

# HBP Benefits Summary

Benefit Program Features		<i>EHP</i>	<i>OUT OF NETWORK</i>
		Cleveland Clinic Quality Alliance Network	
<b>Annual Deductible</b>	Single Family	None None	
<b>Out-of-Pocket Maximum</b>	Single Family	\$3,950 \$7,900	
<b>Medical Benefit Program Features</b>			
<b>PCP Office Visit</b> (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)		100% of Allowed Amount	Not Covered
<b>PCP Virtual Visits</b>		100% of Allowed Amount	Not Covered
<b>Specialist Office Visits</b>		100% of Allowed Amount after \$35 copay (no referral required)	Not Covered
<b>Specialist Virtual Visits</b>		100% of Allowed Amount	Not Covered
<b>Maternity Care</b>		\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
<b>Routine (Annual) Physical Exam by Primary Care Physician</b>		100% of Allowed Amount	Not Covered
<b>Routine (Annual) Vision Exam</b>		100% of Allowed Amount after \$35 co-pay	Not Covered
<b>Inpatient Hospital Services<sup>1</sup></b>		\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
<b>Outpatient Hospital Services</b>		100% of Allowed Amount	Not Covered
Radiology –		100% of Allowed Amount	Not Covered
MRI/CT Scans (non-emergent) <sup>1</sup>		\$75 co-pay, then 100% of Allowed Amount	Not Covered
<b>Laboratory/Diagnostic Tests</b>		100% of Allowed Amount	Not Covered
<b>Emergency Department</b>			
Emergency Care / ER Hospital Admission		100% after \$250 co-pay / \$350 if admitted	100% after \$250 co-pay / \$350 if admitted
Urgent Care		100% after \$50 co-pay	100% after \$50 co-pay
<b>Medical Supplies and Durable Medical Equipment</b>		80% of Allowed Amount	Not Covered
<b>Skilled Nursing Care<sup>1</sup></b>		\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
60 Days per Benefit Year			
<b>Acute Inpatient Rehab<sup>1</sup></b>		\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
60 Days per Benefit Year			
<b>Long-Term Acute Care<sup>1</sup></b>		\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
60 Days per Benefit Year			
<b>Hospice</b>		100% of Allowed Amount	Not Covered
Symptom Management		100% of Allowed Amount	Not Covered
Respite Care		100% of Allowed Amount	Not Covered
<b>Home Health Care<sup>1</sup></b>		100% of Allowed Amount	Not Covered
60 Visits per Benefit Year			
<b>Acupuncture</b>		50% of Allowed Amount	Not Covered
Maximum of 10 Visits/Benefit Year			
<b>Chiropractic</b>		100% of Allowed Amount after \$35 co-pay	Not Covered
Maximum of 30 Visits/Benefit Year			

All co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for bariatric surgery and the Autism School. **Retirees Over 65:** Co-payments and coinsurance do not apply with the exception of coinsurance for hearing aids.

1. Precertification required.

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

## HBP Benefits Summary (continued)

Medical Benefit Program Features	<i>EHP</i>	<i>OUT OF NETWORK</i>
	Cleveland Clinic Quality Alliance Network	
<b>Therapy Services (Rehabilitative)</b> Occupational/Speech/Physical	100% of Allowed Amount after a \$10 copay. 30 Visits per Therapy per Calendar Year	Not Covered
<b>Therapy Services (Habilitative)</b> Physical/Occupational/Speech a. Developmental Delay, Cerebral Palsy, Apraxia  b. Autism and Autism Spectrum Disorder	100% of Allowed Amount 30 Visits per Therapy per Calendar Year  100% of Allowed Amount (No visit limitation)	Not Covered
<b>Dental</b> – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
<b>Family Planning</b> <sup>2</sup>	100% of Allowed Amount	Not Covered
<b>Infertility Treatment</b> <sup>1,2</sup>	100% of Allowed Amount LTM: (\$15,000 Medical, \$6,000 Pharmacy)	Not Covered
<b>Hearing Aids</b>	50% of Charge up to \$3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
<b>Organ Transplant</b> <sup>1</sup> Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
<b>Behavioral Health Benefit Program Features</b>		
<b>Physician Office Vists</b>	100% of Allowed Amount after a \$35 co-pay	Not Covered
<b>Outpatient Coverage</b> Outpatient (OP Visits) <sup>3</sup> Psychological and Neuro-Psychological Testing <sup>4</sup>	100% of Allowed Amount 100% of Allowed Amount	Not Covered
<b>Outpatient Telemedicine/Virtual Consultation</b>	100% of Allowed Amount	Not Covered
<b>Inpatient Coverage</b> <sup>1</sup>	\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
<b>Intensive Outpatient (OP)</b>	100% of Allowed Amount	Not Covered
<b>Partial Hospitalization Programs (PHP)</b> <sup>1</sup>	100% of Allowed Amount	Not Covered
<b>Residential Treatment</b> <sup>1</sup>	\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
<b>Transcranial Magnetic Stimulation (TMS)</b> <sup>1</sup> 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	Not Covered

All co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for bariatric surgery and the Autism School. **Retirees Over 65:** Co-payments and coinsurance do not apply with the exception of coinsurance for hearing aids.

1. Precertification required.

2. Marymount employees are subject to family planning exclusions including transgender services, infertility treatment, abortion, vasectomy, Norplant, Depo Provera, IUD, tubal ligation, and oral contraceptives, except if clinically appropriate.

3. 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.

4. Psychological and Neuro-Psychological Testing: Up to 8 hours of testing are automatically reimbursed without precertification. Testing must be done by trained Behavioral Health Specialists.

*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 care.

# Non-Medicare Retiree HBP Prescription Drug Benefit

Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2022 (Retirees under 65)

Categories	TIER 1	TIER 2	TIER 3	TIER 4	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
	Preferred Generics (Non-Specialty)	Preferred Brands (Non-Specialty)	Non-Preferred Brands and Generics (Non-Formulary)	Specialty Brand/ Generic Drugs (Hi-Tech)		
<b>Annual Deductible</b>	\$200 Individual \$400 Family	<i>(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)</i>			No	No
<b>Member % Co-insurance Cleveland Clinic Pharmacies:</b> up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
<b>Member % Co-insurance CVS Store Pharmacies:</b> 30-Day Supply <b>Mail Service Program:</b> 90-Day Supply	20%	30%	50%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
<b>Cleveland Clinic Pharmacies including Specialty &amp; Home Delivery:</b> 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
<b>Retail Pharmacies:</b> 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
<b>CVS/caremark Mail Service Program:</b> 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
<b>Is there an Annual Out-of-pocket Maximum?</b>	No	No	No	No	No	No
<b>Components of Each Category</b>			<b>Brand Name Drugs</b> See the <b>EHP Prescription Drug Benefit Formulary</b>	<b>Specialty Drugs<sup>5,6</sup></b> Complete list of Specialty Drugs and Copay Card Assistance Program in the <b>EHP Prescription Drug Benefit Formulary</b>	<b>Lifestyle Drugs</b> See the <b>EHP Prescription Drug Benefit Formulary</b>	<b>Over-the-Counter Drugs</b> See the <b>EHP Prescription Drug Benefit Formulary</b>
<b>Prior Authorization Required</b>	See the <b>EHP Prescription Drug Benefit Formulary</b> for list of pharmaceuticals requiring prior authorization				No	N/A
<b>Diabetic Supplies<sup>7</sup> Asthma Delivery Devices<sup>7</sup> and Prescription Vitamins<sup>8</sup></b>	Co-insurance 20%			No	No	N/A
<b>Pharmacies<sup>9</sup> in the Retail Network</b>	Cleveland Clinic Pharmacies (in Ohio and Florida), Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Home Delivery Pharmacy, CVS store pharmacies (including CVS pharmacies located in Target stores), CVS/caremark Mail Service, CVS/specialty Pharmacy					

**Note:** Benefit Program includes: generic oral contraceptives – covered for Marymount for clinical appropriateness only under the HBP.

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

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 insulin pumps and insulin pump 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, and injection pens. 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.

# Medicare Eligible and Approved Retiree HBP Prescription Drug Benefit

Administered Through SilverScript®

The Following Is a Summary Overview of the Prescription Drug Benefit for 2022 (Retirees 65 and over)

Categories	TIER 1	TIER 2	TIER 3	TIER 4
	Generic Rx	Preferred Brands (Formulary)	Non-Preferred Brands (Non-Formulary)	Specialty Drugs (Hi-Tech)
<b>Annual Deductible</b>	\$100 Individual (Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)			
<b>Member % Co-insurance Cleveland Clinic Pharmacies:</b> Outpatient: up to 90-Day Supply Specialty & Home Delivery: up to 90-Day Supply	15%	25%	45%	20%
<b>Member % Co-insurance CVS/caremark Retail:</b> up to 90-Day Supply <b>Mail Service Program:</b> up to 90-Day Supply	20%	30%	50%	20%
<b>Cleveland Clinic Pharmacies including Specialty &amp; Home Delivery:</b> 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
<b>CVS/caremark Retail up to 90-Day Supply:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$5 Minimum/ \$75 Maximum per Month Supply	Yes \$5 Minimum/ \$75 Maximum per Month Supply	No	N/A
<b>CVS/caremark Mail Service:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$15 Minimum/ \$225 Maximum 90-Day Supply	Yes \$15 Minimum/ \$225 Maximum 90-Day Supply	No	Yes No Minimum/ \$100 Maximum per Month Supply
<b>Is there an Annual Out-of-pocket Maximum?</b>	No	No	No	No
<b>Components of Each Category</b>	Generic Drugs	Brand Drugs		Specialty Drugs
	<p>You will be sent a copy of the SilverScript's <i>Preferred Drug List</i>. You may also contact SilverScript to request a copy of the <i>Preferred Drug List</i> by calling the toll-free number on your SilverScript card.</p> <p><b>Medicare Part B vs. Medicare Part D</b> Please note: Most medications are covered under Medicare Part D, but there are some medications that can be covered under both Medicare Part B (i.e., the Medicare outpatient benefit) or Medicare Part D (i.e., the Medicare prescription drug benefit) depending on what the drug is used for and how it is administered. Please consult the SilverScript Prescription Drug Formulary or contact SilverScript using the toll-free phone number on the back of your SilverScript card for more information regarding Medicare Part B vs. Medicare Part D medications.</p>			
<b>Major Chains in the Retail Network</b>	ACME, Cleveland Clinic Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy), Costco, CVS, Discount Drug Mart, Giant Eagle, K-Mart, Marc's, Medicine Shoppe, Rite Aid, Target, Walgreens, Wal-Mart, plus other chains and independent pharmacies.			

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**Note:** Effective January 1, 2018, diabetic testing supplies will no longer be covered under the Medicare Part D program. They will now be covered under Medicare Part B.

See the *Retiree Health Plan Prescription Drug Benefit Handbook* for SilverScript's Request for Medicare Prescription Drug Coverage Determination for Prior Authorization