 216.448.2053

Email: **cehpao@ccf.org**

Mailing address:

Cleveland Clinic Health Benefit Program
EHP Customer Service
25900 Science Park Drive / AC242
Beachwood, OH 44122

EHP Medical Management

Find out about health plan programs designed to assist members with complex medical and behavioral health needs, self-management care needs for those with chronic illnesses, health promotion programs and rare condition case management. See Section Three: "Health Benefit Program Coverage."

Life Event Changes

Certain changes that affect you and/or your dependents – such as a marriage, birth, divorce, spousal loss of coverage, or qualifying for Medicare – **and may result in the need to make changes to your benefit elections** (see Section Five: "Administrative Information").

HBP Quick Reference Guide

<table>
<tr><th colspan="3">CLEVELAND CLINIC EMPLOYEE HEALTH PLAN
Phone: 216.986.1050 Toll-free: 888.246.6648
TTY: 711</th></tr>
<tr><th>Employee Health Plan
(see options below)</th><th>Medical Management
Option 2</th><th rowspan="2">Pharmacy Management
Option 4</th></tr>
<tr><td>• Benefit Determination (Opt 1)
• Billing (Opt 1)
• EHP Wellness/Healthy Choice (Opt 3)
• Eligibility Verification (Opt 1)
• Referral/Claims Issues (Opt 1)
EHP Wellness fax: 216.448.2055
Eligibility fax: 216.448.2054
General fax: 216.448.2053
Email address: cehpao@ccf.org
Web address (Internet):
employeehealthplan.clevelandclinic.org
or via the intranet by clicking on the “Employee Health Plan” link.</td><td>• Case Management
• Coordinated Care Programs
• Precertification for Notification and Medical Necessity
Coordinated Care fax: 216.442.5795
Medical Management fax: 216.442.5791
Emergency Room Transfer Line: 866.721.9803</td></tr>
<tr><td colspan="2">AETNA (Cleveland Clinic HBP TPA)
Option 5</td></tr>
<tr><td colspan="2">• Mailing address: P.O. Box 981106, El Paso, TX 79998-1106
• Phone number (toll-free): 833.414.2331
• Web address: aetna.com</td><td rowspan="3">• Formulary Drug Review
• Pharmacy Management Programs
Pharmacy fax: 216.442.5790
• Cleveland Clinic Home Delivery Pharmacy
Phone: 216.448.4200 or toll-free: 888.276.0885
Fax: 216.448.5603
• Cleveland Clinic Home Infusion Pharmacy (injectables only)
Phone: 216.444.HOME (4663) or toll-free: 800.263.0403
• Cleveland Clinic Pharmacy Information Hotline
Phone: 216.445.MEDS (6337) or toll-free: 866.650.MEDS (6337)
Web address:
clevelandclinic.org/pharmacy
• Cleveland Clinic Specialty Pharmacy
Phone: 216.448.7732 or toll-free: 844.216.7732
Fax: 216.448.5601
• CVS Caremark
Phone: 866.804.5876
Email address:
customerservice@caremark.com
Web address: caremark.com</td></tr>
<tr><th colspan="2">CLEVELAND CLINIC
CAREGIVER OFFICE SERVICE CENTER</th></tr>
<tr><td>Phone: 216.448.2247
Toll-free: 877.688.2247
Fax: 216.448.0645</td><td>Option 1: Benefits, Retirement, Life Events, Talent Acquisition
Option 2: Kronos
Option 3: Leave of Absence, PTO, FMLA
Option 4: Payroll
Option 5: Workday Password Reset
Option 6: Employment Verification</td></tr>
</table>

For MEDICARE information: toll-free at 800.Medicare (800.633.4227)

Section Two
TIERED NETWORK OF PROVIDERS

Two-Tier Network

The Cleveland Clinic Health Benefit Program (HBP) offers two different networks to choose from. As a HBP member, you can use any tier throughout the benefit year and may receive care from providers in either tier if you choose. **The tier you select**, however, determines the amount of coverage you will receive. To receive the maximum coverage, you must use Tier 1 providers.

Tier 1

Tier 1 providers include the Cleveland Clinic Quality Alliance (QA) network and the Florida clinically integrated network. These networks include Cleveland Clinic facilities and employed physicians as well as contracted facilities and providers in Florida and Ohio. See page 11 for detailed information on supplemented providers in the Florida region. The Tier 1 Network of Providers includes Primary Care Providers (PCP), Specialist Providers (SP), Behavioral Health Providers, and Ancillary Services Providers. (i.e., those providing services related to dialysis, ambulances, transportation, durable medical equipment (DME), home health, skilled nursing facilities, Hospice and others).

If you receive services from a Tier 1 PCP, you are covered at 100%. Physician practices considered primary care include Family Practice, Internal Medicine, Gynecology, Obstetrics, and Pediatrics. All other physician specialists are reimbursed at 100% after a $35 co-payment per visit. You do not require a referral to see a specialist.

Note: Some PCPs are classified as "Specialists" because they specialize in a specific area and, for the most part, only see patients with medical conditions in their area of specialty. For example, an Oncology Gynecologist may only see cancer patients. In these instances, a co-payment of $35 is applied.

In addition to Specialty Care, co-payments are also required for other services such as annual eye examinations, therapy services (Occupational (OT)/Physical (PT)/Speech (ST)), chiropractic services, maternity services, outpatient MRI/CT scans, pre-admission testing and emergency/urgent care. Durable medical equipment (DME) and medical supplies, such as insulin pumps/pump supplies, are covered at 80%. **Note:** Pediatric Type 1 Diabetes supplies are covered at 100% for members age 0 through 17.

You have a maximum out-of-pocket (OOP) expense per year. For those who elect Employee Only coverage, the maximum is $3,950 per year; Family I and Family II coverage (including + One Child and + Spouse) is $7,900 per year. In Tier 1, all co-payments and co-insurance accrue to your annual OOP maximum with the exception of bariatric surgery and Autism School. The Prescription Drug Benefit has its own OOP maximums so co-insurances for these services do ***not*** accrue to your HBP medical OOP maximum. See Prescription Drug Benefit chart on page 5.

It is important to understand that not all physicians on the Cleveland Clinic and Regional hospital medical staff are in the Tier 1 network. **It is the member's responsibility to verify and obtain the most current Tier participation each time services are obtained.** The most current Tier 1 provider information can be found on the Internet at the Aetna.com website. **Note:** You must register on the Aetna website using your plan ID to access your plan-specific network of providers.

The HBP does not print a hardcopy Provider Directory. If you do not have access to a website you can either call the Aetna Concierge at 833.414.2331 or the Health Benefit Program Customer Service Unit at 216.986.1050 or toll-free 888.246.6648, Option 1 to request a listing of doctors in your geographic area by physician specialty. The Health Benefit Program Customer Service Unit can assist with problem resolution related to claims for healthcare services when services have been obtained from a Tier 1 provider.

To estimate costs associated with a particular Covered Charge and/or provider, visit the Aetna Transparency in Coverage Price Transparency Tool, available through your online Aetna Health Account.

To estimate costs associated with a particular Covered Charge and/or provider, visit the Aetna Transparency in Coverage Price Transparency Tool, available through your online Aetna Health Account.

Cleveland Clinic Hospitals in the Tier 1 Network

Akron Childrens
214 West Bowery Street
Akron, OH 44308 .....330.543.1000 ..... **www.akronchildrens.org**

Akron General Medical Center
Akron General Avenue
Akron, OH 44307 .....330.344.6000 ..... **www.akrongeneral.org**

Lodi Community Hospital
225 Elyria Street
Lodi, OH 44254..... 330.948.1222 ..... **www.lodihospital.org**

Edwin Shaw Rehabilitation Institute
1345 Corporate Drive
Hudson, OH 44236.....330.650.9610 ..... **www.akrongeneral.org**
(refer to above website for locations)

Ashtabula County Medical Center
2420 Lake Avenue
Ashtabula, OH 44004..... 440.997.2262 ..... **www.acmchealth.org**

Glenbeigh Hospital of Rock Creek
2863 State Route 45
Rock Creek, OH 44084.....440.563.3400 ..... **www.glenbeigh.com/rock-creek**

Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44195 .....216.444.2200 ..... **www.ccf.org**

Cleveland Clinic Children's
9500 Euclid Avenue
Cleveland, OH 44195 .....216.444.KIDS (5437).. **www.clevelandclinic.org/childrens**

Cleveland Clinic Children's Hospital for Rehabilitation
2801 Martin Luther King, Jr. Drive
Cleveland, OH 44104 .....216.636.KIDS (5437).. **www.clevelandclinic.org/childrensrehab**

Cleveland Clinic Avon Hospital
33300 Cleveland Clinic Boulevard
Avon, OH 44011 .....440.695.5000 ..... **http://my.clevelandclinic.org/locations/avon-hospital**

Euclid Hospital
18901 Lakeshore Boulevard
Euclid, OH 44119 .....216.531.9000 ..... **www.euclidhospital.org**

Fairview Hospital
18101 Lorain Avenue
Cleveland, OH 44111 .....216.476.7000 ..... **www.fairviewhospital.org**

Cleveland Clinic Hospitals in the Tier 1 Network (continued)

Hillcrest Hospital
6780 Mayfield Road
Mayfield Heights, OH 44124 .....440.312.4500 ..... **www.hillcresthospital.org**

Lutheran Hospital
1730 W. 25th Street
Cleveland, OH 44113 .....216.696.4300 ..... **www.lutheranhospital.org**

Marymount Hospital
12300 McCracken Road
Garfield Heights, OH 44125 .....216.581.0500 ..... **www.marymount.org**

Medina Hospital
1000 East Washington Street (Route 18)
Medina, OH 44256 .....330.725.1000 ..... **www.medinahospital.org**

Mercy Hospital
1320 Mercy Drive NW
Canton, OH 44708 .....330.489.1000 ..... **www.cantonmercy.org**

South Pointe Hospital
20000 Harvard Road
Warrensville Heights, OH 44122 .....216.491.6000 ..... **www.southpointehospital.org**

Union Hospital
659 Boulevard Street
Dover, OH 44622 .....330.343.3311 ..... **www.unionhospital.org**

CLEVELAND CLINIC FLORIDA

Weston Hospital
3100 Weston Road
Weston, FL 33331.....954.689.5000 ..... **my.clevelandclinic.org/florida**

Martin North Hospital
200 SE Hospital Avenue
Stuart, FL 34974.....772.287.5200 ..... **my.clevelandclinic.org/florida**

Martin South Hospital
2100 SE Salerno Road
Stuart FL 34997.....772.223.2300 ..... **my.clevelandclinic.org/florida**

Indian River
1000 36th Street
Vero Beach, FL 32960 .....772.567.4311 ..... **my.clevelandclinic.org/florida**

Tradition Hospital
10000 SW Innovation Way
Port Saint Lucie, FL 34987.....772.345.8100 ..... **my.clevelandclinic.org/florida**

CLEVELAND CLINIC NEVADA

888 West Bonneville Avenue
Las Vegas, NV 89106 .....702.483.6000 ..... **www.ccf.org/nevada**

Cleveland Clinic Family Health Centers and Ambulatory Facilities can be found by visiting **my.clevelandclinic.org/locations**

Florida Region Network Additions

Tier 1 is supplemented with Aetna providers in the following specialties within the seven counties surrounding our Florida hospitals: **Acupuncture, Allergy, Behavioral Health, Chiropractic, Dermatology, Endocrinology, Nutritionist, OB-GYN/Obstetrics, Ophthalmology, Otolaryngology (ENT), Oral Surgery, Pain Management, Pediatrics** and **Podiatry**. The seven counties include Brevard, Indian River, St. Lucie, Martin, Palm Beach, Broward and Miami-Dade. We have also supplemented additional non-Cleveland Clinic hospitals in support of the admitting privileges of the above provider specialties. They are:

Baptist Hospital, Boca Raton Regional Hospital, Broward Health Medical Center, HCA Florida Hospitals (Bayonet Point, Blake, Lawnwood Medical Center, Oakhill and St. Lucie), Holmes Regional Medical Center Aging Services, Holmes Regional Medical Center OP Pain Infusion and Wound, Holmes Regional Medical Center, Jupiter Medical Center, Memorial Hospital, Memorial Regional Hospital, Palm Bay Community Hospital, St. Mary's Medical Center, University of Miami Hospital and Clinics, West Boca Medical Center

For the specialty of **Behavioral Health**, the EHP network has been supplemented with contracted providers in the Aetna Select Open Access network in both Florida and Ohio.

You can search providers the Residents and Fellows provider directory which can be accessed via our website at **employeehealthplan.clevelandclinic.org** or log in to your Aetna Health account.

Tier 2

The following network is the Tier 2 network:

- Aetna Select Open Access network

Tier 2 providers can be accessed by visiting **MyAetnaWebsite.com**.

The Tier 2 benefits have an annual deductible of $500 for single coverage and $1,500 for family coverage. After the deductible is met, most inpatient, outpatient services and laboratory/diagnostic services will reimburse at 70% after any applicable co-payment. Some services will reimburse at 100% after the deductible is met.

Note: Emergent/urgent care is covered at 100% after the applicable co-payment. Other specifics regarding Tier 2 coverage can be found in the HBP Summary chart on pages 3 and 4.) **Routine health examinations, routine screening tests, and certain other medical services are *not* covered in Tier 2**. See the Benefits Coverage Clarification section on page 18.

Tier 2 benefits include treatment for non-routine services such as treatment and/or follow-up for sprains, diabetes, hypertension, or any chronic condition, rehab therapies, colds, wounds, follow-up treatment for emergent/urgent care services (usually used for students outside the Tier 1 network) or if a member is on vacation and requires care. Urgent visits to the infirmary for college students are treated as such and a co-pay will apply. These types of visits are usually denied because they are not generally contracted with Aetna. Contact EHP Customer Services for resolution.

Note: The University Hospital System, University Hospital Case Medical Center, Summa Health System, Aultman Hospital System and their affiliates are not considered in the EHP or Aetna networks.

The EHP Customer Service Unit has limited ability to assist with non-Tier 1 provider problem resolution.

Note: The HBP has administrative contracts with the Tier 2 provider network. There are no individual contracts with the providers (physicians and hospitals) in this network. Because the network holds the individual provider contracts, members must contact the network that provided services directly to resolve discrepancies with claim payment issues. The HBP cannot resolve Tier 2 claim payment issues or quote the dollar amount of your financial obligation.

There are services that are covered benefits ONLY when provided within the Tier 1 Network of Providers and all HBP guidelines have been met. Note that there is no Tier 2 coverage for these services. (See Benefits Coverage Clarification on page 18.)

Section Three

HEALTH BENEFIT PROGRAM COVERAGE

Cleveland Clinic Health Benefit Program Benefits

The Health Benefit Program (HBP) is committed to providing comprehensive healthcare coverage for all members. This is accomplished by ensuring that quality-oriented, culturally sensitive healthcare services are provided at the appropriate level in the proper setting, in a timely manner. Reimbursement for all medical, behavioral health, and pharmacy services is based on medical necessity.

The EHP Medical Management and Pharmacy Departments utilize scientific evidence-based criteria to authorize covered services for the population accessing services. The EHP Medical Management and Pharmacy Departments oversee:

- Precertification for Medical Necessity and Notification
- Case Management – EHP Medical Management Department
- Pharmacy Precertification – EHP Pharmacy Management Department
- Pharmacy Utilization Management Programs – EHP Pharmacy Management Department

Although you may choose to use a provider from either the Tier 1 or Tier 2 provider networks (as explained in Section Two), we encourage you to develop a relationship with a Primary Care Provider (PCP). Physician practices considered primary care include most Family Practice, Internal Medicine, Gynecology, Obstetrics, and Pediatrics. This will provide you with the advantage of having a physician knowledgeable about your healthcare and can provide:

- Preventive healthcare
- Care if you become ill
- Advice regarding the need to see a specialist

Because a single physician coordinates your care, you can feel assured that you are receiving the best possible healthcare available within the HBP Network of Providers.

See Section One: “Getting Started” for an overview of your medical, behavioral health, and pharmacy coverage. The HBP Benefits Summary chart on pages 3 and 4 summarizes Tier 1 and Tier 2 provider coverage for medical and behavioral health services, as well as deductible and out-of-pocket maximum information. The Health Benefit Program features include physician office visits, hospital services, diagnostic services and emergency services. Behavioral Health includes all services for mental health and substance abuse.

The Prescription Drug Benefit Summary chart on page 5 summarizes drug categories, such as generic and formulary; lists prescription drugs, including Cleveland Clinic Pharmacies, CVS Caremark Retail, and home delivery programs (detailed in this section), and lists annual deductibles and co-insurances.

Read this section of the *Summary Plan Description (SPD)* in its entirety so that you have a thorough understanding of your medical, behavioral health, and prescription drug benefits. HBP services, Medical Management programs, precertification/ medical necessity guidelines and options for filling your prescription medications are explained in detail.

This section of the *SPD* addresses:

Note that all covered services must be medically necessary and are subject to coverage exclusions. **The HBP has the right to review all claim reimbursements retrospectively and adjust payment according to the HBP guidelines. This means the member may be financially accountable for services after they have been rendered.** If you want the maximum benefit reimbursement, you should contact EHP Medical Management and/or Pharmacy Departments prior to obtaining medical, behavioral health, and pharmacy services.

CMS Medicare Guidelines on Ordering Tests for Family Members

The Employee Health Plan follows Medicare guidelines when providing services or ordering tests for family members or themselves. Medicare expressly bars payment for any and all services rendered by physicians to themselves, immediate relatives, partners or members of the household.

The rule defines "immediate relatives" broadly to include husband and wife; natural or adoptive parent, child and sibling; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild; and spouse of grandparent and grandchild.

EHP Medical Management

The following pages detail your health benefits coverage. Aetna is the Third-Party Administrator (TPA) that will reimburse medical and behavioral health claims (See Section Four: "Third-Party Administrator – Aetna"). If you are not certain that a claim was paid/reimbursed correctly, you should contact Aetna for review. If you still disagree, contact EHP Customer Service at 216.986.1050 or toll-free 888.246.6648.

Medical Management includes four elements:

1. **Utilization Management** to establish precertification and determine medical necessity of requested services.
2. **Case Management** for assistance with complex medical and behavioral health needs.

UTILIZATION MANAGEMENT

In order to ensure that provided services are medically necessary, the Medical Management and Pharmacy Departments have established criteria for members to follow so that care is reimbursed correctly and efficiently. These rules and processes are addressed below and in the "Precertification and Concurrent Review for Medical Necessity" section that follows below.

A service is ***NOT*** considered medically necessary if it is:

1. Not ordered by a licensed or accredited physician, hospital, or healthcare provider or other healthcare facility.
2. Not recognized throughout the medical profession as safe and effective, not required for the diagnosis and treatment of a particular illness (physical or behavioral) or injury and is not employed appropriately in a manner consistent with generally accepted United States medical standards.
3. Provided for vocational training.
4. An Educational Service, including those listed below, are not considered medically necessary unless required ***because of*** a ***new*** medical or behavioral condition or a ***change from baseline*** in a previous condition. Educational services that can be received within a school system are ***NOT*** considered medically necessary. Examples of services that are not covered include:

- Training in the activities of daily living; and
- Instruction in scholastic skills such as reading and writing; and
- Preparation for an occupation, or treatment of learning disabilities for academic underachievement.

5. Determined to be – (E/I) which are drugs, devices, medical treatment, or medical procedures that are not considered to be a standard of practice in this healthcare market for a particular diagnosis. These may be under study and not yet recognized throughout the physician's profession in the United States as safe or effective for diagnosis and/or treatment of the illness or injury. This includes, but is not limited to: clinical trials, all treatment protocols based upon or similar to those used in clinical trials, and drugs approved by the Federal Food and Drug Administration that are being used for unrecognized indications. E/I services may be considered excluded or ineligible for precertification. Contact the Aetna concierge, Medical or Pharmacy Management team for more information.

   (E/I) which are drugs, devices, medical treatment, or medical procedures that are not considered to be a standard of practice in this healthcare market for a particular diagnosis. These may be under study and not yet recognized throughout the physician's profession in the United States as safe or effective for diagnosis and/or treatment of the illness or injury. This includes, but is not limited to: clinical trials, all treatment protocols based upon or similar to those used in clinical trials, and drugs approved by the Federal Food and Drug Administration that are being used for unrecognized indications. E/I services may be considered excluded or ineligible for precertification. Contact the Aetna concierge, Medical or Pharmacy Management team for more information.

6. Cosmetic in nature. Services that are obtained related to dermatology or plastic surgery visits may require prior approval and/or may be considered cosmetic in nature and are not a covered benefit. Contact Medical Management for more information.

PRECERTIFICATION AND CONCURRENT REVIEW FOR MEDICAL NECESSITY

The EHP Medical Management and Pharmacy Departments have precertification and clinical review processes to help ensure quality and cost-effective medical care for HBP members. Please note, Emergency Services do not require precertification.

Precertification

Medical necessity approval is required before certain procedures will be covered. **Prior authorization, precertification and prior approval are often used interchangeably.** This *Summary Plan Description (SPD)* uses precertification. Many of our network providers have detailed information about the process to ensure medical necessity and will coordinate with the EHP Medical Management and/or Pharmacy Department to ensure that required precertification guidelines are met. Also, a complete list of medications that require precertification can be found in the *Prescription Drug Benefit Formulary* found on our website at **employeehealthplan.clevelandclinic.org**

For medications billed under the medical benefit without a drug-specific code (i.e. miscellaneous billing codes), these medications will require precertification review by the EHP Pharmacy Management team, if EHP has a precertification policy in place for the specific medication being billed/requested. If the EHP does not have a precertification policy in place, then these medications will follow the Aetna predetermination/clinical claim review process outlined in the predetermination section of this SPD.

Predetermination

A review for coverage of a service or procedure that does not require precertification. This process is completed through Aetna.

Member Responsibility for Precertification

As soon as a member learns from a physician that the services listed below are being recommended, he or she ***MUST*** call Medical Management:

- Bariatric Surgery – see details on page 20.

It is to the member's benefit to remind their physician/provider that this is a requirement so that claims payment issues can be avoided. The member is required to participate in the precertification/medical necessity process for these services to ensure his or her understanding of potential treatment options, to ensure the member has participated in maintenance therapy before advancing to a more aggressive therapy, and to ensure the correct treatment in the correct setting. If the member does not participate in the precertification process before obtaining the service there will be ***NO REIMBURSEMENT*** for the service.

Concurrent Review

This is a medical necessity review for continued use of services that occurs either during a member's hospital stay or during the course of a prescribed treatment (e.g., inpatient stays, home care or skilled nursing facility care).

Member Responsibility for Concurrent Review

In the process of a concurrent review, a determination may be made that the hospital stay or service is no longer medically necessary. In that case, the provider and member will be notified via a letter that further services are being denied. The appeal process will be outlined, but the member should be aware that he or she may be held liable for all charges for continued services if the denial is upheld. It is up to the member to discuss options for discontinuation of treatment and/or other options for care with his or her physician or provider.

Precertification for medical necessity and concurrent reviews are performed on either a prospective or concurrent timeline to assure appropriateness of admissions; continued length-of-stay and levels-of-care within inpatient facilities; and episode of treatment in the outpatient setting. The reviews are conducted as a mechanism for assuring consistent procedures and treatment across the network and for the identification of quality-of-care issues. The reviews are also done to identify discharge planning needs and to initiate discharge planning in a timely fashion.

Any unauthorized programs, services, or visits will not be covered by the HBP under any circumstances and the subsequent charges will be the financial responsibility of the member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency services.

Business hours for the EHP Medical Management and Pharmacy Departments are from 8 a.m. until 4:30 p.m., Monday through Friday.

Cleveland Clinic Employee Health Plan
25900 Science Park Drive, AC242 • Beachwood, OH 44122
Phone: 216.986.1050 • Toll-free: 888.246.6648

EHP Medical Management Fax: 216.442.5791 • Pharmacy Fax: 216.442.5790

Medical and Behavioral Health Services That Require Precertification

For the most current list of services requiring precertification, please see the online version of the *Summary Plan Description* – employeehealthplan.clevelandclinic.org. The following list includes those medical services that must receive precertification for medical neccesity, by the provider of service, prior to being rendered except for emergency/urgent situations. The member is responsible for assuring the precertification has been completed prior to service.

All Inpatient Hospitalizations[10]

- Acute Rehabilitation Admission
- All Inpatient Admissions
- All Inpatient Behavioral Health
- Behavioral Health Residential Treatment
- Elective Hospital Admission[10]
- Inpatient Maternity stays over 48 hours (normal vaginal delivery) or 96 hours (c-section)
- Long Term Acute Care (LTAC) Admissions
- Transplants (Human organ, bone marrow or tissue transplants)
- Out-of-Network and Out-of-Area Care (All) – See Emergency Services on page 25.
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission

10. May be subject to concurrent review.

Outpatient Services

- **Behavioral Health**
  - Applied Behavioral Analysis (ABA)
  - Partial Hospitalization Programs (PHP)
  - Transcranial Magnetic Stimulation (TMS)
- **Medical**
  - Bariatric Surgery
  - Botox
  - Breast reconstruction
  - Capsule Endoscopy
  - Capsule Motility device
  - Circumcision
  - Fixed Wing Conventional Air Transport
  - Gender affirming surgery
  - Home Healthcare
  - Implantable Neurostimulator
  - Injectable or Infused medications covered under the medical benefit
  - Lower extremity prosthetics
  - MRI/MRA/CT scans
  - Resigam/Synagis
  - Durable Medical Equipment (DME)[11]
    - Bone anchored hearing aid
    - Cochlear implants
    - Insulin pumps
    - Power wheelchairs or motorized wheelchairs
    - Scooters

Infertility

Prior authorization for infertility services is completed by Aetna. See page 27 for detailed information.

Special Services

These services require precertification whether inpatient or outpatient:

- Bariatric restrictive procedures or malabsorptive procedures for weight reduction
- All human organ, bone marrow, stem cell and other tissue transplants
- Gene Therapy and CAR-T Therapy

Pharmaceuticals

See the *Prescription Drug Benefit Formulary* for a list of medications that require precertification. This comprehensive list includes medications covered under the medical and/or prescription drug benefit.

Transition of Care (TOC) Coverage Request

If you are currently receiving treatment for Covered Charges from a provider whose network status changes from being a Network Provider to an Out-of-Network provider during such treatment due to termination of the provider's contract, you may be eligible to request continued care from that provider at the Network Provider rate for a temporary period of time if you have one of certain specified conditions. To clarify your eligibility for continuity of care benefits, please contact the Member Services number on your ID card.

Members must request a transition of care either at enrollment to the EHP, or if their provider is changing their network status. The request must be made no later than 90 days after the effective date of their new coverage or the provider network change. All requests must meet clinical and administrative guidelines. Please visit our website at employeehealthplan.clevelandclinic.org. for detailed instructions on filling out the required form and to view the frequently asked questions.

Care Outside of Tier 1 Cleveland Clinic Network of Providers

Under the Health Benefit Plan (HBP), there are no benefits for out-of-network services, except in cases of urgent or emergency care. The EHP Network of Providers encompasses providers within a 130-mile radius of the Cleveland Clinic facility that the member is associated with and supports. If there are providers within this distance who can offer the required service, out-of-network referrals will not be considered.

11. Reimbursement for DME will only be made at the established contracted rate for standard equipment. Any rate differential for "deluxe" equipment will be the member's responsibility.

In certain situations, a physician may determine that a member requires care outside of the member's EHP network of providers. Coverage for such services under the Health Benefit Plan (HBP) is permitted only when the necessary medical or behavioral healthcare cannot be provided within their network.

All out-of-network requests must be initiated by the member by calling the Aetna Concierge at 833.414.2331. Members should contact the Aetna concierge before scheduling any service with an out-of-network provider for further information.

Please note that Akron Children's, University Hospital System, University Case Medical Center, Summa Health System, and Aultman Hospital System and their affiliates are not considered part of the EHP network.

Non-Emergency Ancillary Services and other non-Emergency Covered Charges provided by Out-of-Network providers at EHP Network facilities, where such Out-of-Network providers do not comply with applicable federal notice and consent requirements, will be covered as if provided within the EHP Network. Out-of-Network providers may not bill members for amounts exceeding the applicable Copayment, Coinsurance, or Deductible for these services.

Coverage Clarification

The following pages (18 through 32) provide detailed benefit coverage clarification information about HBP behavioral health and medical services. This information complements and further explains the Benefits Summary charts on pages 3, 4 and 5 in Section One: "Getting Started." Behavioral health, which is listed first, includes all services for mental health and substance abuse. Medical services (pages 20 to 32), are defined and include additional information about coverage criteria and co-payments.

BENEFITS COVERAGE CLARIFICATION

Services That Must Be Provided by HBP Cleveland Clinic Providers

The following services are covered benefits ***ONLY*** when provided by Cleveland Clinic ***AND*** Benefit Guidelines are met. There is ***NO*** coverage for any other provider.

1. Acute Inpatient Rehab.
2. Autism Program (Cleveland Clinic Center forAutism).
3. Bariatric surgery.
4. Botox for migraine.
5. Breast reconstruction in connection with a mastectomy due to breast cancer.
6. Chiropractic services.
7. Cleveland Clinic Summer Treatment Program.
8. Corneal Cross Linking.
9. Dental implants for accidents or certain medical conditions.
10. Family planning services.
11. Genetic testing/counseling.
12. Infertility treatment.
13. Left Ventricular Assist Device (LVAD).
14. Long-Term Acute Care (LTAC) – requests for services outside Northeast Ohio may be reviewed for geographical location, extenuating circumstances, and medical necessity.
15. Neurofeedback and Biofeedback.
16. Outpatient cardiac rehabilitation programs.
17. Protein Sparing Modified Fast (PSMF) diet.
18. RAST (allergy blood) testing.
19. Refractive surgery
20. Residential treatment.
21. Routine care costs for qualifying clinical trials.
22. Routine health maintenance tests, routine screening tests, and standard immunizations.
23. Sclerotherapy or vein stripping for varicose veins.
24. Services for Strabismus repair.
25. Services for treatment of sleep apnea.
26. Temporomandibular Joint Syndrome (TMJ), treatment and appliances.
27. Transcranial Magnetic Stimulation (TMS)
28. Transgender services (Behavioral Health visits, gender affirming surgery and hormonal treatment).
29. Transplant services.
30. Treatment for reduction mammoplasty.
31. Vestibular testing battery.

BEHAVIORAL HEALTH SERVICES

For the specialty of **Behavioral Health**, the Tier 1 network has been supplemented with contracted providers in the Aetna Select Open Access network in both Florida and Ohio.

ADHD Summer Treatment Program

Full benefit coverage applies only if the child and parent each complete their designated portions of the program. Precertification and a medical necessity review are required. HBP coverage for the Summer Treatment Program is $2,000. The member is responsible for the difference between what the HBP covers and the billed charges for the program. An additional $500 will be covered ***ONLY*** if the parents participate in the parent education portion of the program. All outpatient social skills training for children and adolescents with ADHD is covered as group therapy under the behavioral health outpatient benefit.

Autism-Specific Services

Applied Behavioral Analysis (ABA)

ABA services are covered only when provided by a Certified ABA Therapist and only when the diagnosis of Autism and Autism Spectrum Disorder is present. Precertification is required.

Lerner School for Autism

The HBP will cover the Lerner School for Autism at the Cleveland Clinic Center for Autism. A Financial Needs Assessment must be completed prior to determining HBP coverage. Members are required to notify the HBP of any outside funding obtained for their child.

Benefit coverage for a school year is determined by the student's age at the beginning of the school year (or at the start of services if other than September):

- < 4 years – 100%
- 4 through 5 years – 50%
- ≥ 6 years – 25 %

Although the benefit year is from January to December, the HBP will reimburse the Autism School from the dates of September through August and benefit coverage is determined by the student's age as of September (or at the start of services if other than September). For example, a student starting the program in September at age three receives 100% coverage for the entire school year – the benefit coverage is not reduced for that school year when the student turns four.

Any state grant or scholarship, such as the Ohio Autism Scholarship, as well as any school district funding secured by the parents must be disclosed to the HBP. The HBP requires the actual document as confirmation of outside funding. Any secured funding will be subtracted from the total cost of tuition. The remaining tuition balance will be paid according to the benefit coverage in effect at the time of enrollment.

Example: The total tuition is $75,000. If $50,000 school district money is secured, and the benefit coverage based on age is 50%, the parent and the HBP would both be responsible for $12,500 ($75,000 – $50,000 = $25,000 x 50% = $12,500).

If a family has not disclosed any funding from their school district, they must apply for the Ohio Autism Scholarship for any child who is 3 years of age or older. It will be assumed by the HBP that the Ohio Autism Scholarship will be available to any child not receiving funding from their district and factored in accordingly on the invoice starting at 3 years of age. If the family does not apply, or applies late, for the Ohio Autism Scholarship they will be responsible for any amount less than the full amount available to the family. If there are extenuating circumstances, contact the HBP. Personal family or donor awards do not need to be disclosed. The HBP is requesting disclosure of any state grant or school district funds because these monies are to assist with the support of academic programs. If the family does not provide the actual dollar amount of funding from the state grant or school district, the HBP reimbursement will be based on the total tuition and the age of the student at the start of the school year.

Custodial Care

When care is deemed to fall under custodial care, the care is no longer eligible for coverage. Based on the information provided, the member has reached the maximum achievable level of mental function with the current treatment at the current level of care; and/or services are given mainly to maintain, rather than improve, a level of mental function, and/or provide a surrounding free from environmental conditions that can worsen the person's physical or mental state.

Intensive Home-Based Treatment

Approval for Intensive Home-Based Treatment (IHBT) is given on a case by case basis following a review by Medical Management. IHBT services are made available to individuals and their family, and are provided in the home by a specially trained behavioral health professional. Services are usually provided two to five times per week up to an average of four to 10 hours over several weeks. Precertification is required.

Psychological and Neuro-psychological Testing

Up to 8 hours of testing are automatically reimbursed without precertification. Testing is covered in Tier 1 only by trained Behavioral Health Specialists.

Note: If more hours/visits than the Allowed Amounts are utilized, the hours/visits ***will not be covered*** by HBP under any circumstances and the subsequent charges will be the financial responsibility of the member.

Residential Treatment

Residential Treatment (RT): Room and board services are provided on a 24 hour per day basis in conjunction with a highly structured mental health and/or substance abuse treatment program. Residential Treatment programs are generally in non-hospital settings. The patient is able to participate in individual, group and/or family psychotherapy, as well as other activities and/or therapies that address the patient's psychosocial needs within a controlled environment. The focus of the treatment should be to resolve any problems with the patient's support system, as well as the development and maintenance of skills and behavioral changes that will allow the patient to successfully reintegrate into the community. Halfway houses are not considered to be Residential Treatment programs by the HBP therapy programs are not considered a residential treatment program and are not a covered benefit.

Approval for Residential Treatment will be determined by Medical Management on an individual case basis, following a review for medical necessity. This level of care is only available to those members who have received precertification from to the Medical Management Department.

Transcranial Magnetic Stimulation (TMS)

If guidelines are met, initial treatment or depression relapse retreatment, up to 36 treatments per episode. TMS maintenance therapy is considered experimental, investigational, or unproven and not a covered benefit.

MEDICAL SERVICES

Acupuncture

Maximum of 10 visits per benefit year. Coverage is 100% of Allowed Amount after a $35 copay. Aetna considers acupuncture (manual or electroacupuncture) medically necessary for any of the following indications:

A. Chronic (minimum 12 weeks duration) neck pain; or

B. Chronic (minimum 12 weeks duration) headache; or

C. Low back pain; or

D. Nausea of pregnancy; or

E. Pain from osteoarthritis of the knee or hip (adjunctive therapy); or

F. Post-operative and chemotherapy-induced nausea and vomiting; or

G. Post-operative dental pain; or

H. Temporomandibular disorders (TMD).

Bariatric Surgery

- To be eligible for this benefit, a member must be a participant in the HBP for a minimum of two consecutive years.
- Precertification is required through the EHP Medical Management Department. The member must call the Medical Management Department when the surgical workup begins to start the precertification process.
- Members on the EHP plan must have surgery at a Cleveland Clinic Bariatric and Metabolic Institute facility.
- Members on the EHP Plus who live within a 130-mile radius of Cleveland Clinic must have the services completed at a Cleveland Clinic Bariatric and Metabolic Institute facility. If living outside of the 130-mile radius, services must be completed

by an Aetna Institute of Quality Bariatric Surgery facility.

- Laparoscopic band placement (lap band surgery) is not a covered benefit.
- To be eligible for surgery, the member must meet the HBP's established clinical criteria.
- A member may qualify for surgery through the Cleveland Clinic Bariatric and Metabolic Institute, BUT NOT meet HBP clinical criteria. In this instance, the surgery will not be authorized for coverage.
- To qualify, a member must have a BMI greater than 40 (or exceeding 37.5 if of Asian ancestry) OR a BMI of 35 to 40 (or exceeding 32.5 if of Asian ancestry) with significant co-morbidity(ies) such as hypertension, diabetes, coronary artery disease, sleep apnea or nonalcoholic steatohepatitis which are not amenable to maximum conservative treatment.
- Members must be enrolled in all applicable chronic condition, Coordinated Care Programs for at least six months prior to surgery. For instance, weight, and if applicable diabetes and or hypertension.
- If a member with a BMI between 35 to 39.9 does not meet the above criteria and gains weight to reach a BMI of 40, they will not be considered for surgery for one year.
- An upfront $2,750 co-payment is required for the surgical procedure.
- If the surgery coverage is approved, please note you are responsible for all $35 pre-workup specialty provider visit co-payments. Workup visits may include diagnostic and laboratory tests, assessments by endocrinology, psychiatry/psychology, nutrition, general surgery, and possibly other specialists such as cardiology.
- After the surgery is completed, if you meet the program requirements, surgical copay reimbursements are made only to actively employed HBP members or their eligible dependents who successfully participate in the required Coordinated Care Program(s). Talk to your Care Coordinator to learn more.

The following procedures are considered experimental and investigational and not likely a covered benefit because the peer-reviewed medical literature shows them to be either unsafe or inadequately studied. Procedure requests will be reviewed by EHP Medical Management to determine coverage eligibility.

Surgery Description

1. "AspireAssist" device aspiration therapy
2. "Band over sleeve" or LASGB revision of prior sleeve gastrectomy
3. Conversion of a sleeve gastrectomy to a Roux-en-Y gastric bypass for the treatment of bile reflux
4. Conversion to sleeve gastrectomy for hypoglycemia post-RYGB
5. Duodenal ileal switch for the treatment of gastroparesis
6. Gastric bypass as a treatment for gastroparesis in persons not meeting medical necessity criteria for obesity surgery above
7. Laparoscopic gastric diversion with gastro-jejunal reconstruction for the treatment of GERD with esophagitis
8. Laparoscopic single-anastomosis duodeno-ileal bypass with gastric plication
9. Loop gastric bypass
10. Mini gastric bypass
11. Natural orifice transoral endoscopic surgery (NOTES) techniques for bariatric surgery including, but may not be limited to, the following:
    - Endoscopic outlet reduction for treatment of weight gain after Roux-en-Y gastric bypass
    - Mini sleeve gastrectomy
    - Restorative obesity surgery, endoluminal (ROSE) procedure
    - Transoral gastroplasty (TG) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty);
    - Use of any endoscopic closure device (Over the Scope clip [OTSC] system set, Apollo OverStitch endoscopic suturing system, StomaphyX endoluminal fastener and delivery system) in conjunction with NOTES
12. Open adjustable gastric banding
13. Prophylactic pyloroplasty via botulinum toxin injection following laparoscopic sleeve gastrectomy
14. Roux-en-Y gastric bypass as a treatment for gastroesophageal reflux in persons not meeting medical necessity criteria for obesity surgery

15. Roux-en-Y gastrojejunostomy for the treatment of persistent gastro-esophageal reflux disease following Anti reflux surgery in persons not meeting medical necessity criteria for obesity surgery above
16. Silastic ring vertical gastric bypass (Fobi pouch)
17. Use of a coated stent for gastro-jejunal fistula following bariatric surgery

Botox for Migraine

Botox for chronic migraine requires precertification. The member must be seen within six months of the request by a neurologist or headache clinic within Tier 1.

Breast Cancer Prevention Coverage

Under the provisions of the Affordable Care Act mandate regarding breast cancer preventative health services, generic raloxifene and tamoxifen will be covered under the HBP Prescription Drug Benefit at no out-of-pocket expense only for female members 35 years of age or older when accompanied by a valid prescription from the member's healthcare provider.

Breastfeeding Equipment and Supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

Breast pumps are covered at 100% if obtained through an in network Durable Medical Equipment provider or a Cleveland Clinic Pharmacy. One electronic breast pump in a 12-month period or one manual pump in a 12-month period. Must be purchased before the child reaches 36 months of age for a new pregnancy. Claim must be associated with a pregnancy related claim.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Breast Reconstruction

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Cataract Surgery

Cataract surgery is a covered benefit under the HBP for standard intraocular lenses. If the member chooses to receive the non-standard lenses, the HBP will only pay up to the contracted rate for standard intraocular lenses

Chiropractic Services

A maximum of 10 visits are covered per calendar year within the Tier 1 Network of Providers only. There is a $35 co-payment for each visit. X-rays done at the chiropractor's office are a non-covered benefit. Chiropractors are licensed to perform physical therapy. If the Chiropractor performs physical therapy, the visit is counted as a Chiropractic visit. When there are both a chiropractic and physical therapy service, a co-payment will apply for each service. MRIs ordered by a Chiropractor require precertification by the Medical Management Department. If precertification is not obtained, the member may be responsible for payment.

Clinical Trials

Coverage is as follows for qualifying clinical trials:

Qualifying Clinical Trials as defined below, including routine patient care costs as defined below incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Benefits are covered ***ONLY*** in the Tier 1 provider network.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (*i.e.,* Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the medically necessary monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the *Veteran's Administration* (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense*, or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational New Drug Application (IND) reviewed by the *U.S. Food and Drug Administration*;

- The study or investigation is a drug trial that is exempt from having such an Investigational New Drug Application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.
- Members must provide a written letter from the chief of the appropriate department or institute chair at the Cleveland Clinic recommending enrollment in the clinical trial and documenting that no Cleveland Clinic trials are available.

Compression Stockings

Compression stockings are covered at 80% and are limited to six pairs per year.

Contact Lenses and Lens Fittings

Contact lenses and lens fittings are only covered for certain ophthalmologic conditions that are not correctable by glasses. Services must be provided by a Tier 1 provider. The provider may be required to provide supporting documentation to the EHP Medical Management Department in order for the claim to be adjudicated appropriately. Limited to two pairs per year for lenses and two fittings per year, one per pair.

Contraceptive Coverage

Under the provisions of the Affordable Care Act mandate regarding women's preventative health services, contraceptives will be covered under the HBP Prescription Drug Benefit within the following guidelines:

- Diaphragms, Phexxi, emergency contraceptives, generic oral contraceptives, generic injectables (medroxyprogesterone) will be covered with no out-of-pocket expense for the member. However, a prescription from your health care provider is required.
- Brand name oral contraceptives that are not available generically require precertification. If the precertification request is approved, the member will not have any out-of-pocket expense. If the precertification request is denied, the brand name contraceptive will not be covered.
- Members who receive a brand name formulation of a contraceptive that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name contraceptive product and the generic alternative.
- Contraceptive products that do not require a prescription to be purchased are not covered under the HBP Prescription Drug Benefit.
- Mirena and other intrauterine devices (IUDs) are not covered under the HBP Prescription Drug Benefit. Rather, they are covered under the medical benefit and no co-payment will be charged.

Cosmetic Surgery Combined with Medically Necessary Surgery

If a member chooses to have cosmetic surgery at the same time they are having surgery that is medically necessary, the coverage will be as follows:

- The **professional** fee for the cosmetic surgery will ***NOT*** be covered.

If the combined surgeries result in a hospital admission, the coverage will be as follows:

- If the usual course of the medically necessary procedure requires hospitalization, hospital days will be covered at 100%.
- If the usual course of the medically necessary procedure does not require hospitalization, the entire hospital charge is the patient/member's responsibility.

Cosmetic surgery is always an excluded benefit. The treatment of complications resulting from cosmetic surgery is also excluded. Life threatening complications that require inpatient care ***MAY*** be covered but must be reviewed by the Medical Management Department.

In addition, the Medical Management Department reserves the right to retrospectively review these claims and adjust them according to these guidelines. This means the member may be financially accountable for services after they have been rendered.

Court-Ordered Services

Court-ordered services must meet EHP Medical Management medical necessity guidelines.

Custodial Care

Services and supplies meant to help you with activities of daily living or other personal needs is considered "custodial care" which is not covered by the plan.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Dental

This section pertains to dental benefits covered by the Health Benefit Program, ***NOT*** the Dental Benefit Program. Questions about dental coverage should be directed to the Caregiver Office Service Center. ***All services in this section must be provided in the Tier 1 Network.***

1. Dental procedures such as surgical removal of impacted teeth, implants, root canals, crowns, caps, re-implantation, etc., are ***NOT*** covered under the HBP even if they are recommended because of minor accident or injury. The Medical Management Department will review cases of severe trauma resulting in mandibular/maxillary fractures, in which major reconstruction is required within one year of the accident or injury, prior to services being rendered.
2. **Dental Implants:** Dental implants are covered under the HBP when ***ALL*** of the following conditions are met:
   - Implants are determined to be medically necessary, and the medical need is primarily caused by a specific medical condition *e.g.,* congenitally missing teeth or major trauma resulting in mandibular/ maxillary fractures. If medical necessity is determined due to an accident or within one year of major trauma resulting in mandibular/maxillary fractures the patient ***MUST*** have been a HBP member at the time of the accident or injury to be eligible for coverage. Congenitally missing teeth are covered for dental implant replacement.
3. Anesthesia for dental procedures is only covered in cases where anesthesia is necessary to do dental work that is required because of a specific underlying medical condition. To check if services are covered, members or their provider can contact Aetna to complete a predetermination of benefit coverage before scheduling a procedure. ***All anesthesia must be done in the Tier 1 Network.***

DXA Scans (Bone Density)

One screening is covered every two years for women over 65 and men over age 70.

Screening for members under these ages or in need of more frequent scans are covered only if medically necessary.

Durable Medical Equipment (DME)

Reimbursement for DME will only be made at the established contracted rate for standard equipment. Any rate differential for "deluxe" equipment will be the member's responsibility. Over-the-counter DME products are not a covered benefit (*e.g.,* grab bars for showers).

- If the contracted rate is less than the amount of the co-payment, the member is still responsible for the corresponding co-payment/co-insurance.

Emergency Services/Inpatient Notification/Transfers

Emergency & Urgent Care are covered at 100% regardless of the provider as long as the visit meets Emergency or Urgent Care criteria as defined in Section Seven: "Terms and Definitions." A co-payment is required for any emergency department visit. If the visit results in an admission, the emergency co-payment will be waived and the inpatient admission co-pay will be applied. Observation stays in the hospital are not considered admissions and are subject to the ER co-payment.

Emergency transport to an emergency room, even if it is a non-Cleveland Clinic facility, is always covered.

Ambulance transport to home from any healthcare facility or to/from physician or outpatient care visits are not covered.

Foreign Country Claims

Emergency services received while traveling between or while in a foreign country are covered, however, payment up front is typically required by the provider. To obtain reimbursement, the member must provide an itemized receipt from the provider which includes a description of services and codes (in English). A claim form then needs to be submitted to the Third Party Administrator along with the receipts.

The following information addresses notification and transfers to a Cleveland Clinic facility:

Notification and Transfers from a Non-Cleveland Clinic Hospital

The HBP requests notification at the time of admission (including unplanned admissions) or any admission to a Tier 2 or out of network facility. Notification can be from either the member, the members family, or the admitting facility. Members must contact EHP Medical Management at 216.986.1050 or 888.246.6648. These numbers are also on the back of your medical ID card. Notification is requested as the HBP may request to transfer members from a non-network facility to a network facility, as well as to monitor ongoing care and discharge planning needs.

If the member is mentally incapacitated, or in the absence of family members who can make the contact, hospital staff can make the contact as soon as possible. The HBP may request to transfer members from a non-network facility to a Cleveland Clinic facility. All cases will be reviewed by the HBP Medical Director for appropriateness of transfer. If the member or family would like to request a transfer, they should contact EHP Medical Management at 888.246.6648 to request a transfer.

Air ambulance transport requires precertification. Please note, Emergency Services do not require precertification.

Enteral Feedings

Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

Family Planning Services

Family planning means the voluntary process of identifying goals and developing a plan for the number and spacing of children and how those goals may be achieved. These means include a broad range of methods, which may range from choosing not to have sex to the use of other services to limit or enhance the likelihood of conception such as contraceptive methods, natural family planning ("fertility awareness methods"), the management and treatment of infertility, as well as information about or referrals for adoption.

The EHP and Aetna partner with Maven, to provide **additional** support around our family planning coverage. Maven is a digital health platform providing support for pregnancy and postpartum; fertility treatments like IVF, IUI; and early parenthood.

Maven allows our eligible members to book 24/7 coaching and educational appointments with 30+ provider types (doulas, midwives, nutritionists, lactation consultants, surrogacy and adoption* coaches, and more) at no cost to you when booked through Maven. You also get access to Maven's library of virtual classes, content, and community features. Join Maven at **mavenclinic.com/join/cc** or email **support@mavenclinic.com** with any questions.

Note: While access to Maven is open to all EHP members, members seeking fertility treatments must first have precertification by Aetna's Infertility Advocate at 1.833.415.1709. See page 27 for information on infertility coverage.

*Contact the Caregiver Office Service Center for coverage information on adoption.

Genetic Testing/Counseling

Genetic testing must be done by a Tier 1 provider, and some genetic testing requires precertification to ensure medical necessity. Genetic testing/counseling is a covered benefit for a member or a member's covered dependent. It is not covered when the service does not benefit the insured or the insured's covered dependent.

Hair Loss

Cranial prosthesis (wig) is considered Durable Medical Equipment (DME) and is covered at 80 percent. However, many DME companies will not bill insurance. Therefore, you can purchase your cranial prosthesis from a vendor of your choice, however, payment would need to be made upfront by the member and a claim form submitted to Aetna with the receipt. The Aetna claim form can be found on our website at **employeehealthplan.clevelandclinic.org**.

Hearing Aids

Hearing aids are covered at 50% of billed amount up to $3,500 per ear; one aid per ear every three years at Cleveland Clinic in Ohio only. Evaluation, consulting, and dispensing fees are covered at 100% by Cleveland Clinic in Ohio only. Repair of hearing aids ***IS NOT*** covered. There is ***NO*** coverage of the hearing aids, evaluation, consultation, or dispensing fees by any other provider.

Hospice

To be eligible to receive the hospice benefit, patients must have a life expectancy that is less than 12 months and have a caregiver(s) in the home 24 hours a day, 7 days a week. The four levels of service that are included in the benefit are: routine or continuous home care, inpatient respite, inpatient general care, and inpatient symptom management care. Inpatient respite care provides rest and relief for the patient's primary caregivers. Inpatient care provides general care or pain and symptom management not possible in the home setting. Services that are ***NOT*** covered under the hospice benefit include: custodial and/or experimental therapies.

Immunizations

Standard immunizations are covered only when given within the Tier 1 Network of Providers. Immunization and blood tests are ***NOT*** covered for travel or when required for school/work. **Tetanus** toxoid, **Rabies** vaccine and **Meningococcal** polysaccharide vaccines will be covered outside of Cleveland Clinic Tier 1 ***ONLY*** if they are given as part of Emergency/Urgent Care Services. Some immunizations have special coverage rules:

- Intranasal Flu vaccine is covered for members age 2 to 18 only.
- Shingrix shingles vaccine is covered for members age 50 and above.
- Gardasil is covered for males and females age 9 to 45.
- Hepatitis A is covered for children 12 months through age 18. Hepatitis A can be covered outside of this age group only when medical necessity criteria is met and the immunization is preauthorized.
- Measles titers are a covered benefit, but is excluded for travel purposes. Caregivers themselves should have them done through Occupational Health; dependents should go through their primary care physician.

Immunization and blood tests are ***NOT*** covered for travel or when required for school/work. **Tetanus** toxoid, **Rabies** vaccine and **Meningococcal** polysaccharide vaccines will be covered outside of Cleveland Clinic Tier 1 ONLY if they are given as part of Emergency/Urgent Care Services.

Infertility

Coverage for infertility has a lifetime maximum of $15,000 for medical and $6,000 for pharmaceutical. Below are the eligibility requirements and coverage overview.

Eligible Health Plan Members must meet the following requirements:

- Enrolled in EHP, EHP Plus, Martin Health Retiree Under 65 plan
- Between age 18–49 years and if female is premenopausal and could reasonably expect fertility as a natural state; or menopausal and experiencing menopause at a premature age
- Dependent children of plan members are excluded
- Must be a non-smoker/non-tobacco/non-Cannabinoid user (both partners)

- If nicotine use is determined, patient and/or spouse, is required to complete and provide negative cotinine test or other requirements through Health Coaching.
- If Cannabinoid or drug use is determined; patient and/or spouse is required to contact Behavioral Health and provide negative blood test for Cannabinoids or other drugs.
  - Proof of Medical Marijuana card can override this requirement.
- Have approval from the EHP Third Party Administrator (TPA) Aetna's National Infertility Unit (NIU) Health Plan members will not receive coverage until they initiate a review for infertility treatment by contacting the **Aetna Fertility Advocate (FA) at 1.833.415.1709** (8 a.m.–4:30 p.m. EST)

Coverage Limitations:

- Medical plan covers up to $15,000 in infertility treatment per lifetime
- Prescription medications covered up to $6,000 per lifetime
- If both the Caregiver and Spouse are Cleveland Clinic employees, the benefit follows the member being treated (the couple cannot access $30,000 medical benefits / $12,000 pharmacy benefit
- If in a same sex partner relationship, the medical benefit covers a lifetime maximum up to $15,000 in infertility treatment. The prescription drug benefit covers a lifetime maximum up to $6,000

Access to the Benefit:

- Health Plan members will not receive coverage until they initiate a review for infertility treatment by contacting the **Aetna Fertility Advocate (FA) at 1.833.415.1709** (8 a.m.–4:30 p.m. EST)
- The FA reviews eligibility and coverage criteria
- The FA explains precertification process and network requirements
  - **EHP Plan Members:** Treatment is mandatory at Cleveland Clinic's Women's Health Institute. There is no out-of-network coverage for infertility treatment.
  - **EHP Plus Plan Members:** May seek treatment at an Aetna Infertility Institute of Excellence (IOE) provider; if no Infertility IOE within 130 miles, seek treatment with an Aetna network infertility specialist. There is no out-of-network coverage for infertility treatment.
- It is the Health Plan member's responsibility to track expenditure through the FA.

Provider Responsibility:

- After FA indicates eligibility requirements are met, providers contact Aetna NIU at 1.800.575.5999 (8 a.m.–6 p.m. EST) with clinical information and treatment plan to obtain pre-authorization. If additional or different infertility treatment is needed, providers contact Aetna NIU at 1.800.575.5999 to pre-authorize the service for notification of approval
- If the member meets eligibility and clinical criteria, one approval applies to full episode of care. If the member stops treatment for over 1 year and has not used full annual coverage, the approval process is required to start treatment again
- Provider and member determine treatment course
- If the member does not meet eligibility and clinical criteria, coverage is denied
- Provider and Member are notified via phone or fax and letter
- If service is not authorized, provider and member can appeal through the standard appeal process

Sperm, Oocytes, or Embryo Cryopreservation:

- The plan will authorize, with prior authorization, coverage for the harvest, procurement, and storage of sperm, oocytes, or embryos for eligible members, and storage is in association with ongoing infertility care (infertility treatment within 90 days of the cryopreservation).

  Note: In the event that an EHP member stored eggs, sperm, embryos and/or oocytes due to medical necessity (eg. cancer therapy) at an out-of-network (OON) facility prior to enrollment on the EHP Plan, the member will be permitted to continue treatment at the OON facility until the stored contents have been consumed.
- The plan may prior authorize coverage for the harvest, procurement, and short-term storage (<90 days) of sperm, oocytes, or embryos for eligible members, in the presence or absence of ongoing infertility care, when the eligible member requires medical treatment that may render them sterile.

Examples of such treatment include: chemotherapy and/or radiation therapy for cancer and medically necessary gender affirming treatment. A letter of medical necessity from the treating physician is required. Coverage for this indication is limited to one cycle.

- If the member completed social preservation prior to employment at Cleveland Clinic, the EHP will reimburse egg thawing, fertilization, and IVF only if the member has a medical infertility diagnosis, and the provider is an Aetna Select Open Access contracted provider. There is no coverage if the provider in out of network.

  If the member completes social preservation during the time of employment at Cleveland Clinic, regardless of if they are or are not on the Cleveland Clinic EHP or EHP Plus plan, the member is fully aware there is no coverage once egg thawing, fertilization and IVF begins as the member is fully aware social preservation is not a covered benefit.

- **Limitations:**
  - Long-term sperm, oocyte, or embryo storage, defined as greater than 360 days (about 12 months), if the eligible member is receiving infertility treatment (see above), or storage is following medical treatment that rendered them sterile (see above). The Health Plan will not cover storage for the WHI because it is included in the retrieval cost for the first year.
  - Coverage beyond 90 days (about 3 months) after the last cycle of infertility treatment ends, or if a pregnancy occurs.
  - Sperm cryopreservation is a routine procedure for sperm backup without a confirmed physical or psychological diagnosis.

Services Covered with an Approval:

- Artificial Insemination Intra-Cervical
- Artificial Insemination Intra-Uterine
- Sperm Washing Artificial Insemination
- IUI for female without a male partner
- Follicle Puncture Oocyte Retrieval Any Method
- Embryo Transfer Intrauterine
- Gamete Zygote/Embryo Fallopian Transfer Any Meth
- Us Guidance Aspiration Ova Img S&I
- Cul Oocyte/Embryo <4 Days
- Cul Oocyte/Embryo < 4 D Co-Cult Ocyte/Embry
- Asstd Embryo Hatching Microtqs Any Meth
- Oocyte Id From Follicular Flu
- Prepj Embryo Tr
- Sprm Id From Aspir Oth/Thn Seminal
- Cryoprsrv Embryo with medical diagnosis
- Sprm Id From Tstis Tiss Frsh/Cryoprsrvd
- Insemination Oocytes
- Extnd Cul Oocyte/Embryo 4-7 Days
- Asstd Fertilization Microtq </Equal 10 Oocytes
- Asstd Fertilization Microtq > 10 Oocytes
- Storage Per Year Embryo as per cryopreservation criteria above
- Storage Per Year Oocyte as per cryopreservation criteria above
- Storage per year sperm as per cryopreservation criteria above
- Thawing Cryopreserved Embryo as per cryopreservation criteria above
- Thawing Cryopreserved Sperm/Semen Each Aliquot as per cryopreservation criteria above
- Thawing Cryopreserved Oocytes as per cryopreservation criteria above
- Cryopreservation; Immature Oocyte(S) as per cryopreservation criteria above
- Cryopreservation Mature Oocyte(S) as per cryopreservation criteria above
- Cryopreservation; Sperm as per cryopreservation criteria above

- In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(2), and subsequent visualization for determination of development
- Complete cycle, gamete intrafallopian transfer (gift)
- Complete cycle, zygote intrafallopian transfer (zift)
- Complete in vitro fertilization cycle, not otherwise specified
- Frozen in vitro fertilization cycle
- Incomplete cycle, treatment cancelled prior to stimulation
- Frozen embryo transfer procedure cancelled before transfer
- In vitro fertilization procedure cancelled before aspiration
- In vitro fertilization procedure cancelled after aspiration
- Assisted oocyte fertilization
- Donor egg cycle, incomplete
- Donor services for in vitro fertilization (sperm or embryo)
- Stimulated intrauterine insemination (IUI)
- Biopsy, oocyte polar body or embryo blastomere, micro technique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos (Medical Director PA)
- Biopsy, oocyte polar body or embryo blastomere, micro technique (for pre-implantation genetic diagnosis); greater than 5 embryos (Medical Director PA)

  Note: Embryo genetic testing is covered only in situations where both parents are documented carriers for the following diagnoses: cystic fibrosis, fragile X syndrome, sickle cell anemia, thalassemia, hemophilia, Tay-Sachs disease, and/or spinal muscular atrophy, following the American College of Obstetrics and Gynecology (ACOG) recommendations for carrier state screening of parents.

Excluded Services:

- ART procedures deemed experimental and investigational
- Infertility services when the infertile member is not the recipient of the services (like donor egg with gestational carrier; transfer of embryo to gestational carrier)
- Gonadotropin usage greater than 600 IU/day
- Cost of donor oocytes, sperm or embryo and related services
- Services/drugs directly related to non-covered services
- Anti-Mullerian hormone therapy is experimental
- Uterine embryo lavage using Previvo is experimental
- Medications for males: Clomid, HCG, FSH, experimental
- Social egg freezing (SEF, or elective egg freezing without a medical indication) and associated services that use those eggs (including but not limited to egg retrieval, egg storage, egg fertilization, and subsequent embryo implantation) is not a covered benefit. Medically necessary egg freezing that is required for fertility preservation due to a necessary treatment that damages ovaries/eggs during childbearing years of 18 to 44 can be covered if prior authorized at the time of necessary treatment.
- Storage, any type, prior to authorization
- Experimental infertility procedures including CPT codes 0058T, 89335, 89344, and 89354 are considered experimental
- Surrogacy

Maternity Care

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours).

Doula services are ***NOT*** considered medically necessary and therefore are NOT a covered benefit. **If you would like coverage for your newborn, you have 31 days from birth to add the baby to the Health Benefit Program. See Life Event Changes in Section 5.**

Nicotine/Tobacco Cessation

There is a limit of eight (8) visits per calendar year for services related to nicotine cessation.

Observation Stays

Observation stays in the hospital are not considered admissions and are subject to the $250 ER co-payment. If admitted, the ER co-payment will be waived and the $350 co-pay will be applied.

Orthotics

- **Custom-made:** covered at 80% of Allowed Amount.
- **General:** not a covered benefit.
- If the contracted rate is less than the amount of the co-payment, the member is still responsible for the corresponding co-payment/co-insurance.

Orthopedic shoes and diabetic shoes are not considered orthotics.

Pediatric Eye Exams

The EHP covers two pediatric eye exams per calendar year at 100% for patients ages 17 and under. The $35 copay does not apply to these two exams. Any additional eye exams will be subject to the $35 specialty copay.

Pediatric Type 1 Diabetes

Related office visits, medications and supplies for pediatric type 1 diabetes are covered at 100% when applicable precertification is obtained. Pediatric is defined as members age 0 through age 17.

RAST (Allergy Blood) Testing

RAST testing (allergen specific IgE blood testing) will be covered if obtained by a Tier 1 network provider only.

Refractive Surgery

Coverage for refractive surgery includes services for the LASIK, PRK and SMILE procedures. Services must be provided at the Cleveland Clinic for coverage. An assessment is required to determine if you are a candidate for the procedure. The assessment fee is the responsibility of the health plan member. Once determination is made, the surgery and after care up to a year is covered at 100%. The EHP will cover one enhancement per eye per lifetime.

Routine (Annual) Eye Examination

One routine (annual) eye examination is covered per calendar year in the Tier 1 network. Examinations are not covered under the Cleveland Clinic Vision Benefit Program. The Vision Program covers hardware only. Services for contact lenses are not a covered benefit.

Spider Veins and Varicose Veins

- Spider veins – Sclerotherapy is ***NOT*** a covered benefit.
- Varicose veins:
  - Sclerotherapy for symptomatic varicose veins is covered at 100%; and
  - Vein stripping for symptomatic varicose veins is a covered benefit in the Tier 1 Network of Providers only.

Temporomandibular Joint Syndrome (TMJ)

Treatment of TMJ is covered at 100% after a $35 co-pay per specialist office visit. Services and appliances must be received within the Tier 1 Network of Providers and precertification is required.

Therapy

Rehabilitative – Occupational/Physical/Speech[12]

A maximum of 30 visits per therapy are covered per calendar year. A $10 copay per visit is required.

Habilitative – Occupational/Physical/Speech[12]

For the diagnoses of Apraxia, Autism, Autism Spectrum Disorder, Cerebral Palsy, Developmental Delay and Spina Bifida, coverage is 100% of the allowed amount. There is no visit limitation and no copay.

Transgender Services

Transgender services are covered as follows:

- The service request must be completed at Cleveland Clinic.
- The request must go to the Medical Director for review.
- The request must come from the Transgender Medicine/Surgery Program Coordinator and documentation reflects the member meets the current World Professional Association for Transgender Health (WPATH) criteria.
- Covered at 100% of allowed amount after applicable copay for behaviorial health services, gender affirming surgery and hormonal treatments.
- Limit of one reversal per lifetime.

Transplants

Precertification is required for all major organ and tissue transplants including evaluations through EHP Medical Management at 888.246.6648 – this includes but is not limited to kidney, liver, heart, lung and pancreas, stem cell and bone marrow.

- Services completed at the Cleveland Clinic follow the EHP medical necessity criteria.
- Services completed by an Aetna Select Open Access network provider follow the Aetna medical necessity criteria.

Virtual Visit Coverage

Coverage for face-to-face telemedicine visits includes visits for routine and follow-up visits for services such as behavioral health and chronic conditions such as diabetes, hypertension and high cholesterol. Members are required to have a PCP treating them for the condition and to have seen the PCP in person at least once.

Charges for MyChart messages billed by the provider are covered at 100% for EHP members. Audio-only calls are **NOT** covered.

12. Services are not a covered benefit when they are for non-medical conditions. Non-medical conditions include, but are not limited to, impulse control disorders and conduct disorders. Refer to Precertification and Concurrent Review for Medical Necessity rules on page 14 for more information.

CASE MANAGEMENT

The Health Benefit Program (HBP) is committed to helping you and your family stay healthy. If faced with medical illness, we are also committed to helping you with important decisions to ensure that you get the healthcare you need.

The EHP Medical Management Department offers Case Management Programs that provides members with telephone access to a Case Coordinator (Registered Nurse or Licensed Social Worker/Counselor) for assistance with complex medical care needs, complex behavioral health needs, network access issues, and referrals to community services. Members can self-refer or be referred by their physician or family for evaluation.

If you have a medical or behavioral health question related to a Case Management Program, the Medical Management Department can be reached at 216.986.1050, option 2 or toll-free at 888.246.6648, option 2 during regular business hours of 8 a.m. to 4:30 p.m. Monday through Friday, excluding holidays. A confidential voicemail box is available to accept non-urgent messages after hours.

Cleveland Clinic EHP Prescription Drug Benefit *(Administered by CVS Caremark)*

Prescription Drug Benefit Administration

The Prescription Drug Benefit is administered through CVS Caremark under the guidance of the EHP Pharmacy Management Department. You can contact the EHP Pharmacy Management Department as follows:

- Monday through Friday from 8 a.m. to 4:30 p.m.
- Phone: 216.986.1050, option 4 or toll-free 888.246.6648, option 4

CVS Caremark has a dedicated toll-free Customer Service phone number that members can call 24 hours a day, seven days a week: 866.804.5876. CVS Caremark is also available through email at **customerservice@caremark.com**.

If your CVS Caremark prescription card is lost or stolen, contact CVS Caremark at the phone number or email address above for a replacement card.

Members can also go to the CVS Caremark website at **https://www.caremark.com** for the following:

- Prescription refills for CVS Caremark Mail Service
- Order status
- Pharmacy locations
- Benefit coverage
- Request forms
- Frequently Asked Questions
- 13 month drug history
- Additional health information

When you call CVS Caremark or visit their website, please have the following information available:

- Member's ID Number
- Member's Date of Birth
- Payment Method

Prescription Drug Benefit Program Overview

The Prescription Drug Benefit chart on page 5 summarizes drug categories such as non-specialty preferred generics, non-specialty preferred brand drugs, non-preferred brands and generics, and specialty brand/generic drugs, as well as deductible and out-of-pocket maximum information. This pharmacy section is a resource for information regarding:

- Options for filling your prescription medications;
- The HBP Prescription Drug Benefit guidelines;
- Benefits coverage and clarification; and

• Pharmacy Management programs

Understanding the *EHP Prescription Drug Formulary*

The medications in the *EHP Prescription Drug Formulary* are chosen by a group of healthcare professionals known as the Pharmacy and Therapeutics (P & T) Committee. This committee reviews and selects FDA-approved prescription medications for inclusion in the *EHP Prescription Drug Formulary* based on the drug's safety, effectiveness, quality and cost to the benefit program. All medications that have been reviewed but not added to the *EHP Prescription Drug Formulary* or that have not yet been reviewed by the P & T Committee are considered Non-Formulary.

You are encouraged to share the drug formulary with your physician when he or she is prescribing your medication to help insure the most appropriate prescription drug therapy for your needs. Appropriate and cost-effective use of pharmaceutical therapies can be key to a successful strategy for improving individual member care while helping to keep the cost of prescription medications affordable.

The P & T Committee reviews and updates the *EHP Prescription Drug Formulary* throughout the year. Medications may be added to or removed from the drug formulary during the year. The Cleveland Clinic Employee Health Plan may add medications to the drug formulary four times a year. Medications may be removed from the drug formulary twice a year, once at the start of the benefit year in January and again at mid-year in July.

The drug formulary is available on our website at **https://employeehealthplan.clevelandclinic.org** and is updated on a quarterly basis. The listing of a drug in the *EHP Prescription Drug Formulary* does not guarantee coverage.

Filling Your Prescriptions

Through your Prescription Drug Benefit you have six options for filling your prescription drug medication(s). The six options described on the following pages include: Cleveland Clinic Outpatient Pharmacies; Cleveland Clinic Specialty Pharmacy; Cleveland Clinic Home Delivery Pharmacy; the CVS store pharmacies; the CVS Caremark mail Service Program; and the CVS Caremark Specialty Pharmacy.

Cleveland Clinic Outpatient Pharmacies and Specialty/Home Delivery Pharmacy[14]

EHP members receive a lower percentage co-insurance for their prescriptions by using Cleveland Clinic Outpatient Pharmacies in Ohio and Florida (Option 1) or the Specialty/Home Delivery Pharmacy (Option 2). In addition, a deductible will not be charged for prescriptions filled at these pharmacies with a generic medication. Call the pharmacy hotline at 216.445.MEDS (6337) for answers to your questions and to obtain pharmacist consultation services. You may receive up to a 90-day supply of medication at any of the Cleveland Clinic Outpatient Pharmacies.

You may pick up your prescriptions at any of the locations listed below or you can have your prescription(s) mailed to your home by using the Cleveland Clinic Specialty/Home Delivery Pharmacy. There is a turnaround time of up to ten business days for all specialty/home delivery pharmacy orders. **Please note:** You cannot drop off or pick up prescription orders at the Cleveland Clinic Specialty/Home Delivery Pharmacy.

Cleveland Clinic Pharmacies, Specialty, or Home Delivery Pharmacy

- **Cleveland Clinic Specialty Pharmacy**
  Direct Dial: 216.448.7732; Fax: 216.448.5601
  Toll-free: 844.216.7732; Fax: 844.337.3209
  Monday–Friday, 7 a.m.–6 p.m.

- **Cleveland Clinic Home Delivery Pharmacy**
  Direct Dial: 216.448.4200; Fax: 216.448.5603
  Toll-free: 855.276.0885
  Monday–Friday, 7 a.m.–6 p.m.

14. The Cleveland Clinic Specialty/Home Delivery Pharmacy is only available to members within the states of Florida, Indiana, Michigan, Nevada, New Jersey, New York (only for specialty medications), Ohio, Pennsylvania, Virginia, West Virginia and Wisconsin. All other members can utilize the CVS Caremark Mail Service Program.

Cleveland Clinic Pharmacies – Locations and Hours of Operation

• Akron General Medical Center Location

Akron General Medical Center
Ambulatory Care Pharmacy
1 Akron General Avenue, Akron, OH 44307

330.344.7732, Fax: 330.344.2927
Monday–Friday, 8 a.m.–6:30 p.m.

• Cleveland Clinic Pharmacies On Main Campus

Euclid Avenue Pharmacy (Parking Garage)
216.445.MEDS (6337), Fax: 216.445.6015
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.636.0760
Monday–Friday, 7 a.m.–8 p.m.
Saturday, Sunday and all Cleveland Clinic Holidays, 9 a.m.–5 p.m.

Crile Pharmacy (A Building)
216.445.MEDS (6337), Fax: 216.445.7403
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.636.0761
Monday–Friday, 8 a.m.–6 p.m.

Cleveland Clinic Children's Pharmacy (R Building)
216.445.MEDS (6337), Fax: 216.444.9514
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.636.0762
Monday–Friday, 9 a.m.–6 p.m.

Taussig Cancer Center (CA Building)
216.445.MEDS (6337), Fax: 216.445.2172
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.636.0763
Monday–Friday, 8 a.m.–6 p.m.

• Cleveland Clinic Family Health Centers

Beachwood Family Health Center Pharmacy
26900 Cedar Road, Beachwood, OH 44122
216.445.MEDS (6337), Fax: 216.839.3271
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.839.3270
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

Independence Ambulatory Pharmacy
5001 Rockside Road, Independence, OH 44131
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.986.4610
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

Middleburgh Heights Ambulatory Pharmacy
17840 Bagley Road, Middleburgh Heights, OH 44130
Toll-free: 866.650.MEDS (6337), Fax: 440.202.2810
Direct Dial: 440.202.2800
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

North Coast Cancer Care Ambulatory Pharmacy
417 Quarry Lakes Drive, Sandusky, OH 44870
Toll-free: 866.650.MEDS (6337), Fax: 419.609.2869
Direct Dial: 419.609.2845
Monday–Friday, 9 a.m.–4 p.m.

Richard E. Jacobs Family Health Center Pharmacy
33100 Cleveland Clinic Boulevard, Avon, OH 44011
216.445.MEDS (6337), Fax: 440.965.4109
Toll-free: 866.650.MEDS (6337)
Direct Dial: 440.695.4100
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.
Saturday, 9 a.m.–1 p.m.

Stephanie Tubbs Jones Health Center Pharmacy
13944 Euclid Avenue, East Cleveland, OH 44112
216.445.MEDS (6337), Fax: 216.767.4128
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.767.4200
Monday–Friday, 9 a.m.–5 p.m.

Strongsville Family Health Center Pharmacy
16761 Southpark Center, Strongsville, OH 44136
216.445.MEDS (6337), Fax: 440.878.3148
Toll-free: 866.650.MEDS (6337)
Direct Dial: 440.878.3125
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

Twinsburg Family Health Center Pharmacy
8701 Darrow Road, Twinsburg, OH 44087
216.445.MEDS (6337), Fax: 330.888.4105
Toll-free: 866.650.MEDS (6337)
Direct Dial: 330.888.4200
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

Willoughby Hills Family Health Center Pharmacy
2570 SOM Center Road, Willoughby, OH 44094
216.445.MEDS (6337), Fax: 440.516.8629
Toll-free: 866.650.MEDS (6337)
Direct Dial: 440.516.8620
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

• Cleveland Clinic Regional Hospital Locations

Fairview Hospital Health Center Pharmacy
18099 Lorain Road, Cleveland, OH 44111
216.445.MEDS (6337), Fax: 216.476.9905
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.476.7119
Monday–Friday, 7 a.m.–7 p.m.; Saturday, 9 a.m.–1 p.m.

Hillcrest Ambulatory Pharmacy
6770 Mayfield Road, Mayfield Heights, OH 44124
440.312.5854, Fax: 440.312.5856
Monday–Friday, 7 a.m.–7 p.m.; Saturday, 9 a.m.–1 p.m.

Indian River Hospital Pharmacy
1000 36th St. Vero Beach, FL 32960
772.290.6970, Fax: 772.290.6971
Monday–Friday, 9 a.m.–5:30 p.m.

Lutheran Hospital Ambulatory Pharmacy
1730 West 25th Street, Cleveland, OH 44113
216.445.MEDS (6337), Fax: 419.774.3140
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.696.7055
Monday–Friday, 9 a.m.–5 p.m.

Mansfield Cancer Center Ambulatory Pharmacy
1125 Aspira Court, Mansfield, OH 44906
216.445.MEDS (6337), Fax: 419.774.3140
Toll-free: 866.650.MEDS (6337)
Direct Dial: 419.774.3121
Monday–Friday, 8 a.m.–4 p.m.

Marymount Family Pharmacy
12000 McCracken Road, Suite 151
Garfield Heights, OH 44125
216.445.MEDS (6337), Fax: 216.587.8844
Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.587.8822
Monday–Friday, 8 a.m.–6 p.m.

Medina Hospital Ambulatory Pharmacy
1000 East Washington Street, Medina, OH 44256
216.445.MEDS (6337), Fax: 330.721.5495
Toll-free: 866.650.MEDS (6337)
Direct Dial: 330.721.5490
Monday–Friday, 9 a.m.–5 p.m.

Mercy Professional Pharmacy
1330 Mercy Drive NW, Canton, OH 44708
330.489.1400, Fax: 330.489.1175
Monday–Friday, 7 a.m.–7 p.m.; Saturday, 9 a.m.–1 p.m.

Cleveland Clinic Florida Ambulatory Pharmacy
2950 Cleveland Clinic Boulevard, Weston, FL 33331
954.659.MEDS (6337), Fax: 954.659.6338
Toll-free: 866.2WESTON (293.7866)
Direct Dial: 954.659.6337
Monday–Friday, 8 a.m.–7 p.m.

Martin Memorial Medical Center Pharmacy
200 SE Hospital Ave., Stuart FL 34995
772.288.5813, Fax:772.221.2064
Monday–Friday, 7:30 a.m.–6 p.m.

Martin Health Physician Group Traditional Pharmacy
10080 SW Innovation Way, Suite 102
Port Lucie, FL 34987
772.345.8166, Fax: 772.345.8167
Monday–Friday, 7:30 a.m.–6 p.m.

Union Hospital Outpatient Pharmacy ..... 330.365.3845, Fax: 330-365-3817
659 Boulevard Street, Dover, OH 44622 Monday–Friday: 7 a.m.–6 p.m.,
Saturday: 7 a.m.–3 p.m., Sunday: Closed

Cleveland Clinic Specialty/Home Delivery Pharmacy Ordering Instructions

The Specialty/Home Delivery Pharmacy is designed to ship medication directly to your home with **no shipping charge.** By using the Specialty/Home Delivery Pharmacy, members receive a lower percentage co-insurance for their medications compared to the CVS Caremark Retail Pharmacy Network and can enjoy the convenience of having 90-day supplies of their maintenance medications delivered directly to their home. Here's how you can get started:

1. Go to the MyRefills website at **https://myrefills.clevelandclinic.net** to set up your account, change your billing information and shipping address, or to check on the status of your order.

   You may also set up your account by completing a Specialty/Home Delivery Service Processing Form. You can call the Home Delivery Pharmacy at 216.448.4200 or toll-free at 855.276.0885 to have this form mailed or faxed to you. The form is also available on our website at **https://employeehealthplan.clevelandclinic.org**. Fill out the form to indicate payment and shipping information for you and your dependents. This information will be kept on file to avoid filling out a form every time you place a prescription order.

   Note: you will have to set up your Specialty/Home Delivery account before the Specialty/Home Delivery Pharmacy can process and ship your order. In addition, each member that wishes to use the Specialty/Home Delivery Pharmacy needs a separate account.

2. The Specialty/Home Delivery Pharmacy receives prescription order in the following ways:
   - Called in by your physician to 855.276.0885
   - Faxed in by your physician to 216.448.5603
   - e-Scripted by your physician via EPIC (CCF Home Delivery Pharmacy)
   - Requested online through **https://myrefills.clevelandclinic.net**.
   - If you have a hard copy of a new prescription, by law, you cannot fax the prescription to the Specialty/Home Delivery Pharmacy. Please mail the prescription to:

     Cleveland Clinic Specialty/Home Delivery Pharmacy
     9500 Euclid Ave. AC5b-137
     Cleveland, OH 44195
     Phone: 216.448.4200, Fax: 216.448.5603
   - If you are transferring a prescription from a pharmacy other than a Cleveland Clinic Outpatient Pharmacy, please contact the Specialty/Home Delivery Pharmacy at 216.448.4200 for assistance. **Please note:** Members cannot drop off or pick up their orders at the Specialty/Home Delivery Pharmacy. Orders will be shipped free of charge to the address you designate.

The Cleveland Clinic Specialty/Home Delivery Pharmacy is available Monday-Friday from 7 a.m. to 6 p.m. Please allow **ten business days** from the time they **receive** your prescription(s) for delivery.

Please note: Eligibility is based upon the date the Specialty/Home Delivery Pharmacy processes your prescription order and not on the day your order was received.

Please call 216.448.4200 for questions or additional information on the Cleveland Clinic Home Delivery Pharmacy or call 216.448.7732 to speak with the Cleveland Clinic Specialty Pharmacy

Advantages of Utilizing the Cleveland Clinic Outpatient Pharmacies and Home Delivery Pharmacy

- *Lower cost:* You will pay less for prescription co-insurance. In addition, your deductible will be waived for prescriptions filled with a generic medication at these pharmacies.
- Discount card available for non-covered medications (EXPO Card).
- *Convenience:* You may request a 90-day supply of non-specialty medications at any Cleveland Clinic Outpatient Pharmacy. **Note: The prescription must be written for a 90-day supply.**

- *Peace of mind:* You will have access to a toll-free hotline number for questions ad pharmacist consultation services during regular business hours.

CVS Caremark Retail Pharmacy Network

Members have the option of picking up acute care prescriptions such as antibiotic therapy or pain medications or the first fill of any maintenance medication (limited to a 30-day supply) at any Cleveland Clinic Outpatient Pharmacy or CVS store pharmacy. Refills of maintenance medications must be obtained through one of the three options identified in the Mandatory Maintenance Drug Program section on page 42. A complete list of these pharmacies can be found on the CVS Caremark website at **https://www.caremark.com**. Please note that when using a CVS store pharmacy or the CVS Caremark Program, member co-insurance is higher when compared to obtaining your prescriptions from a Cleveland Clinic Outpatient Pharmacy.

CVS Caremark Mail Service Program

New Prescriptions

CVS Caremark's Mail Service Program provides a way for you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home. Follow this easy step-by-step ordering procedure:

1. Ask your doctor to write/electronically send two prescriptions.
2. Visit the CVS Caremark website at **https://www.caremark.com**. Click on "Get Started" and create a CVS account. Have your provider send prescriptions electronically to CVS mail order.
3. Complete a Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate payment for each prescription. Be sure to include your **original prescription**, not a photocopy. Forms are available on CVS Caremark's website at **https://www.caremark.com**.

Mail Service Refills

Once you have processed a prescription through CVS Caremark, you can obtain refills using the Internet, phone or mail. Please order your prescription three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from CVS Caremark. You will receive specific instructions related to refills from CVS Caremark.

Prescription Drug Benefit Guidelines

Deductible

The Prescription Drug Benefit has an annual deductible of $200 individual/$400 family.

Note: The annual deductible is waived if:

1. The member uses a Cleveland Clinic Outpatient Pharmacy to obtain their prescription **and**
2. The prescription is filled using a **generic** medication

   This waiver is considered a value-added benefit. All prescriptions filled at a non-Cleveland Clinic Pharmacy and all prescriptions filled with a brand name medication at any Cleveland Clinic Outpatient Pharmacy or Specialty/Home Delivery Pharmacy are subject to the annual deductible.

   Note: Members who live in an area of the country not serviced by a Cleveland Clinic Outpatient Pharmacy or Specialty/Home Delivery Pharmacy are not eligible for a waiver of the annual pharmacy deductible. The amount you have contributed to your annual deductible resets to $0 at midnight on December 31 each year. It is based on a rolling 365 days.

Deductible and Out-of-Pocket Maximum

Your annual deductible must be satisfied before your out-of-pocket pharmacy expenses begin accumulating toward your annual out-of-pocket maximum expense. Not all pharmacy charges apply toward the deductible and out-of-pocket (OOP) maximum expenses. The total charges for medications not covered by the benefit program (e.g. Viagra, Levitra, weight control products, cosmetic agents, etc.) do not apply to either the deductible or out-of-pocket expenses.

In addition, if a generic version of the prescribed brand medication exists, the Prescription Drug Benefit will cover only up to the price of the generic version. If you receive the brand name medication, you are required to pay the price difference between the generic and the brand medication. That difference does not apply to the deductible or the OOP maximum (see Generic Medication Policy below).

Generic Medication Policy

The Cleveland Clinic HBP supports and encourages the use of FDA-approved generic medications that are both chemically and therapeutically equivalent to manufacturers' brand name products. Generically equivalent products are safe and effective treatments that offer savings as alternatives to brand name products.

Drugs that are available as a Non-Specialty generics (Tier 1) or Specialty generics (Tier 4) are designated in the *EHP Prescription Drug Formulary* with an asterisk (*). Specialty generics will have an (SP) and an asterisk (*) in their entry to denote they are covered at Tier 4. However, certain generic medications are considered non-preferred medications and are listed in the *EHP Prescription Drug Formulary.* All other drugs listed are Preferred Non-Specialty Brands (Tier 2) or Specialty (SP) Brand drugs (Tier 4).

If a member or physician requests the brand name drug be dispensed when a generic is available, the participant will be required to pay their generic co-insurance AND the cost difference between the brand name drug price and the generic drug price.

Prior Authorization

Prior authorization is required for coverage of certain medications. These medications are listed in the Pharmacy Management Program section of the EHP Prescription Drug Formulary. This list may change during the year due to new drugs being approved by the FDA or as new indications are established for previously approved drugs. A Prior Authorization, Formulary Exception and Appeal form must be completed, or sufficient documentation must be submitted by the member's provider before a case will be reviewed. Please refer to the Formulary Failure Review Process below for information about obtaining a form. Completed forms can be faxed to 216.442.5790.

All prior authorization requests must meet the clinical criteria approved by the Pharmacy and Therapeutics (P & T) Committee before approval is granted. Obtaining medications through a previous insurance plan or from prior use and participation in a manufacturer bridge or assistance program does not supersede EHP medication-specific prior authorization criteria and does not guarantee coverage under the EHP. Members will still be required to meet all of the EHP P&T approved prior authorization criteria for coverage of the requested medication. In some cases, approvals will be given a limited authorization date. If a limited authorization is given, both the member and the physician will receive documentation on when this authorization will expire. Prior authorization approvals are subject to future plan benefit changes or utilization management programs that may impact coverage of the authorized medication. A response will be faxed to the requesting physician, and the member will be informed of the request and the decision via mail.

Note: Prior authorization approvals are effective from the initial date of the authorization. No refunds or adjustments will be made for previously purchased medications. Depending upon the strength and/or formulation of the drug prescribed by your provider, different quantity limits apply. Please consult the Quantity Level Limits section located in the Pharmacy Management Program section of the EHP Drug Formulary for specific quantity limits that apply to the particular strength/formulation of your medication.

Formulary Failure Review Process

The *EHP Prescription Drug Formulary* is designed to meet the needs of the majority of HBP members. However, if it is determined that you require treatment with a medication not included in the *EHP Prescription Drug Formulary,* your physician may request a review for preferred coverage of a Non-Formulary medication. To start the review process, your physician should call the EHP Pharmacy Management Department at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 and request a *Prior Authorization, Formulary Exception and Appeal Form.* The form is also available online at **https://employeehealthplan.clevelandclinic.org**.

Physicians should complete the form using specific laboratory data, physical exam findings, and other supporting documentation whenever possible in order to document the medical necessity of using a Non-Formulary medication. Approvals will be granted only if the physician can document ineffectiveness of Formulary alternatives or the reasonable expectation of harm from the use of Formulary medications. A separate form should be submitted for each member for each Non-Formulary drug.

All requests must be in writing and signed by the prescribing physician. If a Non-Formulary, Non-Specialty brand name drug is approved, the member will be responsible for a 30% coinsurance with no monthly maximum out-of-pocket. If a Non-Formulary, Non-Specialty generic drug is approved, the member will be responsible for 20% coinsurance with no monthly maximum out-of-pocket. If a Non-Formulary, Specialty brand name or Specialty generic drug is approved, the member will be responsible for 20% coinsurance with no monthly maximum out-of-pocket.

Note: Lower co-insurance will be assessed from the date of authorization. No refunds or adjustments will be made for previously purchased prescriptions. Depending upon the strength and/or formulation of the drug prescribed by your provider, different quantity limits apply. Please consult the Quantity Level Limits section located in the Pharmacy Management Program section of the *EHP Prescription Drug Formulary* for specific quantity limits that apply to the particular strength/formulation of your medication.

Instructions for a Physician on How to Complete the *Prior Authorization, Formulary Exception and Appeal Form* (available on our website at https://employeehealthplan.clevelandclinic.org):

1. Complete all information requested.
2. Submit a **separate form** for each member and for each drug you wish to have reviewed.
3. Keep a copy for your records.
4. Fax the form to: Cleveland Clinic Employee Health Plan
   EHP Pharmacy Management Department – 216.442.5790

   OR

   Mail the form to: Cleveland Clinic Employee Health Plan
   EHP Pharmacy Management Department
   6000 West Creek Road, Suite 20, Independence, OH 44131

Exception Process – Once received, requests will be processed within 10 days. Expedited requests (processed with 72 hours) may be made by calling EHP Pharmacy Management at 216.986.1050, option 4. In most cases, these requests will be reviewed and processed the same business day; however, calls received after 4 p.m. or during the weekend will be handled the next business day. One of the following criteria must be met to file an expedited request:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility (e.g. hospital, skilled nursing facility).
- The timeframe required for a standard review would compromise the member's life, health or functional status.
- The drug requires administration in a timeframe that will not be met using the standard process.

Pharmacy Benefits Coverage Clarification

The following pages included detailed benefit coverage clarification information about the EHP Prescription Drug Benefit. This information complements and further explains the Prescription Drug Benefit chart on page 5 in this SPD.

Breast Cancer Prevention Coverage

Under the provisions of the Affordable Care Act mandate regarding breast cancer preventive health services, generic raloxifene and tamoxifen will be covered under the EHP Prescription Drug Benefit at no out-of-pocket expense only for female members 35 years of age or older when accompanied by a valid prescription from the member's healthcare provider.

Two medications used in the prevention of breast cancer, generic anastrozole and generic exemestane, will also be covered at no member cost. If the member's individual medical condition meets the criteria set forth by the United States Preventive Services Task Force. Members or providers can obtain the *Aromatase Inhibitor for Breast Cancer Risk Reduction Formulary Exception form* located on our website at **https://employeehealthplan.clevelandclinic.org** to request coverage of these medications at no member cost.

Contraceptive Coverage

Under the provisions of the Affordable Care Act mandate regarding women's preventive health services, contraceptives will be covered under the EHP Prescription Drug Benefit within the following guidelines:

- Diaphragms, emergency contraceptives, generic oral contraceptives, generic injectables (medroxyprogesterone) will be covered with no out-of-pocket expense for the member. However, a prescription from your health care provider is required.
- Brand name oral contraceptives that are not available generically require prior authorization. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization is denied, the brand name contraceptive will not be covered.
- Members who receive brand name formulation of a contraceptive that is available generically will not pay any co-insurance, but will be charged the difference in cost between the brand name contraceptive product and the generic alternative.

- Contraceptive products that do not require a prescription to be purchased are not covered under the EHP Prescription Drug Benefit.
- Mirena and other intrauterine devices (IUD's) are not covered under the EHP Prescription Drug Benefit. Rather, they are covered under the medical benefit and no copayment will be charged.

Oral Medications for Onychomycosis (Nail Fungus)

All oral prescriptions for the treatment of nail fungus are covered at the Non-Preferred rate (see the Prescription Drug Benefit chart on page 5), which is 45% at Cleveland Clinic Outpatient Pharmacies and Home Delivery Service or 50% at all other locations. This Non-Preferred rate is in effect for brand name and generic medications appropriate for treating this condition. Formulary overrides to reimburse 25% at Cleveland Clinic Outpatient Pharmacies or 30% at all other locations are given to members who have this condition and diabetes or some form of peripheral vascular disease (poor blood flow). Overrides are also given to any member who has the fingernail form of this condition; however, only one course of treatment will be covered at the formulary rate in a lifetime. To obtain an override, please have your health care provider complete and submit a *Prior Authorization Formulary Exception and Appeal Form*.

Over-the-Counter (OTC) Medications

Certain over-the-counter (OTC) medications that are available without a prescription are covered under the Prescription Drug Benefit.

The member must have a prescription from his or her provider and fill the prescription at a Cleveland Clinic Pharmacy or CVS Caremark Retail Network Pharmacy. The list includes:

- **Iron Supplements:** Covered at 100% for members 0-12 months
- **Oral Fluoride Products:** Covered at 100% for members age 0-5 years
- **Folic Acid:** Covered at 100% for **female** members age 40 and under
- **Nicotine Cessation Medications:**
  - Must be prescribed by an EHP approved Nicotine Cessation provider (in person) or EHP Nicotine Cessation Health Coaching program provider (online only)
  - Coverage includes generic bupropion, generic varenicline tablets, generic nicotine gum, generic nicotine lozenges, and generic nicotine patches.
  - **Prescriptions must be filled at any Cleveland Clinic Outpatient Pharmacy**

All other OTC medications are not covered. When an OTC drug is available in the identical strength and dosage form as the prescription medication, and is approved for the same indications, the prescription drug is usually not covered by the HBP. Providers should recommend the equivalent OTC product to the member.

Pre-exposure Prophylaxis (PrEP) Coverage

Under the provisions of the Affordable Care Act mandate regarding PrEP treatment, medications used in members at high risk for HIV infection will be provided at no member cost, if the use is for PrEP. If the use is for the treatment of HIV infection or for post-exposure prophylaxis, the member's copayment will be adjusted upward to maximize the financial benefit offered by the pharmaceutical manufacturer as part of the Specialty Drug Copay Care Assistance Program. Truvada will remain the preferred agent, with Descovy being the alternative product. Both generic Truvada and Descovy will continue to require prior authorization. Coverage request approved by PrEP will be coded in the pharmacy claims adjudication system such that the member's annual pharmacy deductible and any co-insurance are waived.

Statin Medications for Prior Prevention of Cardiovascular Disease

Under the provisions of the Affordable Care Act mandate regarding cardiovascular disease preventive health services, generic formulary low to moderate dose statins will be covered under the EHP Prescription Drug Benefit at no member out-of-pocket expense within the following guidelines:

1. Members are between 40 and 75 years of age.
2. Members on generic formulary low to moderate dose statins require prior authorization in order to receive their medication at no member out-of-pocket expense. To begin this process, please have the prescribing provider submit a *USPSTF Copay Free Statin Coverage Request Form* (available on our website at **https://employeehealthplan.clevelandclinic.org**) to the EHP Pharmacy Management Department. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the standard plan benefits will apply regarding statin coverage.

3. Members who receive a brand name formulation of a formulary statin that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name statin product and the generic alternative.
4. For members who do not go through the prior authorization process, the standard plan benefits will apply regarding statin coverage.
5. Statin products that do not require a prescription to be purchased are not covered under the Prescription Drug Benefit (i.e. red yeast rice).

Pharmacy Management Programs

All medications pertaining to the following programs can be found in the Pharmacy Management Program section of the *EHP Prescription Drug Formulary* or on our website.

Mandatory Maintenance Drug Program

Members may use any of the Cleveland Clinic Outpatient Pharmacies or a CVS store pharmacy for obtaining prescription medications for an immediate need, a one-time prescription medication (example: antibiotics), or the **first fill** of a maintenance medication (limited to a 30-day supply). Maintenance medications include drugs taken regularly to treat chronic medical conditions such as asthma, diabetes or high blood pressure, as well as drugs taken on a long-term basis, such as contraceptives.

Refills of all maintenance drugs must be obtained through one of the following three options:

- **Cleveland Clinic Pharmacy Home Delivery Service** – Home delivery enables you to order up to a 90-day supply of your maintenance medication refill prescriptions, which are delivered to your home, saving you a trip to the pharmacy. There is no extra charge for home delivery, and you will save 5% on your co-insurance compared to using the CVS Caremark Mail Service Program (see page 37 for details).
- **Cleveland Clinic Outpatient Pharmacies** – Drop off your maintenance prescriptions for refill at any of the Cleveland Clinic Outpatient Pharmacy locations in northeast Ohio or the Weston Pharmacy in Florida. You can obtain up to a 90-day supply of medication and you will save 5% on your co-insurance (see page 34 for details).
- **CVS Caremark Mail Service Program** – You can order up to a 90-day supply of your maintenance medication prescription to be delivered to your home, but you not get the same 5% discount available when you order your prescription from a Cleveland Clinic Outpatient Pharmacy or the Home Delivery Pharmacy.

In addition, some maintenance medications must be refilled for three month supplies at a Cleveland Clinic Outpatient Pharmacy, through the Cleveland Clinic Home Delivery Pharmacy, or through the CVS Caremark Mail Service in order to be covered. A complete list of these maintenance medications can be found at **https://employeehealthplan.clevelandclinic.org**.

Medications Limited by Provider Specialty

The continual development of complex drug therapy options requires that certain medications be prescribed by an appropriate specialist (e.g. cardiologist, neurologist, oncologist) to ensure appropriate use. If these medications are not prescribed by an approved specialist prior authorization must be obtained for coverage under the Prescription Drug Benefit. The first medication included in this category is **Multaq**, which must be prescribed by a cardiologist. Additional medication limited by provider specialty (prescription written by a specialist) may be added to the *EHP Prescription Drug Formulary* in the future. Prescriptions written by non-specialists will need prior authorization. Please consult the prescription drug formulary to determine if your medication is limited by provider specialty.

Quantity Level Limits

Quantity level limits are applied to medication for various reasons. For example, to prevent medication misuse or abuse, to promote adherence to an appropriate course of therapy for reasons of efficacy and safety, and to prevent the stockpiling of medication. The HBP will continue to monitor drug utilization to possible expand quantity level limits for other medications. A list of these medications can be found in the Pharmacy Management Program section of the *EHP Prescription Drug Formulary*.

Split Fill Program

Members **beginning** therapy with any of the medications in this program will be limited to a 15-day supply for the initial two months of therapy to ensure the member tolerates the medication. Please refer to Pharmacy Management Program section of the *EHP Prescriptions Drug Formulary.*

Step Therapy Program

The Step Therapy Program promotes the first-line use of effective, value-based medications over higher cost alternatives. Prescriptions for equally effective – but less expensive – generic medications for covered conditions will be approved with preferred rates. The Step Therapy Program stops payment of prescription claims for higher cost alternative medications that have not received prior authorization. The medications included in this program can be found in the Pharmacy Management Program section of the *EHP Prescription Drug Formulary.*

Specialty Drug Benefit

Specialty brand and generic drugs can be obtained from any Cleveland Clinic Outpatient Pharmacy including the Specialty Pharmacy or from the CVS Specialty Pharmacy. Members enjoy lower out-of-pocket expenses by using a Cleveland Clinic Outpatient Pharmacy to obtain their specialty drugs. Members with certain chronic conditions may wish to participate in the Accordant Rare Condition Management Program (see page 37). Specialty drugs are limited to a 30-day supply.

Members will be responsible for their co-insurance for all drugs that are determined to be self-administrable by the member. Self-administrable medications are defined as medications that are typically administered orally or subcutaneously (SC) and have patient instruction for use in the package insert (PI). Some intramuscular injections are also considered self-administrable due to frequency of injection and PI instructions for the patient on how to self-administer the drug. A co-insurance applies at all locations where the drug can be obtained. If a self-administrable drug is administered in a doctor's office, the member will be responsible for the office copayment as well as the drug co-insurance. If administered in the physician's office, the co-insurance is not applied to the pharmacy deductible or out-of-pocket maximum, unless stated otherwise in the list of specialty drugs in the EHP Prescription Drug Formulary as being a medication that is white-bagged. White-bagging refers to a specialty pharmaceutical that is not intended to be self-administered being shipped or delivered by an in-network specialty pharmacy directly to the location where it will be administered by the member's chosen health care provider.

Specialty drugs CANNOT be obtained through the CVS Caremark Retail Pharmacy Network. There are two options for obtaining these medications:

1. Cleveland Clinic Specialty Pharmacy or Cleveland Clinic Outpatient Pharmacies in Ohio and Florida
2. CVS Specialty Pharmacy – toll-free at 800.237.2767

A full list of specialty medications can be found in the Pharmacy Management Program section of the *EHP Prescription Drug Formulary*.

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug benefit for you and your family, Cleveland Clinic EHP has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the EHP's prescription benefit specialty drug list are included in the program and will be subject to a 30% co-insurance. However, if a member enrolls in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications – in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members must call PrudentRx at 1.800.578.4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you choose to opt out of the program, you must call 1.800.578.4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution, after satisfying their annual prescription benefit deductible.

If you or a covered family member are not currently taking, but will start a new specialty medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

PrudentRx improves upon the current EHP specialty drug copay card assistance program and provides deeper discounts for our members on many specialty medications. There are a handful of specialty medications currently a part of our internal EHP specialty drug copay card assistance program that are not included in the PrudentRx program. Our existing EHP specialty drug copay card assistance program will continue to provide discounts for these drugs. Since either list may be updated periodically, please visit the EHP website at **https://employeehealthplan.clevelandclinic.org** for an up-to-date list of specialty medications included in each program.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available upon request. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1.800.578.4403 to address any questions regarding the PrudentRx Solution.

Specialty Drug Copay Card Assistance Program

The Cleveland Clinic Employee Health Plan reserves the right to change/adjust specialty drug copays to meet the needs of a manufacturer sponsored variable member copay assistance program. As such, certain specialty medications require the use of the manufacturer's copay assistance card. For those specialty medications included in the Copay Card Assistance Program, the member's copay will be adjusted upward to maximize the financial benefit offered by the pharmaceutical manufacturer, but this adjustment will be completely offset by the copay card, such that members will have **no additional out-of-pocket expense above and beyond what they are currently paying for their specialty medication.** The value of the manufacturer's copay card will apply to your annual deductible but will not apply to your annual out-of-pocket maximum.

In the event the manufacturer discontinues a specialty medication's copay assistance card, the member's cost share will revert back to the benefit design outlined.

Please refer to the EHP Prescription Drug Formulary for a full list of specialty medications included in the Copay Card Assistance Program. If you have questions, please contact EHP Pharmacy Management at 216.986.1050, option 4.

Prescription Drug Benefit Exclusions

1. The replacement of lost or damaged prescriptions.* Stolen medications will be covered at the benefit program rate when accompanied by a police report.
2. Drugs prescribed for the treatment of sexual dysfunction.
3. Drugs to enhance libido function.
4. Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.
5. Drugs used for experimental or investigational purposes.
6. Drugs used for cosmetic purposes.
7. Drugs not included in the Patient Protection and Affordable Care Act that can be purchased without a prescription.
8. Medicinal foods (regardless of whether they require a prescription or not).
9. Insulin pumps and insulin pump supplies except for Omnipod Dash, Omnipod 5 G6 – covered under pharmacy benefit with prior authorization).
10. Prescriptions ordered or provided by a member of your immediate family.
11. Histamine H2 Receptor Antagonist (H2RA) drugs for members one year of age or older.
12. Proton Pump Inhibitor (PPI) drugs for members one year of age or older.

13. Nasal corticosteroid drugs.
14. Medical devices approved via the FDA 510(k) Premarket Notification review process.
15. Unapproved prescription drugs that do not have FDA approval such as drugs grandfathered, DESI, or GRAS/E.
16. Viscosupplementation and intra-articular hyluronate products.
17. Aduhelm
18. Amondys 45
19. Elevidys
20. Emflaza
21. Exondys 51
22. Makena
23. Vyondys 53
24. Autologus serum eye drops (ASED)
25. Nasal Antihistamine drugs
26. Anti-Obesity Medications

Refer to the Pharmacy Management Program section of the *EHP Prescription Drug Formulary* to see Discounted Drugs at 100% Coinsurance and Non Covered Drugs.

* Members may contact Pharmacy Management at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 between the hours of 8 a.m. and 4:30 p.m., Monday through Friday to request an override so that they are able to purchase a replacement supply at their expense. The member will be responsible for 100% of the discounted price.

Prescription Drug Coverage Under Medicare

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) includes a prescription drug program to Medicare Part D for individuals who are enrolled in Medicare.

Typically, individuals become "entitled to" Medicare Part A when they reach age 65 and receive Social Security benefits. An individual is eligible for Medicare Part D Prescription Drug Benefits if covered by Medicare Part A and/or enrolled in Medicare Part B. Individuals under age 65 may also become entitled to Medicare benefits if they receive at least 24 months of Social Security benefits based on disability.

Members potentially eligible for Medicare Part D include:

- Active working employees who become Medicare eligible;
- Dependents (such as spouses) of active working employees who are Medicare eligible;
- Disabled dependents (e.g., children) eligible for Medicare; and
- Long-Term Disability (LTD) recipients who become Medicare eligible.

All Medicare prescription drug plans provide a standard level of coverage established by Medicare. Some plans, however, offer additional coverage for a higher premium.

The Health Benefit Program determined that your existing coverage with the HBP is as good as standard Medicare coverage. In many cases, coverage under the HBP actually exceeds the standard Medicare coverage.

If you should become Medicare eligible, it is important that you evaluate both the HBP's SilverScript® Prescription Drug Benefit and the Medicare Prescription Drug Benefit to determine which benefit program best meets your specific needs. Compare your current coverage, including which drugs are covered, with the drug coverage and cost of plans offering Medicare Prescription Drug Benefits before making a decision to enroll with a Medicare program.

It is important to note that if you enroll in a Medicare Part D plan other than through the HBP SilverScript®, you may no longer participate in the HBP. You will lose both your Cleveland Clinic medical and pharmacy benefits and will not be eligible to return to the HBP in the future.

Detailed information about the Medicare prescription drug plans that offer prescription drug coverage is available on Medicare's website at medicare.gov or by calling Medicare at 800.MEDICARE (800.63.4227). TTY users should call 877.486.2048.

Income Related Monthly Adjustment Amounts (IRMAA)

The Social Security Administration (SSA) makes an initial determination whether the income-related monthly adjustment amount (IRMAA) applies to Medicare beneficiaries with Part B, Part D, or both based on using Internal Revenue Service (IRS) data two years prior to claiming benefits. If your income is above a certain amount, you will be required to pay IRMAA.

If your filing status and yearly income in 2023 was:			Income-related Monthly adjustment amount
File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	
$106,000 or less	$212,000 or less	$106,000 or less	$0.00
Above $106,000 up to $133,000	Above $212,000 up to $265,000	Not Applicable	$13.30
Above $133,000 up to $166,000	Above $265,000 up to $332,000	Not Applicable	$34.30
Above $166,000 up to $199,000	Above $332,000 up to $398,000	Not Applicable	$55.40
Above $199,000 up to $500,000	Above $398,000 up to $750,000	Above $103,000 and less than $397,000	$76.50
$500,000 or above	$750,000 or above	$397,000 and above	$83.50

IRMAA will either be automatically withheld from your Social Security check or you will receive a monthly invoice. Failure to comply with IRMAA will result in Centers for Medicare & Medicaid Services (CMS) terminating your coverage with Part B, Part D or both. As a result, this will also include termination of your Retiree Medical and Pharmacy Benefits with Cleveland Clinic. For more information regarding IRMAA, please go to the Medicare website: medicare.gov or call toll-free at 800.MEDICARE (800.633.4227).

Exclusions

Cleveland Clinic Health Benefit Program Coverage Exclusions

Coverage is not provided for the following services and supplies:

General Exclusions

- Treatment that is not a covered service, even if authorized or deemed medically necessary by your physician.
- Care which is not medically necessary and/or has not received precertification. **If precertification is required and *NOT* obtained, the Health Benefit Program (HBP) is not obligated to reimburse for services even if it is a covered benefit.**
- Any treatment not recommended or approved by a physician or medical provider.
- Medical services that do not benefit the insured (*e.g.,* organ donation or certain genetic tests).
- Services ordered or provided by a member of your immediate family.
- Services that are not reasonable or necessary for the diagnosis or treatment of sickness or injury, including a non-medically necessary circumcision for a non-newborn or non-newly adopted child (up to one year after adoption), or any services associated with the use of general anesthesia when local anesthesia would be acceptable.
- Expenses payable in your behalf under Medicare, whether you are enrolled or not.
- Expenses paid by another Healthcare Plan.
- Services received under the following circumstances:
  - Physical examinations or services required by an insurance company to obtain insurance;
  - Physical examinations or services required by a governmental agency such as the Federal Aviation Administration, Department of Transportation, and Immigration and Naturalization Services;
  - Physical examinations or services required by an employer in order to begin or continue working, unless medically necessary;

  - Premarital examinations and associated required testing; or
  - Physical examinations or screening test for professional school or private school.
- Services provided at no charge or that normally would not generate a charge in the absence of this or another insurance plan.
- Treatment for any sickness or injury caused by war, acts of war or similar events – whether the war is declared or undeclared.
- Treatment for sickness or injury contracted while in any branch of the armed forces.
- Treatment for sickness or injury incurred while committing a felony, or other criminal activity.
- Expenses reimbursed for which you are entitled to reimbursement through any public program.
- Services or expenses that are prohibited by laws in the area in which you live.
- Charges in connection with an occupational injury covered by workers' compensation.
- Services for educational, vocational, or training purposes unless for an underlying medical condition.
- Services of any kind for developmental, diversional, or recreational purposes.
- Charges associated with eVisits, telephone consultations, missed appointments, completion of claim forms, or copies of medical records.
- Expenses associated with custodial, domiciliary, convalescent or intermediate care.
- Hospitalization for "rest cures" or convalescence in a nursing home.
- Charges incurred for care in which the member left the medical/behavioral health facility against medical advice (AMA).
- Bathroom convenience items including but not limited to tub rails, handrails and elevated toilet seats.
- Charges for experimental or investigational procedures, drugs, devices, or medical treatments.
- Services that would normally be reimbursed by Corporate Health.
- Personal clothing or comfort items such as orthopedic shoes, diabetic shoes, wigs, or hygiene items.
- Non-covered services or services specifically excluded in the text of this *Summary Plan Description*.
- Care that occurred prior to your effective date or after your coverage has been terminated.

Medical Coverage Exclusions

- Private duty nursing.
- Expenses solely for cosmetic procedures or complications from cosmetic procedures.
- Generally, services or procedures submitted with unlisted procedure codes are not covered. This may include some services with new procedure or new technology represented by unlisted or non-specific CPT codes.
- Charges for the removal of skin tags
- Expenses for the treatment of obesity, with the exception of registered dietician services, unless treatment has received precertification through the Medical Management Department.
- Services or expenses incurred for lap band surgery.
- Charges associated with teeth or periodontia unless specifically defined elsewhere in this *Summary Plan Description*.
- Reversal of voluntary infertility.
- Services for couples in which either partner has undergone a sterilization procedure, with or without surgical reversal, or in which the woman has had a hysterectomy, unless there are unique circumstances as determined by the Medical Management Department.
- Any new technology used in an experimental or investigational program.
- Charges associated with a gestational carrier program (surrogate parenting) for the member or the gestational carrier unless the member has congenital absence of the uterus or a traumatic insult to the uterus. This includes costs related to or resulting from a member becoming pregnant, as well as the delivery.
- Doula services.
- Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.
- Services provided for fitting of contact lenses.

- Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
- Hearing aid accessories.
- Charges associated with the rental or purchase of durable medical equipment (DME) when rental expense exceeds purchase price, or for replacement of equipment that can be repaired.
- Sales tax on medical supplies/DME items.
- Over-the-counter DME products, (i.e., grab bars for showers).
- Rehabilitation (lift) chairs.
- Home defibrillators.
- Take home supplies.
- Cardiac rehab stages 3 and 4.
- General orthotics that can be purchased over-the-counter including devices such as splints, shoe inserts, arch supports, and braces.
- Retrieval and implantation of non-human or artificial organs.
- Harvesting of human organs or bone marrow when the ***recipient is not*** a HBP member.
- Hypnosis.
- Massage therapy even if provided by a physical therapist.
- Alternative and homeopathic therapies.
- Alternative Care Programs.
- X-rays taken in a chiropractor's office.
- Treatment for paring of corns and calluses or trimming of toenails, unless the patient has complications associated with circulation or diabetes.
- Full body CT scans.
- Quantitative Sensory Testing (QST).
- Auditory processing testing.
- Hepatitis A Immunization.
- Nasal flu vaccine, FluMist for members greater than 18 years of age. (FluMist is covered for members ages 2 to 18.)
- Travel Clinic and related services (*e.g.*, immunizations, medications).
- Sclerotherapy for spider veins.
- Unattended electrical stimulation.
- Cervical home traction units.
- Ambulance transport to home from any healthcare facility or to/from physician or outpatient care visits.
- CT colonoscopy is excluded except in cases where routine colonoscopy has been attempted and failed.
- Viscosupplementation products such as Euflexxa, Gel-One, Synvisc, or Synvisc One.

Behavioral Health Coverage Exclusions

- Services for mental disability or intellectual disability, except for services rendered for necessity of evaluation of the diagnosis of mental or intellectual disability.
- Athletic performance enhancement training, evaluation, or counseling.
- Services required by an employer in order to begin or continue working, unless they are medically necessary and have received precertification from the Medical Management Department.
- Counseling services for weight control or reduction that are not related to a primary Axis I disorder such as Anorexia or Bulimia.
- Behavioral modification programs unless authorized through the Medical Management Department.
- Services for Transcranial Magnetic Stimulation (TMS) maintenance therapy.
- Services for residential treatment solely for the treatment of gambling addiction or sexual addition.

- Report writing and/or court testimony for any purpose.
- School meetings for any purpose.
- Time spent traveling or travel expenses incurred by a service provider.
- Any travel expenses for a member other than for emergency transport by a private ambulance service or non-emergent transport that has received precertification from the Medical Management Department.
- Residential level of care solely for the purpose of treating nicotine and/or smoking addictions (excluding marijuana).
- Residential level of care solely for the purpose of treating gambling or sexual addictions.
- Halfway houses.
- Wilderness therapy programs
- There is no coverage for school meetings by outpatient behavioral health practitioners.

Prescription Drug Benefit Exclusions

- The replacement of lost or damaged prescriptions.* Stolen medications will be covered at the benefit program rate when accompanied by a police report.
- Drugs prescribed for the treatment of sexual dysfunction.
- Drugs to enhance libido function.
- Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.
- Drugs used for experimental or investigational purposes.
- Drugs used for cosmetic purposes.
- Drugs not included in the Patient Protection and Affordable Care Act that can be purchased without a prescription.
- Medicinal foods (regardless of whether they require a prescription or not).
- Insulin pumps and insulin pump supplies with the exception of Omnipod Dash, Omnipod 5 G6.
- Prescriptions ordered or provided by a member of your immediate family.
- Histamine H2 Receptor Antagonist (H2RA) drugs for members one year of age or older.
- Proton Pump Inhibitor (PPI) drugs for members one year of age or older.
- Nasal corticosteroid drugs.
- Medical devices approved via the FDA 510(k) Premarket Notification review process.
- Unapproved prescription drugs that do not have FDA approval such as drugs grandfathered, DESI, or GRAS/E.
- Viscosupplementation and intra-articular hyluronate products.
- Aduhelm
- Amondys 45
- Emflaza
- Exondys 51
- Makena
- Vyondys 53
- Weight loss products
- Autologus serum eye drops (ASED)
- Nasal Antihistamine drugs
- Weight loss products

These prescription drug benefit exclusions also apply to the EHP medical benefit with exception of insulin pumps and insulin pump supplies.

Section Four
THIRD-PARTY ADMINISTRATOR – AETNA

Cleveland Clinic Health Benefit Program
Third-Party Administrator (TPA) Aetna

The Health Benefit Program (HBP) is partnered with Aetna to administer your health benefit program benefits accurately and efficiently. Aetna provides claims processing for all members who receive healthcare services and functions as the Third-Party Administrator (TPA) for the HBP. In this role, they are responsible for:

1. Member eligibility verification
2. Benefit coverage determinations
3. Processing claims and claims appeals
4. Issuing statements of Explanation of Benefits (EOB)
5. Coordinating benefits if a member is covered by more than one health plan
6. Subrogation processing
7. Workers' Compensation coordination

Information regarding contacting Aetna is available in the Quick Reference Guide on page 7.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process used to pay healthcare expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare. Annual healthcare expenses for the HBP exceeds $400 million per year. Coordination of Benefits helps achieve cost savings for members.

If you/your dependents are covered by more than one healthcare insurance policy, the TPA follows rules established by state law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). When we talk about "plan" through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care services contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or in connection with a particular organization or group

The combined payments of all healthcare insurance policies will not exceed the actual amount of your bills. See Section One: "Getting Started" for information about completing the COB form to ensure that your dependents' healthcare claims will be paid.

Process for Determining Which Health Plan Is Primary

To determine which health plan is primary, the TPA has to consider both the coordination of benefit provision of the other health plan and which member of your family is involved in a claim. The primary health plan will be determined by the **first** of the following that applies:

1. **Non-Coordinating Plan:** If you have another group plan that does not coordinate benefits, it will always be primary.
2. **Employee:** The plan that covers you as an active employee is always primary and pays before a plan covering the person as a dependent, laid-off employee or retiree.

3. **Children:**
   - **Birthday Rule** – When your children's healthcare expenses are involved, the TPA follows the "birthday rule." The birthday rule states that the health plan of the parent with the first birthday in the calendar year is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your health plan will be primary for all of your children.
   - **Gender Rule and other Health Plan Rules** – Sometimes a spouse's health plan has some other coordination of benefits rule, such as a gender rule, which states that the father's health plan is always primary. In cases of the gender rule or other specific health plan coordination of benefits rules for children, the TPA will follow the rules of that health plan.
4. **Children (Parents Divorced or Separated):**
   - If the court decree makes one parent responsible for healthcare expenses, that parent's plan is primary.

     Note: The Cleveland Clinic Health Benefit Program reimburses claims according to its plan rules (i.e., network requirements must be adhered to even if a court decree dictates the Cleveland Clinic employee's health insurance is primary for children living outside of the Network of Providers).
   - If the court decree gives joint custody and does not mention healthcare, the TPA follows the birthday rule.
   - If neither of those rules applies, the order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.
5. **Other Situations:** For all other situations not described previously, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

How the TPA Pays as Primary

As primary, the TPA will pay the full benefit provided by your health plan as if you had no other coverage, provided it is a covered benefit under the HBP and all Network Provider and Medical Management Department rules have been followed.

How the TPA Pays as Secondary

Based on Coordination of Benefits (COB), if the HBP is secondary, it will pay only if the services are provided by a HBP network provider – Tier 1 or Tier 2. As secondary, the TPA's payments will be based on the balance left after the primary health plan has paid. A copy of the Explanation of Benefits (EOB) from the primary health plan must be submitted to the TPA. The TPA will pay no more than that balance. In no event will the TPA pay more than it would have paid had the TPA been primary. The TPA will pay no more than the "allowable expense" for the healthcare involved. If the TPA's allowable expense is lower than the primary plan's, the TPA will use the primary health plan's allowable expense. The primary health plan's allowable expense may be less than the actual bill.

- **The TPA will NOT pay any co-payments required by the primary health plan.**
- **If a member seeks services from a Tier 2 provider, before the Health Benefit Program will reimburse as secondary, the deductible must be met.**

When the member becomes Medicare eligible at age 65, the Cleveland Clinic Health Benefit Program will pay as secondary, as if the member has Medicare Part B, whether or not the member has enrolled in Medicare Part B. This means the Cleveland Clinic Health Benefit Program will only reimburse 20% of the Allowed Amount. This does not apply to actively working age 65 or older employees.

Enforcement of Coordination of Benefits (COB) Provision

The TPA will coordinate benefits provided that the TPA is informed by you, or some other person or organization, of your coverage under any other health benefit program.

In order to apply and enforce this provision or any provision of similar purpose of any other healthcare benefit program, it is agreed that:

- Any person claiming benefits described under this benefit program will furnish the TPA with any information the TPA needs; and
- The TPA may, without the consent of or notice to any person, release or obtain from any source any necessary information needed to complete the claims adjudication process.

Facility of Payment

If payment is made under any other health benefit program that the TPA should have made under this provision, then the TPA has the right to pay whoever paid under the Cleveland Clinic Health Benefit Program. The TPA will determine the necessary amount under this provision. Amounts so paid are benefits under this health benefit program and the TPA is discharged from liability to the extent of such amounts paid for covered services.

Right of Recovery

If the TPA pays more for covered services than this provision requires, the TPA has the right to recover the excess from anyone to or for whom the payment was made. The member agrees to do whatever is necessary to secure the TPA's right to recover the excess payment.

Coordination Disputes

If you disagree with the way the TPA has paid a claim, your first attempt to resolve the problem should be by contacting the TPA. You must follow the TPA appeal process (see page 64). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint at 614.644.2673 or toll-free at 800.686.1526.

Workers' Compensation

If a Cleveland Clinic employee has an accident or injury at work, the employee must file a claim through the Bureau of Workers' Compensation. The employee is required to:

- Complete and file an Incident Report immediately.
- Visit their Primary Care Provider, a Cleveland Clinic or Regional hospital Occupational Safety Department, or a Cleveland Clinic or Regional hospital Emergency Department immediately and forward the report to the applicable Department so that workers' compensation can be processed.

Services related to the injury or accident should be registered as workers' compensation. The claims for these services should be submitted to the Bureau of Workers' Compensation for reimbursement.

The Cleveland Clinic Health Benefit Program will not reimburse work-related claims until all workers' compensation procedural requirements have been completed, and the Bureau of Workers' Compensation has determined that it will not cover the submitted claim.

Claims Information

Using Tier 1 or Tier 2 (see Section Two) network providers within the Cleveland Clinic Health Benefit Program allows you, in most instances, to receive care without sending any claims or paperwork to the Third-Party Administrator (TPA). After you receive care, you will receive an Explanation of Benefits (EOB) from the TPA, only if a co-payment or co-insurance was owed for treatment. An EOB is a statement that explains how the bill was paid by the TPA.
An example is provided on the following page.

Members can view any EOB statement at the Aetna website 24/7, by registering at Aetna's website at **aetna.com**.

Understanding your Explanation of Benefits (EOB) statement

What information will be on your EOB statement

- Your name and address
- Your member ID
- The group number — this identifies your plan
- The group name — typically, this is your employer
- Customer service contact information

It's easy to track your spending and savings

We make it easy to understand what you owe.*

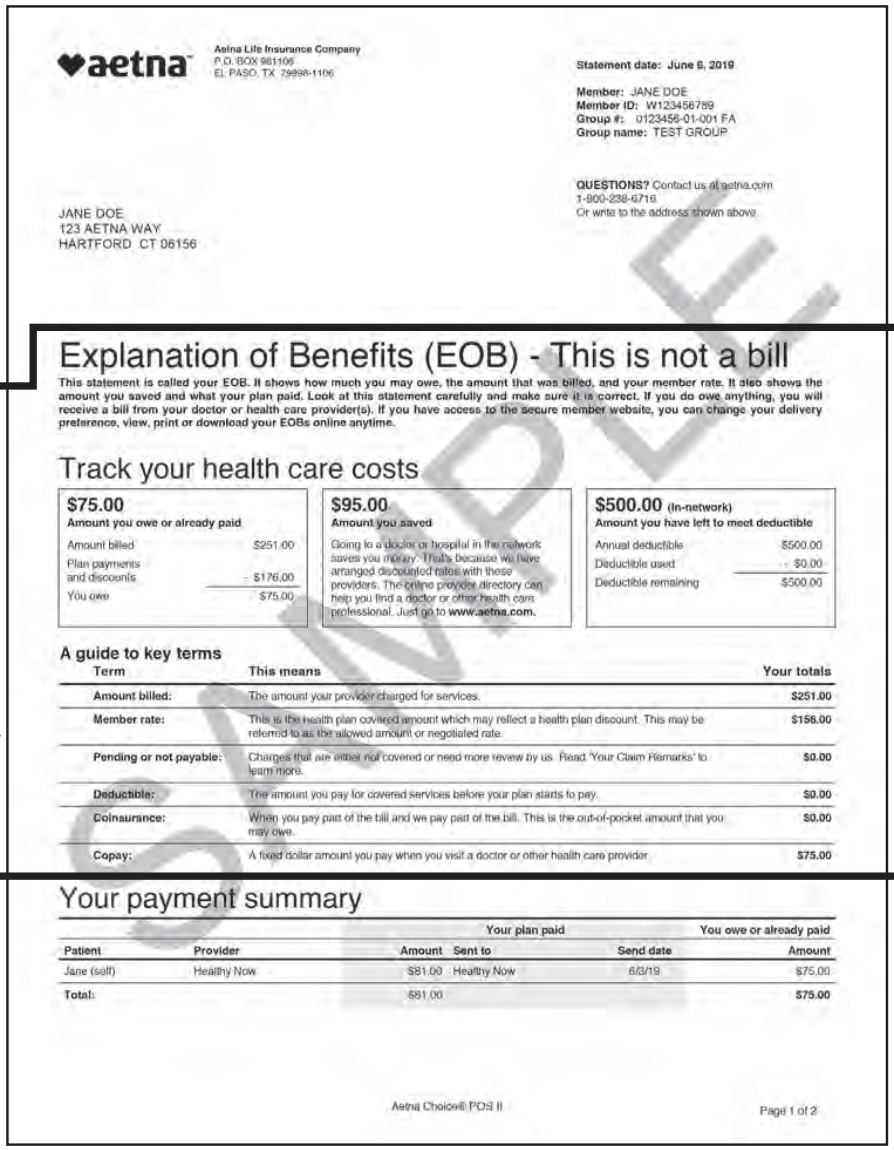
We tell you what you've saved by using an in-network provider.*

We also clearly show the remaining amount you have to pay in order to meet your yearly in-network family or individual deductible.*

Your payment summary

This includes a summary about any payments made and what you owe for the claims listed on the EOB statement.

*This section may not always be included. The sections are based on your benefits.



aetna

Aetna Life Insurance Company
P.O. BOX 981106
EL PASO, TX 79998-1106

Statement date: June 6, 2019

Member: JANE DOE
Member ID: W123456789
Group #: 0123456-01-001 FA
Group name: TEST GROUP

QUESTIONS? Contact us at aetna.com
1-800-238-6716
Or write to the address shown above

JANE DOE
123 AETNA WAY
HARTFORD CT 06156

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBs online anytime.

Track your health care costs

$75.00
Amount you owe or already paid

Amount billed	$251.00
Plan payments and discounts	- $176.00
You owe	$75.00

$95.00
Amount you saved

Going to a doctor or hospital in the network saves you money. That's because we have arranged discounted rates with these providers. The online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

$500.00 (In-network)
Amount you have left to meet deductible

Annual deductible	$500.00
Deductible used	- $0.00
Deductible remaining	$500.00

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	$251.00
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	$156.00
Pending or not payable:	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	$0.00
Deductible:	The amount you pay for covered services before your plan starts to pay.	$0.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	$0.00
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	$75.00

Your payment summary

Patient	Provider	Your plan paid Amount	Sent to	You owe or already paid Send date	Amount
Jane (self)	Healthy Now	$81.00	Healthy Now	6/3/19	$75.00
Total:		$81.00			$75.00

Aetna Choice® POS II

Page 1 of 2

Your claims up close

We provide detailed information for each claim shown on your EOB statement.

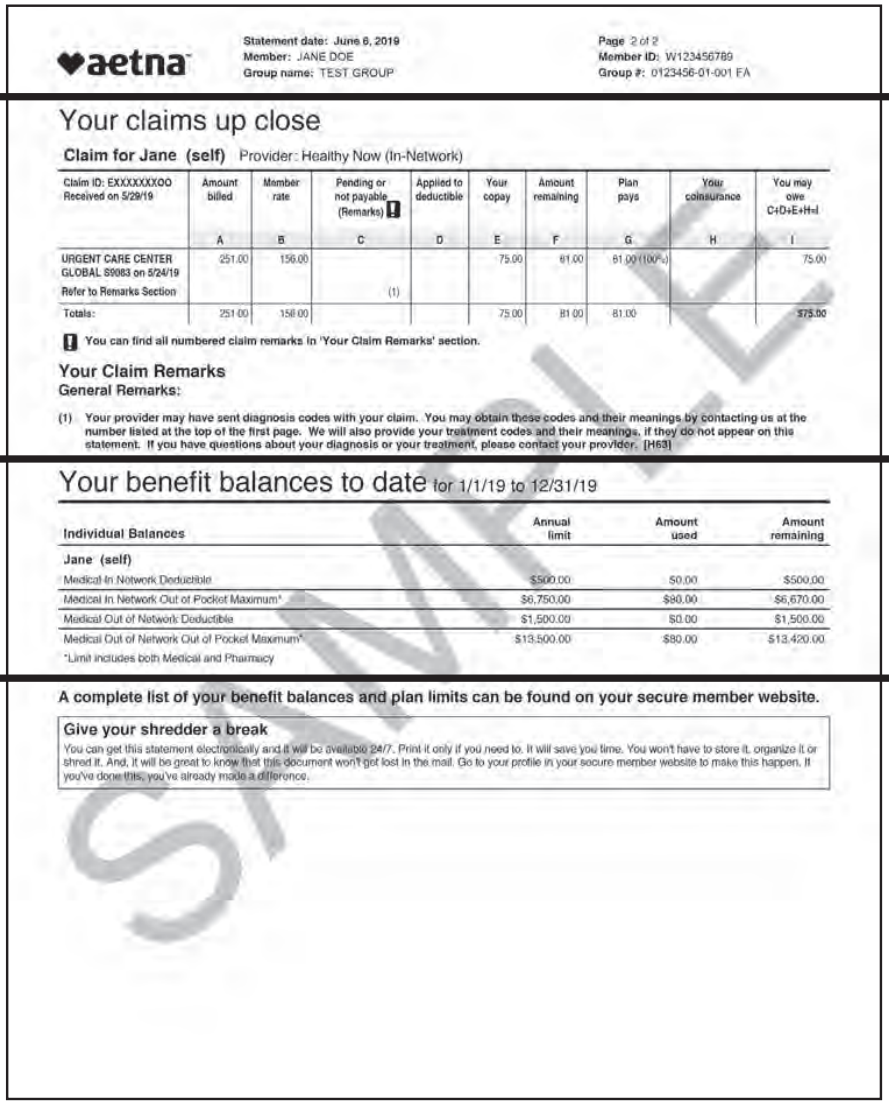
We break down each charge to show how your benefits were applied, what the plan paid and the amount you owe.

Your benefit balances

This provides a summary of financial limits for the benefit year listed.

Messages

In the last section, find helpful messages from us or your employer.



aetna

Statement date: June 6, 2019
Member: JANE DOE
Group name: TEST GROUP

Page 2 of 2
Member ID: W123456789
Group #: 0123456-01-001 FA

Your claims up close

Claim for Jane (self) Provider: Healthy Now (In-Network)

Claim ID: EXXXXXXXOO Received on 5/28/19	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
URGENT CARE CENTER GLOBAL $9083 on 5/24/19	251.00	156.00			75.00	81.00	81.00 (100%)		75.00
Refer to Remarks Section			(1)						
Totals:	251.00	156.00			75.00	81.00	81.00		$75.00

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks
General Remarks:

(1) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [H63]

Your benefit balances to date for 1/1/19 to 12/31/19

Individual Balances	Annual limit	Amount used	Amount remaining
Jane (self)			
Medical In Network Deductible	$500.00	$0.00	$500.00
Medical In Network Out of Pocket Maximum*	$6,750.00	$80.00	$6,670.00
Medical Out of Network Deductible	$1,500.00	$0.00	$1,500.00
Medical Out of Network Out of Pocket Maximum*	$13,500.00	$80.00	$13,420.00

*Limit includes both Medical and Pharmacy

A complete list of your benefit balances and plan limits can be found on your secure member website.

Give your shredder a break

You can get this statement electronically and it will be available 24/7. Print it only if you need to. It will save you time. You won't have to store it, organize it or shred it. And, it will be great to know that this document won't get lost in the mail. Go to your profile in your secure member website to make this happen. If you've done this, you've already made a difference.

On Aetna.com, you can view, print or download your EOB statement and other documents, anytime.

Want to stop paper? It's easy. Go to **Aetna.com** to log in to your member website. Go to your account settings, provide a current email address and select your paper-saving preferences.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

For illustrative purposes only. This is a sample EOB and does not reflect actual charges or services rendered, nor does it reflect actual charges or services received by an actual Aetna® member. Health benefits and health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **Aetna.com**.

Section Five
ADMINISTRATIVE INFORMATION

This section of the *Summary Plan Description (SPD)* includes all of the information you need about:

- The Registration Process
- Eligibility
- Coverage Options
- The Enrollment Process
- Employee Contributions
- Your Identification Card
- Life Event Changes
- Continuation of Coverage

The Registration Process

It is important that your provider has your and your dependents' correct address and telephone number, as well as any information about your spouse's employer and medical insurer. Correct registration information helps to ensure that your claim will be paid correctly and in a timely manner. **Therefore, please bring all applicable insurance cards with you when you receive medical services. The registrar will verify that the correct demographic and insurance information is accurate.**

Members with a workers' compensation case should advise the appointment scheduler at the time the visit is being scheduled that the visit is related to a work injury. This notification helps ensure proper claim payment through the Bureau of Workers' Compensation.

Eligibility

You are eligible to participate in the Cleveland Clinic Health Benefit Program (HBP) if you are a benefits eligible regular full-time or part-time employee of Cleveland Clinic and certain subsidiaries, a Cleveland Clinic hospital, or a student in a Cleveland Clinic-sponsored educational program.

Your eligible dependents will be covered under the HBP only if you *elect* coverage for them and provide documentation that they are eligible dependents.

Eligibility Under the Affordable Care Act

Cleveland Clinic uses a look-back measurement method to determine who is a full-time employee for purposes of Health Benefit Program coverage. You are considered a full-time employee if you are employed, on average, at least 30 hours of service per week (or 130 hours of service in a calendar month).

The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Cleveland Clinic employees and involves three different periods:

- A **measurement period** for counting your hours of service.
  - If you are an ongoing employee, this measurement period (which is also called the "standard measurement period") runs from November 1 through October 31 and will determine your Plan eligibility for the stability period that follows the measurement period.
  - If you are a new employee, the measurement period will begin on your date of hire.[14]

14. Prior to September 2016, the measurement period for new employees started on the first month following date of hire.

- A **stability period** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of Cleveland Clinic. There are exceptions to this general rule for employees who experience certain changes in employment status. The stability period lasts 12 months.
- An **administrative period** is a short period between the measurement period and the stability period when Cleveland Clinic performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period lasts up to two months.

Special rules apply when employees are rehired by Cleveland Clinic or return from an unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this is just a general overview of how the rules work. More complex rules may apply to your situation. Cleveland Clinic intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, contact the Caregiver Office Service Center at 216.448.2247 or toll-free at 877.688.2247.

Please note: you are eligible to participate in Cleveland Clinic's Healthy Choice wellness programs; however, there are no premium discounts available for this special "ACA coverage."

Coverage Options – Retirees

1. Individual: Only the retiree is covered under the health plan.
2. Family: If coverage is elected, each family member will be covered under a single contract and will have their own identification number and card.

Dependents Eligible for Coverage

Dependents eligible for the Health Benefit Program include:

1. Your lawful spouse (neither divorced nor legally separated).
2. Your children who are: your natural children, stepchildren, legally adopted children (or under placement for adoption), or children under an officially court-appointed guardianship who are under age 26.
3. Your unmarried children age 26 or older who are disabled as determined by the Social Security Administration. Proof of disability must be provided to Human Resources within 31 days after the determination of disability. The child must be covered under the Health Benefit Program at the time he or she attains age 26 and must be receiving principal financial support from the subscriber.

Ineligible members include the employee's parents, grandchildren, nieces, nephews, ex-spouses, common-law marriage partners (after the year 1991), domestic partners and foster children who have not been legally adopted or who have not been placed for adoption.

Dependent Eligibility Verification

New Hires or New Enrollees

All new hires and/or existing employees enrolling themselves and/or their dependents for the first time are contacted by our consultant, Willis Towers Watson (WTW), to provide supporting documentation for verification of dependent eligibility. Acceptable documentation for verification is as follows:

Spouse

- Copy of marriage license, or
- Copy of page one of your most recent tax return (you may cross out wage information)

Children under age 26

Natural born children:

- Copy of birth certificate or one of the following:
  - Copy of page one of your most recent tax return (you may cross out wage information)

- Copy of court-issued qualified medical child support order (QMCSO)
- Copy of divorce decree

Stepchildren/Custodial:

- Copy of birth certificate and one of the following:
  - Marriage license
  - Copy of court-issued qualified medical child support order (QMCSO)
  - Copy of divorce decree
  - Custodial papers

Adopted Children:

- Adoption papers

Health Benefit Enrollment Process

New Hires

When you begin working at a Cleveland Clinic facility, you are given an opportunity to enroll in the Cleveland Clinic Residents and Fellows Health Benefit Program (HBP). ***You must enroll within 31 days of your start date in order for your coverage to become effective from your first day of active employment.***

Note: When you enroll your dependents, you will be contacted and asked to provide documentation as verification of eligibility, see above for detailed information. Failure to provide this documentation by the date specified will result in the termination of benefits for your dependents.

If you ***DO NOT*** take advantage of any of these opportunities to elect coverage for yourself or your dependents, you will not receive health benefit program coverage and will not be entitled to health benefit program coverage until the n**ext open enrollment offering unless you experience a life event change**, which is described in the Life Event Changes in Section 5. Open enrollment takes place annually, at which time benefit-eligible employees have the opportunity to elect coverage for the upcoming calendar year.

If an employee begins employment between October and December, near the open enrollment period, he/ she will have the opportunity to elect benefits for the current year and will also be given information about making benefit election changes for the new calendar year.

If you have further questions on how to apply for coverage, contact the Caregiver Office Service Center at 216.448.2247 or toll-free at 877.688.2247.

Coverage-Effective Date

As long as you have enrolled in the Health Benefit Program within 31 days of your start date, your coverage is effective on the first day you actively start to work. It takes approximately 15 business days from the time your paperwork is received by Human Resources to the time your benefit selection is processed with the Third-Party Administrator (TPA). See Section Four for TPA information. If you require services prior to your benefit being processed, your claims may be denied. These claims will be adjusted on the backend when the TPA processes your benefit selections data.

Current Employees

Current employees have the opportunity each year to re-enroll for their coverage through the Open Enrollment process. Through this process, you can choose to keep the same coverage you have or make changes to it for the coming calendar year. If you did not previously elect coverage through HBP, you have the opportunity to do so at this time and your coverage will become effective on the first day of the new calendar year.

At the time of open enrollment, you may take advantage of the Flexible Spending Account (FSA). The FSA helps save money on healthcare related expenses such as front-end deductible and co-payment/ co-insurance for medical, prescription drugs, dental services, eyeglasses and contact lenses. You will pay no Federal, State or Social Security tax on the money reimbursed to you.

Detailed information about the FSA program can be obtained from the Caregiver Office Service Center.

Retiree Contributions

Information on retiree contributions is available through the Caregiver Office Service Center. Retirees are not eligible to participate in the Healthy Choice Program.

Benefit Program Identification Card

Your Cleveland Clinic Health Benefit Program (HBP) Identification (ID) card(s) will be mailed to your home directly from Aetna, our Third-Party Administrator (TPA). See Section Four for TPA information. Members with Employee Only coverage will receive an ID card with their name and 10-character number plus the two-digit **suffix** 01. For coverage other than Employee Only, each member of the family will receive an ID card listing his or her name and the contract holder's 10-character number, followed by a two-digit **suffix** to identify each family member. The contract holder's suffix will always be 01.

For example:

W1234 56789-01 Contract Holder's ID Number
W123456–02 Dependent
W123456–03 Dependent
W123456–04 Dependent

Your ID card(s) contains the following information:

1. Name of EHP Enrollee
2. Member ID Number (contract holder's 10-character ID number + suffix)
3. Group Name
4. Group Number
5. Co-payment Requirements
6. Aetna Claim Submission Phone Number/Mailing Address
7. EHP Medical Management Department Phone Number, Precertification for Medical Necessity for Medical, Behavioral Health, and Case Management programs
8. Emergency Room Transfer Call Line
9. Information regarding Tier 2 Network

It takes approximately 15 business days from the time you enroll to the time your benefit selection is processed with the TPA. Promptly submitting your selections reduces delays in receiving your ID cards and helps avoid possible claims issues.

If your ID card(s) are lost or stolen, you may contact the Third-Party Administrator (TPA) for a replacement card. Please have the contract holder's Social Security Number available for the Customer Service Representative. See the Quick Reference Guide on page 7 for appropriate phone numbers/contacts.

Life Event Changes

To help Cleveland Clinic design a cost-effective Health Benefit Program each year, maintain costs, and to anticipate future needs, you are required to keep your selected benefit elections unless you or your dependents experience a "Life Event Change."

Under Internal Revenue Service guidelines, the following occurrences meet the definition of a **qualifying life event** and permit you to change certain elections:

1. Changes in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
2. Changes in the number of dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death.
3. Employment status changes, meaning an employee, spouse or dependent starts a new job or loses a current job.
4. Work schedule changes, meaning a reduction or increase in hours of employment for the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or the beginning or end of an unpaid leave of absence.
5. Changes in work location, meaning a change in the place of residence or work of an employee, spouse, or dependent.
6. A dependent satisfies – or no longer satisfies – the Benefit Program requirements for unmarried dependents because of age, job status or other circumstances.
7. A qualified medical child support court order (QMCSO), or other similar order, that requires health coverage for an employee's child.

8. The employee, spouse or dependent qualifies for Medicare or Medicaid. (If this happens, health benefit program coverage may be cancelled for that individual.)
9. If there is a loss of coverage or significant increase or decrease in the cost of a benefit or a significant coverage curtailment (e.g., a significant increase in cost-sharing) or coverage improvement during a plan year you may be able to change certain benefit elections.
10. In addition, the Dependent Care Flexible Spending Account (FSA) has additional status change events which permit you to change your election during the year.
    a. For example, if you are participating in the Dependent Care Flexible Spending account and there your dependent no longer meets the qualifications to be eligible for dependent care.
    b. Another example of a permitted change is if you change dependent care providers, you may change your contribution amount. A change in your provider also includes going from having a dependent care provider to not having one. If your dependent care provider increases their cost and the provider is not a relative, you may make an election change (You may not change your election under the Dependent Care FSA if the cost change is imposed by a dependent care provider who is your relative.)

If you experience a qualifying life event and wish to change your coverage, you must do so within 31 days of the event and provide the necessary supporting documentation. Any adjustment to coverage must be consistent with the change resulting from the qualifying life event. To initiate a life event change, visit the Caregiver Workday and Portal and click on the "Benefits" worklet. If you need assistance, contact the Caregiver Office Service Center at 216.448.2247 or toll-free at 877.688.2247.

Employees/dependents covered under another health plan who lose that coverage as a result of one of the life events listed above are eligible to participate in the HBP.

Note: Life Event changes require the completion of a COB form at the time of the event.

Continuation of Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may require that you and/or your dependents be provided with the opportunity to continue your group healthcare coverage on a contributory basis under the following circumstances. The extension of coverage applies to almost all employee health plans providing medical, dental, prescription drug, vision, or hearing benefits. You will be able to continue coverage through COBRA by paying all of the costs of the health plan you choose, including any portion formerly paid for by the Cleveland Clinic facility that employed you.

Qualifying Events: Who, When, and for How Long

If your HBP coverage terminates, you and your covered dependents may continue medical care coverage for up to 18 months:

1. If your employment terminates for any reason, including retirement, other than gross misconduct; or
2. If you lose your coverage due to a reduction in your hours of employment; or
3. If you or a dependent become disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months (29 months total).

Your covered dependents may continue such coverage under the HBP for up to 36 months:

1. If you die while covered by the Benefit Program; or
2. If you and your spouse are divorced, your marriage is annulled or you are legally separated from your spouse; or
3. If you become eligible for Medicare; or
4. If your dependent child is no longer eligible for coverage under the HBP.

If you are entitled to Medicare benefits at the time coverage terminates due to your termination of employment or reduction in hours, the continuation period for covered dependents will be the longer of:

1. 18 months from the date coverage terminates due to your termination of employment or reduction of hours; or
2. 36 months from the date you became entitled to Medicare.

When Continued Coverage Ends
The continued coverage will end for any qualified person when:

1. The cost of continued coverage is not paid on or before the date it is due; or
2. That person becomes eligible for Medicare, if later than the date of the COBRA election; or
3. That person becomes covered under another group health plan unless that other plan contains an exclusion or limitation with respect to any pre-existing health condition; or
4. The HBP terminates for all Employees; or
5. You or your dependent are no longer deemed disabled during the additional 11-month extended period; or
6. The last day of the applicable 18, 29 or 36-month time limit.

How to Obtain Coverage
When your coverage terminates, Human Resources will notify the COBRA Administrator (PayFlex). PayFlex then notifies you of your election rights. You will need to make your election **within 60 days** of the event in order to be eligible for continuation of coverage. For questions regarding COBRA, PayFlex can be reached at 800.359.3921 or you can contact the Caregiver Office Service Center. There is generally a 1-2 week lag time between when PayFlex processes the first paid premium and the time the Third-Party Administrator (TPA) is updated. ***You will be able to receive covered care during this lag time. However, be prepared to provide proof of insurance or be prepared to resubmit the claim if denied the first time.***

If you elect to continue any benefits under COBRA, the first payment must be made within 45 days of your election to continue coverage. The first payment covers the period beginning with the date the qualifying event occurred through the date the continuation coverage was elected. Thereafter, monthly payments are due on the first of the month and must be paid within the 31 day grace period following the due date.

COBRA regulations may change from time to time. The extension of coverage will be provided in accordance with current law.

Because COBRA rules are complicated, if you have any questions about eligibility, contact the Caregiver Office Service Center.

Veteran Reemployment
Cleveland Clinic and the regional hospitals will also comply with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

This law enables employees who take leaves of absence to serve in the armed forces to continue their medical coverage in a manner similar to COBRA.

Retirement and Medicare Enrollment

Health benefits in which you are currently enrolled will continue through the end of the month in which you retire unless you:

- Elect the Cleveland Clinic Retiree Health Benefit Program (HBP) coverage offered through the Cleveland Clinic facility you are employed by; or
- Continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). See COBRA section on page 59 for more information.

Medicare Parts A and B become your **primary** insurance when you or your covered dependent become Medicare eligible. Following are specific scenarios of Medicare eligibility:

1. When you turn 65 (and retire)
2. Long Term Disability (LTD) and you turn 65 while on LTD, the EHP remains primary up to 24 months from your LTD start date
3. If you have the diagnosis of end-stage renal disease there is a 30-month coordination period and then Medicare becomes primary

When any of the above occurs, you **must** enroll in Medicare Part B. The Employee Health Plan becomes the secondary insurance once you become Medicare eligible. This means if you do not enroll in Medicare Part B, you will be responsible for 80% of your physicians' bills (out of your pocket) because the health plan pays only 20% (what Medicare does not pay) as the secondary insurance. **Note:** This does not apply to **actively working** age 65 or older employees or spouses.

Retired Medicare-eligible members are automatically enrolled in SilverScript when they choose the EHP as their supplement medical plan. The prescription drug plan for retired Medicare-eligible members is administered by SilverScript. SilverScript is an approved Medicare Part D prescription drug plan for Cleveland Clinic only. SilverScript is an affiliate of CVS Caremark, the plan's pharmacy benefit manager. The SilverScript plan is a separate pharmacy plan with its own formulary and is not managed by the EHP. It is important to review this drug formulary before retirement to confirm if the medications you are on are included in the SilverScript formulary. This should be done prior to choosing the EHP as your supplement plan to Medicare Parts A and B. If the medications you are taking are not on the SilverScript formulary, you will need to ask your physician to change your medication to one that is on the formulary for benefit coverage.

If you retire before age 65, you will need to contact the Caregiver Service Center when you turn 65 for important information.

Termination of Coverage

Your coverage under the HBP terminates the last day of the month in which:

- You transfer to a non-benefits eligible position; or
- You terminate employment; or
- You or your dependent(s) are no longer eligible health benefit program participants.

You may elect to extend coverage if the HBP coverage is lost due to one of the COBRA-related provisions beginning on page 59.

Section Six
HBP MEMBERS' RIGHTS AND RESPONSIBILITIES

This section of the *Summary Plan Description (SPD)* includes information about Health Benefit Program (HBP) members' rights and responsibilities. You will find information about:

- Benefit Determination for Claims
- Filing a Complaint
- Appeals Process
- Reimbursement and Subrogation Rights of the HBP
- Cleveland Clinic Employee Health Plan Non-Discrimination Notice
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Employee Retirement Income Security Act of 1974 (ERISA)
- Statement of Your Rights Under ERISA

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could:

1. seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of ***urgent*** can be made by:

1. an individual acting on behalf of the Benefit Program and applying the judgment of a prudent layperson who possesses an average knowledge of medicine; or
2. any physician with knowledge of the claimant's medical condition can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with the Benefit Program's claim procedures and all of the required information is received, the Benefit Program will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Benefit Program's receipt of the claim.

If you do not follow the Benefit Program's procedures or we do not receive all of the information necessary to make a benefit determination, the Benefit Program will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once the Benefit Program receives the requested information, we will notify you of the benefit determination as soon as possible but not later than 48 hours after receipt of the information.

The Benefit Program may notify you of its benefit determination decision orally and follow with written or electronic notification no later than three days after the oral notification.

Concurrent Care Claims

A **Concurrent Care Claim** is any claim for ongoing treatment, including the Benefit Program's approval for a number of treatments. The decision is adverse if the Benefit Program decided to reduce or terminate benefits for the ongoing treatment (unless it's due to a health benefit program amendment or health benefit program termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with the Benefit Program's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The Benefit Program will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours if urgent or 72 hours if standard after its receipt of the claim.

If the Benefit Program reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. The Benefit Program will notify you, in advance, of the reduction of termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

Pre-Service Claims

A **Pre-Service Claim** is a claim for a benefit which requires some form of preapproval or precertification by the Benefit Program before service takes place.

If you file a Pre-Service Claim in accordance with the Benefit Program's claim procedures and all the required information is received, the Benefit Program will notify you of its benefit determination within 15 days after receipt of the claim. The Benefit Program may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Benefit Program. The Benefit Program will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all the necessary information to process your claim, the Benefit Program will notify you in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims

A **Post-Service Claim** is any claim that is not a Pre-Service Claim.

If you file a Post-Service Claim in accordance with the Benefit Program's claim procedures and all of the required information is received, the Benefit Program will notify you of its benefit determination within 30 days after receipt of the claim. The Benefit Program may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Benefit Program. The Benefit Program will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, the Benefit Program will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of a denial of a benefit will include the following:

- The specific reason for the denial;
- Sufficient information to identify the claim involved, including the date of services, the healthcare provider, and the claim amount, if applicable;
- Reference to the specific Benefit Program provision on which the denial is based;
- A description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- A description of the Benefit Program's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- Your right to bring a civil action under Federal law following the denial of a claim after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request; and
- If the claim was denied based on Medical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Benefit Program to your circumstances will be provided free of charge upon request.

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the employee should have the following information available:

- Name of patient
- Identification number
- Claim number(s) (if applicable)
- Date(s) of service

If your complaint is regarding a claim, an Aetna Concierge representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Aetna Concierge will telephone the member with the response. If attempts to telephone the member are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the member will receive a check, Explanation of Benefits or letter explaining the revised decision.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

Appeals Process

Urgent Review Process

A request for an expedited or "urgent" review must be certified by your Provider that your condition could, without immediate medical attention, result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function; or
2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your physician should call the Aetna Concierge telephone number on your identification card as soon as possible.

Urgent reviews will be resolved within 72 hours after the receipt of the request..

The expedited review process does not apply to prescheduled treatments, therapies, surgeries or other procedures that do not require immediate action.

When you request an internal review for an urgent care claim or for a concurrent care claim that is urgent, you may also be eligible to file a request at the same time for an expedited external review.

Filing an Appeal

If you are not satisfied with any of the following:

- A benefit determination decision;
- A Medical Necessity determination decision;
- A determination of your eligibility to participate in the Benefit Program or health insurance coverage; or
- A decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums); then you may file an appeal.

To submit an appeal, you may use the Member Complaint and Appeal form found on the EHP website or write a letter with the following information: employee's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the provider/ facility name; and any supporting information or medical records, dental X-rays or photographs you would like considered in the appeal. Send the letter and records to:

Aetna
Customer Resolution Team
P. O. Box 14002
Lexington, KY 40512
Fax: 859.425.3379

The request for review must come directly from the patient unless he/she is a minor or has chosen an authorized representative. You can choose another person to represent you during the appeal process, as long as Aetna or the Health Benefit Plan has a signed and dated statement from you authorizing the person to act on your behalf.

You will receive continued coverage pending the outcome of the appeals process. This means that the Benefit Program may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.

Two-Level Mandatory Appeal Process

The Benefit Program offers all members a two-level **mandatory** appeal process. You must complete these levels of appeal before any additional action is taken unless you have an urgent claim appeal.

First-level mandatory appeals related to a claim decision must be filed within 180 days from the date on the denial of benefits notification letter. A second appeal must be requested within 60 days from the first-level appeal denial date. All requests for an appeal may be made in writing as described on page 65.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this benefit program. The internal appeal process is a review of your appeal by our clinical team, including, a physician consultant and/or other licensed healthcare professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations based on Medical Necessity and appropriateness, experimental treatment, or that are based in whole or in part on a medical judgment, are made by healthcare professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The physician consultant who reviews the appeal will not have made any prior decisions about your claim and will not be a subordinate of the professional who made the initial determination on your claim. These healthcare professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, the Benefit Program considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires. Additionally, if the Benefit Program decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or could affect the ability of the patient to regain maximum functions. The appeal must be decided within 72 hours of the request. There is only one level of urgent claim appeal.
- When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external appeal as described below. You may also decide to file a request for an expedited external appeal without requesting an internal appeal.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the Benefit Program. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date of the denial.

Post-Service Claim Appeal

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claim appeals, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date of the original denial.

Appeal Denial Notices

All notices of a denial of benefits relative to appeals will include the following:

- The specific reasons for the denial;
- Sufficient information to identify the claim involved, including the date(s) of service, the healthcare provider, and the claim amount, if applicable;
- Reference to the specific benefit program provisions on which the denial is based;
- Statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Benefit Program to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- A statement of your right to bring civil action under Federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Second Level of Appeal

- This appeal level for standard requests is filed through Aetna to be reviewed by the Health Plan Advisory Committee (HPAC). Members who are not satisfied with the decision following the first standard appeal have the right to appeal the denial a second time. The member is required to follow this internal procedure before going to the External Review Process on page 67. The HPAC members may include the HBP Chief Medical Officer, Senior Director, Legal Counsel, Cleveland Clinic Medical Director, Director of Health and Welfare Benefits, Director of Retirement/Voluntary Benefit Plan, Director of Medical Management, Pharmacy Director, and Behavioral Health representatives as needed.
- Members or their Personal Representative must submit a written request for a second appeal review within 60 calendar days following the date of the decision regarding the first appeal. The HBP will assume that the member received the determination letter regarding the first appeal five days following the date of the determination letter.
- Members may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second appeal review is submitted.
- Members have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second appeal review will take into account all comments, documents, records and other information submitted that related to the claim that either were not submitted previously or were not considered in the initial benefit decision. When indicated, the review will be conducted by physicians who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the HBP will consult with a healthcare professional with training and experience in the relevant medical field. This healthcare professional may not have been involved in the original denial decision or first appeal, nor be supervised by the healthcare professional who was involved. If the HBP has obtained medical or vocational experts in connection with the claim, they will be identified upon the member's request, regardless of whether the HBP relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the member will receive written notification letting them know if the claim is being approved or denied. It will also notify them of their right to request an external review or file suit under ERISA after they have completed all mandatory appeal levels described in this *SPD*.

Regarding voluntary appeal level, the HBP agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the member has followed the mandatory appeal level as required on page 65. The HBP also agrees that it will not charge the member a fee for going through the voluntary appeal process, and it will not assert failure to exhaust administrative remedies if a member elects to pursue a claim in court before following this voluntary appeal process. A member's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the HBP. For any questions regarding the voluntary level of appeal including applicable rules, a member's right to representation (Personal Representative) or other details, please contact the Aetna Concierge. Refer to the ERISA Statement of Rights section on page 71 of this SPD for details on a member's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above.

Send Medical Appeals to:
Aetna
Customer Resolution Team
P.O. Box 14002
Lexington, KY 40512
Fax: 859.425.3379

Send Pharmacy Appeals to:
Health Benefit Program Pharmacy Appeals
6000 West Creek Road, Suite 20
Independence, OH 44131
Phone: 216.986.1050 (option 4)
or toll-free at 888.246.6648 (option 4)

Time Periods for Making Decision on Appeals

After reviewing a claim that has been appealed, the TPA or HBP will notify the member of its decision within the following timeframes, although members may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Benefit Program will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

The timelines below apply to the mandatory appeal levels.

- ***Pre-Service Claim:*** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 calendar days after the Benefit Program receives the request for review.
- ***Post-Service Claim:*** Within a reasonable period of time but not later than 30 calendar days after the Benefit Program receives the request for review.
- ***Concurrent Care Claim:*** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 calendar days after the Benefit Program receives the request for review.

External Review Process

In accordance with Federal law, the HBP has also established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within 120 days from your receipt of the notice of denial from the second-level mandatory standard internal appeal or if an urgent review, within 60 days of the initial notice of denial. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. For claims for which external review is initiated:
   a. Before September 20, 2011, the adverse benefit determination does not relate to your failure to meet the requirements of eligibility under the Benefit Program;
   b. On or after September 20, 2011, the adverse benefit determination involves medical judgment or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the Benefit Program at the time the service was requested or, in the case of retrospective review, were covered under the Benefit Program when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The Benefit Program is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical condition and the external review.

External Review for Non-Urgent Care Claim Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to the Aetna Appeal Unit at the following address. The form is available on the EHP website.

Aetna
Customer Resolution Team
P.O. Box 14002
Lexington, KY 40512
Fax: 859.425.3379

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you 10 business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. If the IRO reverses the adverse benefit determination, the Benefit Program will provide coverage, subject to other terms, limitations and conditions of your benefit program.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for urgent or expedited claims may be requested orally or in writing. A request for an expedited review should be made by contacting Aetna Concierge at the number on the back of your identification card. You may request an external review for urgent or expedited claims either before a voluntary internal review or at the same time you request an expedited internal review of your claim.

An expedited review may be requested if your condition, without immediate medical attention, could result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function; or
2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. If the IRO reverses the adverse benefit determination, the Benefit Program will provide coverage, subject to other terms, limitations and conditions of your *Summary Plan Description*.

Time Period for Making Decision on Provider Appeals

The provider has one level of post claim appeal. After reviewing a claim that has been appealed, the TPA or HBP will notify the provider of its decision within a reasonable period of time but not later than 60 calendar days after the Benefit Program receives the request for review.

Reimbursement and Subrogation Rights of the Plan

This Section of this *Summary Plan Description* addresses the Cleveland Clinic Health Benefit Program's (referred to as the "Benefit Program") "subrogation" and "reimbursement" rights. The terms "Covered Person," " Third Party," "Claim," and "Claim Proceeds" are defined at the end of this section.

First, this Benefit Program does not provide any benefits to a Covered Person to the extent that there is any other type of non-healthcare insurance coverage that would provide reimbursement for a Covered Person's medical expenses (including auto insurance that provides underinsured and non-insured motorist coverage, and insurance maintained by Cleveland Clinic or its affiliates on employees and insurance maintained by other employers).

Second, if a Covered Person has a Claim against a Third Party, this Benefit Program will provide benefits to, or on behalf of, a Covered Person only under the following terms and conditions:

1. To the extent that benefits are provided under this Benefit Program, the Benefit Program shall be subrogated to all of the Covered Person's Claims against any Third Party. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure the subrogation rights of the Benefit Program. The Covered Person shall do nothing to prejudice the subrogation rights of the Benefit Program. By submitting a claim for benefits under the Benefit Program, the Covered Person hereby agrees to cooperate with the Benefit Program and/or any representatives of the Benefit Program in completing subrogation forms and in giving such information surrounding any accident or other set of facts and circumstances as the Benefit Program or its representatives deem necessary to fully investigate and enforce the Benefit Program's subrogation rights.
2. The Benefit Program is also granted a right of reimbursement from any Claim Proceeds. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph 1, but only to the extent of the benefits provided under this Benefit Program.
3. The Benefit Program, by providing benefits hereunder, is hereby granted a lien on any Claim Proceeds intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the Claim Proceeds and the Benefit Program shall be entitled to assert security interest thereon. By the acceptance of benefits under the Benefit Program, the Covered Person and his/her representatives agree to hold the Claim Proceeds in trust for the benefit of the Benefit Program to the extent of 100% of all benefits paid by the Benefit Program on behalf of the Covered Person.
4. By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Benefit Program an amount equal to the benefits paid against any Claim Proceeds. This assignment is binding on an attorney who represents the Covered Person whether or not an agent of the participant and on any insurance company or other financially responsible party against whom a Covered Person may have a claim.
5. The subrogation and reimbursement rights and liens apply to any Claim Proceeds received or payable to the Covered Person, including but not limited to the following:
   a. Payments made directly by a third party tortfeasor, or any insurance company on behalf of a third party tortfeasor, or any other payments on behalf of a third party tortfeasor.
   b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
   c. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as the result of negligence or alleged negligence of a third party.
   d. Any workers compensation award or settlement.
   e. Any recovery made pursuant to no-fault insurance.
   f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
6. No adult Covered Person hereunder may assign any rights that such person may have to recover medical expenses from any Third Party to any minor child or children of said adult Covered Person without the prior express written consent of the Benefit Program. The Benefit Program's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
7. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Benefit Program.
8. The Benefit Program's rights of subrogation and reimbursement shall be a prior lien against any Claim Proceeds, and shall not be defeated nor reduced by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Benefit Program's recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Benefit Program's rights of subrogation and reimbursement provide the Benefit Program with the right to receive the first dollars of any Claim Proceeds, irrespective of whether the Covered Person has been fully compensated or partially compensated for all or any of injuries, damages or other claims of the Covered Person.
9. No Covered Person hereunder shall incur any expenses on behalf of the Benefit Program in pursuit of the Benefit Program's

rights hereunder, specifically, no court costs or attorney's fees may be deducted from the Benefit Program's recovery without the prior express written consent of the Benefit Program. This right shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."

10. The Benefit Program shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.

11. The benefits under this Benefit Program are secondary to any coverage under no-fault or similar insurance.

12. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Benefit Program shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Benefit Program shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Covered Person has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

13. Any reference to state law in any other provision of this Benefit Program shall not be applicable to this provision if the Benefit Program is governed by ERISA. By acceptance of benefits under the Benefit Program, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Benefit Program shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Benefit Program, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

For purposes of this Section:

"Covered Person" includes, individually and collectively, a participant, beneficiary or any other covered person under this Benefit Program. A reference to a Covered Person includes the Covered Person's estate and any representative of the Covered Person.

"Third Party" refers to any person or entity who, with respect to a claim for benefits of a Covered Person, is not the Covered Person (e.g., a third party tortfeasor). References to a Third Party include, without limitation, any auto or other insurer that provides coverage of any kind (including non-insured or underinsured motorist coverage) to the Covered Person or to any Third Party, including insurers that provide coverage to employees of the Cleveland Clinic or another employer. The term Third Party also may refer to another person who is a Covered Person under this Benefit Program.

"Claim" means any type of legal, equitable, insurance, or other claim that a Covered Person (or any representative of the Covered Person) has against a Third Party, if that claim could, or would, provide any amount of money or other consideration to the Covered Person because of, or in any way attributable to, the Covered Person's claim for benefits under this Benefit Program, or because of any set of facts and circumstances that are in any way related to the Covered Person's claim for benefits under the Benefit Program. The reference to a Covered Person's Claims includes, without limitation, claims of pain and suffering and loss of consortium, as well as claims for consequential, punitive, exemplary or other damages.

"Claim Proceeds" includes any money or other consideration recovered from, or payable by, any Third Party that is attributable to a Claim of a Covered Person. Claim Proceeds includes, without limitation, amounts received by settlement, judgment or otherwise, and any insurance proceeds of any kind, or in satisfaction of any judgment or settlement, insurance claim of any kind, or otherwise. Claim Proceeds includes, without limitation, proceeds received by a Covered Person for claims of pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages.

Cleveland Clinic Employee Health Plan Non-Discrimination Notice

Cleveland Clinic's Employee Health Plan (EHP) (https://employeehealthplan.clevelandclinic.org) complies with applicable laws and does not discriminate on the basis of race, color, culture, ethnicity, national origin (including limited English proficiency and primary language), age, disability, religion, socioeconomic status, or sex (including but not limited to sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). EHP does not exclude people or treat them differently in any health programs and/or activities because of race, color, culture, ethnicity, national origin (including limited English proficiency and primary language), age, disability, religion, socioeconomic status, or sex (including but not limited to sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes).

EHP provides, free of charge, reasonable modifications for individuals with disabilities, and appropriate auxiliary aides and services and language assistance to enable individuals to have an equal opportunity to access its health programs and/or activities. Such modifications, auxiliary aids and services and language assistance may include:

- Qualified interpreters (including ASL interpreter services).

- Information in other formats (i.e., audio, accessible electronic formats, other formats).
- Information written in other languages.

If you need interpreter or other communication related services, please contact **Cleveland Clinic Global Patient Services Dispatch** at 1.833.858.1813 or 216.445.7044.

If you require other reasonable modifications due to a disability, please contact **Cleveland Clinic Section 1557 Coordinator** at:

Cleveland Clinic Ombudsman Department
Attn: Section 1557 Coordinator
9500 Euclid Avenue, A-50
Cleveland, Ohio 44195
Telephone: 1.800.223.2273
Fax: 216.445.6086
Email: ombudsman@ccf.org
Webpage: **https://my.clevelandclinic.org/departments/patient-experience/depts/office-patient-experience/ombudsman**

EHP shall provide reasonable accommodations to allow qualified individuals with disabilities to access its health programs and/or activities. You cannot be retaliated against for exercising these rights.

If you believe that EHP has failed to provide appropriate modifications, auxiliary aids and services and language assistance services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including but not limited to sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes), you can file a grievance with Cleveland Clinic Ombudsman Department, using the contact information above. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Cleveland Clinic Ombudsman Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services via any of the following:

- email (**OCRComplaint@hhs.gov**)
- Phone (toll-free at: 1.800.368.1019, TDD: 1.800.537.7697)
- OCR Complaint Portal (**ocrportal.hhs.gov/ocr/smartscreen/main.jsf)**
- USPS at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is Federal law that pertains to group health plans. HIPAA has the following four basic provisions:

- It prohibits an employer health plan from imposing pre-existing condition exclusions on employees and dependents.
- It prohibits an employer health plan from prohibiting enrollment or charging a higher employee contribution amount or premium because of “health status-related factors.”
- It requires an employer health plan to allow enrollment for employees and dependents who lose coverage under other plans or insurance policies or have a qualifying life event.
- It requires employer health plans to establish privacy and security standards to protect the confidentiality and integrity of individually identifiable health information.

Any other questions or issues related to the HIPAA law should be directed to the Caregiver Office Service Center.

A Statement of Your Rights Under ERISA

As a participant in the Cleveland Clinic Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) which are described below.

Receive Information about Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan and/or this Benefit Program including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, **https://www.dol.gov/general/topic/health-plans/erisa or https://www.dol.gov/general/contact** or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866.444.3272.

ERISA Required Information

This information is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about the Plan. The following provides information specific to the Cleveland Clinic Welfare Benefit Plan (the "Plan"), and the Cleveland Clinic Health Benefit Program (the "Benefit Program") which is a component of the Plan and is a welfare plan that provides benefits to certain employees.

Official Plan Name.....Cleveland Clinic Welfare Benefits Plan

Official Benefit Program Name.....Cleveland Clinic Health Benefit Program

Plan Number.....530

Type of Administration

The Benefit Program is a self-insured benefit plan offering medical benefits. Cleveland Clinic has contracted with Aetna, a third-party administrator, to administer the Benefit Program.

Contributions to the Benefit Programs

Benefit Program benefits are paid from the general assets of Cleveland Clinic. However, Cleveland Clinic has contracted with a third-party administrator to assist in the administration of the Benefit Program.

Funding Medium

Benefits provided by this Benefit Program are provided through Cleveland Clinic and through employee contributions. The Plan Sponsor shall from time to time determine the amount of contributions payable by Participants.

Plan Sponsor, Plan Administrator and Plan Fiduciary

Cleveland Clinic
25900 Science Park Drive / AC242
Beachwood, OH 44122
216.986.0500 or toll-free at 888.246.6648

The administration of the Plan, including the Benefit Program, will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to the interpretation and operation of the Plan including any portion thereof. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

Cleveland Clinic
Law Department / AC321
3050 Science Park Drive Beachwood, OH 44122
Service of legal process may also be made on the Plan Administrator.

Plan Year

January 1–December 31
Records and reports for the Plan, including Benefit Programs contained therein, are kept on a calendar year (January 1–December 31). The Plan Year is also the Fiscal Year.

Employer Identification Number of Plan Sponsor

34-0714585

Benefit Program Effective Date

The Plan is effective as of January 1, 2013 and the provisions of the Benefit Program are effective January 1, 2024.

Plan Documentation

If there are any discrepancies between this *Summary Plan Description (SPD)* and the provisions of the Cleveland Clinic Welfare Benefits Plan Document, including the contract, the Plan Document will prevail. No oral interpretations can change this Plan. The Plan Sponsor also reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion. The decisions of the Plan Administrator, Claims Administrator and Appeals Administrator, as applicable, shall be final and conclusive with respect to all questions relating to the Plan.

Future of the Plan

The Plan Sponsor reserves the right to amend, modify, suspend or terminate the Plan, including this Benefit Program, in whole or in part, at any time, including retroactively, without notice, in such manner as it shall determine regardless of a participant's status, which may result in the termination or modification of an member's coverage under the Benefit Program. If the Plan or Benefit Program is amended, modified, or terminated, the rights of members are limited to benefits incurred prior to the Plan's amendment, modification or termination. However, no participant has a vested right to the continuation of any particular benefit provided by the Plan

No Employment Contract.....This *SPD* does not create any contractual rights to employment nor does it guarantee the right to receive benefits under the Plan or Benefit Program. Benefits are payable under the Plan or Benefit Program only to individuals who have satisfied all of the conditions under the Plan document for receiving benefits.

Delegation of Responsibility.....The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan. The Plan Administrator, Claims Administrator, and/or Appeals Administrator, as applicable, may seek such expert advice as reasonably necessary with respect to the Plan or Benefit Program. The Plan Administrator, Claims Administrator, and/or Appeals Administrator, as applicable, shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful. The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Section Seven
TERMS AND DEFINITIONS

Definition of Terms

Access to Care:

- ***Immediate*** is defined as having access to emergency services immediately for a life-threatening emergency.
- ***Emergent*** is defined as having access to emergency services within six hours for a non-life-threatening emergency.
- ***Urgent*** is defined as having access to care within 48 hours.
- ***Routine*** is defined as having access to a routine office visit within 10 business days.

Activities of Daily Living – The skill and performance of physical, psychological, and emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.

Against Medical Advice (AMA) – The act of an individual leaving the care of a medical facility without proper discharge by a physician.

Allowed Amount – Negotiated charges for allowed healthcare services as described in this SPD.

Ancillary Services – Ancillary services are medical services or supplies that are not provided by acute care hospitals or doctors but are used to support providers in treating patients. Examples of ancillary services providers include those providing services related to dialysis, ambulances, transportation, durable medical equipment (DME), home health, skilled nursing facilities, Hospice and others.

Behavioral Health – Refers to and includes all services for mental health and substance abuse.

Behavioral Health Levels of Care

1. ***Outpatient Visits (OP):*** Ambulatory care, usually non-urgent, for problems or conditions that can be treated on a periodic basis.
2. ***Intensive Outpatient Program (IOP):*** Similar to Partial Hospitalization Program (PHP) in that they are structured programs with a multi-disciplinary team approach and a variety of treatment modalities. The program is usually less restrictive than a PHP. Patients are more stable, considered low risk for self harm, can function in the community and manage some daily activities, but require more comprehensive services than can be provided at an outpatient level of care. The patient participates in the program a minimum of nine hours per week.
3. ***Partial Hospitalization Program (PHP):*** Highly structured ambulatory, multi-disciplinary treatment program with a high staff to patient ratio. A psychiatrist must be available for consultation as needed on an ongoing basis. A PHP includes treatment modalities found in a comprehensive inpatient program. The program may be appropriate whenever a patient does not require 24 hour acute care hospitalization, but does need more comprehensive services than can be provided at an outpatient level of care. The program is open a minimum of 20 hours per week.
4. ***Inpatient (IP):*** A medical facility that is licensed to provide 24 hour, 7 days per week medical care and provides a high degree of safety. The facility employs a multi-disciplinary staff that must include psychiatrists and nurses. Services are comprehensive and usually include medication management, individual, group and/or family psychotherapy, social services, milieu and activity therapy. Inpatient care is not the same as residential care. See page 20 for information regarding Residential Treatment.

Benefits Period – The period of time specified in the Schedule of Benefits during which covered services are rendered and benefit maximums are accumulated; the first and last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Cleveland Clinic and regional hospitals – Fully integrated Healthcare Delivery System that covers all components of healthcare services including Medical Professional, Ambulatory (outpatient/office), Hospital, and certain Ancillary Services.

Cleveland Clinic consists of the following group of hospitals:

Cleveland Clinic Florida Hospitals (Indian River, Martin Health, Tradition and Vero Radiology), Cleveland Clinic, Cleveland

Clinic Children's, Cleveland Clinic Children's Hospital for Rehabilitation, Akron General Hospital, Ashtabula County Medical Center, Cleveland Clinic Avon Hospital, Euclid Hospital, Fairview Hospital, Hillcrest Hospital, Lutheran Hospital, Marymount Hospital, Medina Hospital, Mercy Hospital, South Pointe Hospital, Union Hospital, and Cleveland Clinic Nevada.

COB Smart – COB Smart is a CAQH solution designed to streamline and improve the Coordination of Benefits (COB) process in healthcare. It helps health plans, providers, and clearinghouses determine the correct order of payment when a member has coverage from multiple insurance plans, preventing over payments and reducing administrative costs.

Co-insurance – The payment the employee owes for services rendered when the HBP coverage is less than 100%; co-insurance payments usually accrue toward an annual out-of-pocket maximum and/or annual deductible.

Concurrent Review – This review is conducted either during a member's hospital stay or during the course of a prescribed treatment. The concurrent review may result in additional covered care that exceeds the original authorized Medical Management Department approval.

Contracted Rate – The hospital rate and physician fee schedule that is paid by the Third-Party Administrator (TPA) for the HBP contract.

Coordination of Benefits (COB) – A process that determines which of multiple insurance plans pays for healthcare costs first, and in what order.

Co-payment – A dollar amount that you are required to pay at the time covered services are rendered; generally, a co-payment usually accrues toward an annual out-of-pocket maximum and/or annual deductible.

Covered Charges – Charges for medical services or procedures that are covered by the Cleveland Clinic Health Benefit Program.

Custodial Care – Care which does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- Administration of medication which can be self-administered or administered by a lay person; or
- Help in walking, bathing, dressing, feeding, or the preparation of special diets.

Deductible – An amount, usually stated in dollars, for which you are responsible each benefit period before the TPA will start to reimburse benefits.

Domicilary – A temporary residence, such as for disabled veterans.

Durable Medical Equipment (DME) – Medical equipment used in the home to aid in a better quality of living such as wheelchairs, walkers, infusion pumps and supplies, etc.

Effective Date – Health benefit coverage is effective on the first day of your active employment provided that the individual enrolls in the Plan.

Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or, in the case of a pregnant woman, the health of the woman or her unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Examples of emergency medical conditions include, but are not limited to:

- Chest pain
- Stroke/CVA
- Loss of consciousness
- Hemorrhage
- Multiple trauma

An emergency condition may or may not result in an inpatient hospital admission. Emergency Room Transfer call line is toll-free at 866.721.9803.

Emergency Services – with respect to an Emergency:

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency;
- Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment that are Covered Charges and are required to stabilize the Member if performed by an Out-of-Network provider or facility (regardless of the department of the Hospital in which such further examination or treatment is furnished).
- Services provided by an Out-of-Network provider or facility after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency visit, until:
  1. The provider or facility determines the Member is able to travel using non-medical transportation or non-emergency medical transportation;
  2. The Out-of-Network provider offering these services supplies the Member with a written notice that satisfies notice and consent criteria in accordance with applicable federal law, and the Member gives informed consent to continued treatment by the Out-of-Network provider.

The above limitations do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Experimental or Investigational – Drugs, Devices, Medical treatment, or Medical procedures that are not considered to be a standard of practice in this healthcare market for a particular diagnosis.

Explanation of Benefits (EOB) – A statement received by the patient from the TPA after services have been rendered that explains how the bill was paid.

Family Planning – The ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Fee schedule – The rate the physician is paid by the TPA for the Cleveland Clinic HBP contract.

Habilitative Therapy – Therapy services that help patients maintain, develop skills or functions that they were incapable of developing on their own due to a disability such as Autism, Autism Spectrum Disorder, Developmental Delay, Cerebral Palsy, Spina Bifida or Apraxia.

Hospital – An institution which meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio.

Identification (ID) Card – Card provided to individuals having group health benefit coverage listing the individual's name, group number, and important contact phone numbers to call to verify coverage for health, prescription, and behavioral health/substance abuse benefits. This card should be carried with you at all times.

Independent Freestanding Emergency Department – a health care facility that is geographically separate and distinct from a Hospital under applicable state law and is licensed under state law to provide Emergency Services.

Inpatient – A person who receives care as a registered bed patient in a hospital or other facility provider where a room and board charge is made.

Medical Care – Professional services received from a physician or another healthcare provider to treat a condition.

Medical Management – A comprehensive Physician-directed program utilizing Registered Nurses, Medical Assistants, Social Workers and Counselors to provide education and follow-up to employees to assure the delivery of medically necessary, high quality, and cost-effective healthcare in the most appropriate setting. The Medical Management Department provides Case Management and Utilization Management programs.

Medical Necessity – The services or treatments that meet health plan benefit coverage criteria for diagnosing, preventing, or treating an illness, injury, condition, or its symptoms, and except for clinical trials and other experimental, investigational, or cosmetic purposes, also meets accepted standards of medical care. The services or treatments are not solely for the convenience of the insured, the insured's family or the provider, and provides value by achieving the best possible health outcomes at the lowest reasonable cost

Member – An individual enrolled in and covered by a health benefit plan.

Network Provider – A participating provider who has agreed to accept the Allowed Amount as payment in full for covered services rendered after applicable co-payment/co-insurance. The member is not liable for any amount charged over the Allowed Amount.

- The HBP offers a two-tier provider network. Tier 1 providers are contracted and credentialed through the Cleveland Clinic Community Physician Partnership (CPP). Tier 2 providers are contracted and credentialed through Aetna.

Non-Contracting – The status of a hospital or other facility provider which does not meet the definition of a contracting Cleveland Clinic Health Benefit Program Provider.

Non-Covered Charges – Billed charges for services and supplies which are not covered services under the HBP.

Notification – Process required by HBP of informing the Medical Management Department that an emergency admission has occurred. Notification by the physician is required within two business days of the admission.

Observation Stay – A type of outpatient hospital stay where a patient is monitored and treated for a short period, typically less than 48 hours, to determine if they require further treatment as an inpatient or can be safely discharged.

Out-of-Network – A provider that does not participate in the Tier 1 Network of Providers (Cleveland Clinic Quality Alliance) or Tier 2 Network of Providers (MMO SuperMed network (within the state of Ohio) and Aetna® Open Choice® PPO network (outside the state of Ohio).

Out-of-Pocket Maximum – The accrued value of co-insurance payments that has to be satisfied before the reimbursement for covered services will be provided in full.

Outpatient – The status of a covered person who receives services or supplies through a hospital, other facility provider, physician, or other healthcare provider while not confined as an inpatient.

Participating – The status of a physician or other healthcare provider that has an agreement with the Cleveland Clinic Health Benefit Program to accept Allowed Amount as payment in full.

Pharmacy Management – Responsible for all aspects of the Employee and Retiree Health Plans' Pharmacy Benefit Programs and dedicated to the provision of medically necessary, evidence and value-based medication therapy. Provides customer services as well as clinical support for Utilization Management Programs.

Physician – A person who is licensed and legally authorized to practice medicine.

Precertification – The process of verifying member eligibility and benefit coverage under the HBP. Precertification also includes the process of determining whether or not a patient has met the medical necessity criteria outlined by the HBP for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Prior authorization, precertification and prior approval are often used interchangeably.

Predetermination – A review for coverage of a service or procedure that does not require precertification. This process is completed through Aetna.

Prescription Drug (Federal Legend Drug) – Any medication which by Federal or State law may not be dispensed without a prescription order.

Primary Care Providers (PCP) – Physician practices expert in providing diagnosis and treatment of illness and provision of preventive care; they also serve as coordinators of the overall care of their patients.

Prior Approval – See precertification.

Prior Authorization – See precertification.

Provider – A person or organization responsible for delivering healthcare services.

Quality Alliance – The Quality Alliance (QA) is a clinical integration program that offers patients a higher standard of care through the use of standard clinical guidelines for chronic disease management and preventive care services. The QA includes all Cleveland Clinic employed physicians and a great number of independent Cleveland Clinic-affiliated practitioners who have elected to follow the same standard clinical guidelines for chronic disease management and preventive care services.

Registration – Process of verifying patient information including name, current address, phone number, insurance plan, and group number. **The registration process must be completed anytime a plan member receives healthcare service.**

Rehabilitation Therapy – Therapy services that help you **keep, get back, or improve skills** and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Specialty Care Providers – Physician practices with expertise in a specific medical specialty or sub-specialty.

Subrogation – The legal right of an insurance company to request reimbursement from the at-fault party after it has paid a covered claim.

Surgery:

- The performance of generally accepted operative and other invasive procedures;
- The treatment of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonable and approved by the HBP.

Third-Party Administrator (TPA) – A professional firm that performs administrative functions (e.g., claim processing membership) for a self-funded plan or a group plan.

Transition of Care – A waiver of out-of-network status of a provider to pay at plan's benefit level for a short term, temporary period of time while the member transitions their care or service needs into their elected plan network of participating providers.

Urgent Care – Care received for medical conditions that are unforeseen and require attention within 24 hours. Examples of urgent care include, but are not limited to:

1. Minor cuts/lacerations
2. Minor burns
3. Minor trauma
4. Seemingly minor illnesses that include a high fever
5. Sprains

Usual and Customary Amount (U&C) – The maximum amount allowed for a covered service provided by a physician or other healthcare provider based on the following criteria:

1. The U&C Amount will never exceed the actual amount billed by the physician or other healthcare provider for a given service and for some services may be the amount billed.
2. The U&C Amount may be limited to the customary charge based on the distribution of charges billed by all physicians and other healthcare providers for a given service within a given specialty and geographic area.
3. The U&C Amount must also be reasonable as defined by the Cleveland Clinic Health Benefit Program TPA with respect to customary charges or costs for services of comparable complexity and difficulty.

Notes

Cleveland Clinic

Every life deserves world class care.

9500 Euclid Avenue, Cleveland, OH 44195

Cleveland Clinic is a top-ranked nonprofit academic medical center founded in 1921. With more than 1,300 staffed beds, as well as research and education institutes, the organization is dedicated to providing expert inpatient and hospital care through innovation, quality, teamwork and service.

07/2025