

HBP Benefits Summary

| Benefit Program Features | TIER 1 | TIER 2 |
|---|--|--|
| | Cleveland Clinic Quality Alliance Network | Aetna Select Open Access Network |
| Annual Deductible Single Family | None None | \$500 \$1,500 |
| Out-of-Pocket Maximum Single Family | \$3,950 \$7,900 | \$4,750 \$9,500 |
| Medical Benefit Program Features | | |
| PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics) | 100% of Allowed Amount | \$25 co-pay, then 70% of Allowed Amount (after deductible) |
| PCP Virtual Visits | 100% of Allowed Amount | \$25 co-pay, then 70% of Allowed Amount (after deductible) |
| Specialist Office Visits | 100% of Allowed Amount after \$35 copay (no referral required) | \$50 co-pay, then 70% of Allowed Amount (after deductible) |
| Specialist Virtual Visits | 100% of Allowed Amount | \$50 co-pay, then 70% of Allowed Amount (after deductible) |
| Maternity Care | \$350 co-pay/admission, then 100% of Allowed Amount | \$350 co-pay/admission, then 70% of Allowed Amount (after deductible) |
| Routine (Annual) Physical Exam by Primary Care Physician | 100% of Allowed Amount | Not Covered |
| Routine (Annual) Vision Exam | 100% of Allowed Amount after \$35 co-pay | Not Covered |
| Inpatient Hospital Services¹ | \$350 co-pay/admission, then 100% of Allowed Amount | \$350 co-pay/admissions, then 70% of Allowed Amount (after deductible) |
| Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent) ¹ | 100% of Allowed Amount 100% of Allowed Amount \$75 co-pay, then 100% of Allowed Amount | 70% of Allowed Amount (after deductible) 70% of Allowed Amount (after deductible) \$75 co-pay, then 70% of Allowed Amount (after deductible) |
| Laboratory/Diagnostic Tests | 100% of Allowed Amount | 70% of Allowed Amount (after deductible) |
| Emergency Department Emergency Care Urgent Care | 100% after \$250 co-pay 100% after \$50 co-pay | 100% after \$250 co-pay 100% after \$50 co-pay |
| Medical Supplies and Durable Medical Equipment | 80% of Allowed Amount | 80% of Allowed Amount (after deductible) |
| Skilled Nursing Care¹ 60 Days per Benefit Year | \$350 co-pay/admission, then 100% of Allowed Amount | \$350 co-pay/admission, then 70% of Allowed Amount (after deductible) |
| Acute Inpatient Rehab¹ 60 Days per Benefit Year | \$350 co-pay/admission, then 100% of Allowed Amount | Not Covered |
| Long-Term Acute Care¹ 60 Days per Benefit Year | \$350 co-pay/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 Care¹ 60 Visits per Benefit Year | 100% of Allowed Amount | 70% of Allowed Amount (after deductible) |
| Acupuncture Maximum of 10 Visits/Benefit Year | 50% of Allowed Amount | Not Covered |
| Chiropractic Maximum of 30 Visits/Benefit Year | 100% of Allowed Amount after \$35 co-pay | Not Covered |

1. Precertification required.

HBP Benefits Summary (continued)

| Medical Benefit Program Features | TIER 1 | TIER 2 |
|---|---|---|
| | Cleveland Clinic Quality Alliance Network | 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 (Habitative) Physical/Occupational/Speech a. Developmental Delay, Cerebral Palsy, Apraxia | 100% of Allowed Amount 30 Visits per Therapy per Calendar Year | Not Covered |
| b. Autism and Autism Spectrum Disorder | 100% of Allowed Amount (No visit limitation) | |
| Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries | 100% of Allowed Amount | Not Covered |
| Family Planning ² Voluntary Abortion | 100% of Allowed Amount 100% of Allowed Amount | Not Covered 100% of Allowed Amount |
| Infertility – Diagnostic Only | 100% of Allowed Amount | Not Covered |
| Hearing Aids | 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) ³ | 100% of Allowed Amount | 100% of Allowed Amount (after deductible) |
| Office Visits | \$35 co-pay, then 100% of Allowed Amount | \$50 co-pay, then 70% of Allowed Amount (after deductible) |
| Psychological and Neuro-Psychological Testing ⁴ | 100% of Allowed Amount | Not Covered |
| Outpatient Telemedicine/Virtual Consultation | 100% of Allowed Amount | 100% of Allowed Amount (after deductible) |
| Inpatient Coverage ¹ | \$350 co-pay/admission, then 100% of Allowed Amount | \$350 co-pay/admission, then 70% of Allowed Amount (after deductible) |
| Intensive Outpatient (OP) | 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 co-pay/admission, then 100% of Allowed Amount | Not Covered |
| Transcranial Magnetic Stimulation (TMS) ¹ 36 Therapy Related Visits per Benefit Year | 100% of Allowed Amount | Not Covered |

For Tier 1, 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.

1. Precertification required.

2. Marymount employees are subject to family planning exclusions including 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 eight hours testing are automatically covered without precertification. Testing is covered in Tier 1 only, 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.

HBP Prescription Drug Benefit

Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2022

| 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/Non-Formulary Brands and Generics | Specialty Brand/ Generic Drugs (Hi-Tech) | | |
| Annual Deductible | \$200 Individual \$400 Family | <i>(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)</i> | | | 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 Available through Rx Plan |
| 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 Available through Rx Plan |
| 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 <i>EHP Prescription Drug Benefit Formulary</i> | Specialty Drugs^{5,6} Complete list of Specialty Drugs and Copay Card Assistance Program in the <i>EHP Prescription Drug Benefit Formulary</i> | Lifestyle Drugs See the <i>EHP Prescription Drug Benefit Formulary</i> | Over-the-Counter Drugs See the <i>EHP Prescription Drug Benefit Formulary</i> |
| Pre-certification Required | See the <i>EHP Prescription Drug Benefit Formulary</i> for list of pharmaceuticals requiring precertification | | | | No | N/A |
| Diabetic Supplies⁷ Asthma Delivery Devices⁷ and Prescription Vitamins⁸ | Co-insurance 20% | | | No | No | N/A |
| Pharmacies⁹ in the Retail Network | Cleveland Clinic Pharmacies ClevelandClinic 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.