HBP Benefits Summary

Benefit Program Features		EHP Cleveland Clinic Quality Alliance Network	OUT OF NETWORK
Annual Deductible **Out-of-Pocket Maximum**	Single Family Single Family	None None $3,950 $7,900	
Medical Benefit Program Features			
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)		100% of Allowed Amount	Not Covered
PCP Virtual Visits		100% of Allowed Amount	Not Covered
Specialist Office Visits		100% of Allowed Amount after $35 copay (no referral required)	Not Covered
Specialist Virtual Visits		100% of Allowed Amount	Not Covered
Maternity Care		$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Routine (Annual) Physical Exam by Primary Care Physician **Routine (Annual) Vision Exam**		100% of Allowed Amount 100% of Allowed Amount after $35 co-pay	Not Covered Not Covered
Inpatient Hospital Services[1]		$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
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	Not Covered Not Covered Not Covered
Laboratory/Diagnostic Tests		100% of Allowed Amount	Not Covered
Emergency Department Emergency Care / ER Hospital Admission Urgent Care		100% after $250 co-pay / $350 if admitted 100% after $50 co-pay	100% after $250 co-pay / $350 if admitted 100% after $50 co-pay
Medical Supplies and Durable Medical Equipment		80% of Allowed Amount	Not Covered
Skilled Nursing Care[1] 60 Days per Benefit Year		$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Acute Inpatient Rehab[1] 60 Days per Benefit Year		$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Long-Term Acute Care[1] 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	Not Covered Not Covered Not Covered
Home Health Care[1] 60 Visits per Benefit Year		100% of Allowed Amount	Not Covered
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

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	*EHP* Cleveland Clinic Quality Alliance Network	*OUT OF 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 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
Dental – Surgical extractions for soft/bony impactions, or dental implants[1] for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning[2] (See Coverage Clarifications) Voluntary Abortion	100% of Allowed Amount 100% of Allowed Amount	Not Covered 100% of Allowed Amount
Infertility Treatment[1,2]	100% of Allowed Amount LTM: ($15,000 Medical, $6,000 Pharmacy)	Not Covered
Hearing Aids[5]	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		
Physician Office Vists	100% of Allowed Amount after a $35 co-pay	Not Covered
Outpatient Coverage Outpatient (OP Visits)[3] Psychological and Neuro-Psychological Testing[4]	 100% of Allowed Amount 100% of Allowed Amount	Not Covered
Outpatient Telemedicine/Virtual Consultation	100% of Allowed Amount	Not Covered
Inpatient Coverage[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Intensive Outpatient (OP)	100% of Allowed Amount	Not Covered
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	Not Covered
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

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 and Mercy employees are subject to family planning exclusions including transgender services, infertility treatment, abortion, vasectomy, Depo Provera and tubal ligation. The family planning exclusion also pertains to oral contraceptives, except where 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.
5. 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 care.

HBP Prescription Drug Benefit

Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2023

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 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 ***EHP Prescription Drug Formulary Handbook***	**Specialty Drugs**[6, 7] Complete list of Specialty Drugs and Copay Card Assistance Program in the ***EHP Prescription Drug Formulary Handbook***	**Lifestyle Drugs** See the ***EHP Prescription Drug Formulary Handbook***	**Over-the-Counter Drugs** See the ***EHP Prescription Drug Formulary Handbook***
Prior Authorization Required	See the ***EHP Prescription Drug Formulary Handbook*** for list of pharmaceuticals requiring prior authorization				No	N/A
Diabetic Supplies[8] **Asthma Delivery Devices**[8] **and Prescription Vitamins**[9]	Co-insurance 20%			No	No	N/A
Pharmacies[10] **in the Retail Network**	Cleveland Clinic Pharmacies, 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.

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

7. 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.***

8. Diabetic Supplies – All diabetic supplies covered, except for most insulin pumps and insulin pump supplies (with the exception of Omnipod Dash), 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.

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

10. 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.