Cleveland Clinic

Retiree Health Plan

Summary Plan Description

Calendar Year 2021

Your Guide to Quality Healthcare Services and Healthier Living

Welcome to the Cleveland Clinic Retiree Health Plan, hereafter referred to as the "Health Be efit 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**. Quarterly ***My EHP Health Connection*** newsletters are also sent to members informing them of any health plan updates throughout the year.

The Cleveland Clinic Retiree Health Plan SPD is the health benefit program document. There are no other documents to reference when determining health plan coverage. We encourage you to take the time to read it carefully and to file for future reference.

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

- Medical and behavioral health benefits;
- Prescription drug benefits;
- Network providers;
- Medical and behavioral health case coordination;
- Pharmacy Management programs;
- 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 8 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 Retiree 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
- 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 8.

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 Mutual Health Services, our Third-Party Administrator (TPA), to administer your health plan benefits and provide claims processing for healthcare services.

Mutual Health Services (MHS) – our Third Party Administrator (TPA) – partners with COB Smart®, to identify EHP members who have other insurance coverage. MHS receives weekly files from COB Smart® with those RHP members matching other insurance and will automatically update your record. This means less paperwork for most RHP members. Some smaller insurance companies may not currently participate in COB Smart®. In these instances, you will be asked to complete the COB form. **Note:** Medicare is not included in this process, so the COB form will need to be completed. The form is available on our website at **employeehealthplan.clevelandclinic.org** 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 Mutual Health Services and Coordination of Benefits, see Section Four of the *Summary Plan Description (SPD)*: “Third-Party Administrator (TPA) – Mutual Health Services”.

Two-Tier Provider Network

The Cleveland Clinic Quality Alliance (QA) is the Tier 1 provider network. The Tier 2 provider network consists of providers in the MMO SuperMed network (within the state of Ohio) and Aetna® Open Choice® PPO network (outside the state of Ohio). Your EHP Identification (ID) card reflects these relationships on the back of the card. See page 46 in Section Five: "Administrative Information" for ID card details.

As a HBP member, you can use either of the two provider tiers at anytime throughout the year. However, **to receive maximum coverage, you must use Tier 1 providers**. See page 9 in Section Two: "Tiered Network of Providers" for explanations of all 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 deductible and out-of-pocket maximum information for each tier. The Health Benefit Program features include physician office visits, hospital services, diagnostic services and emergency care, 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 charts on pages 5 and 6 outline drug categories, lists prescription drug delivery options, including Cleveland Clinic Pharmacies, and lists annual deductibles and co-insurance amounts for both groups of retirees (non-Medicare and Medicare eligible and approved).

The HBP Prescription Drug Benefit provides coverage for FDA-approved prescription drugs that are included in the *Cleveland Clinic Retiree Health Plan Prescription Drug Benefit* Handbook* (hereafter referred to as *Handbook* in this *SPD*). The online version of the *Handbook* and *Formulary* can be accessed at **employeehealthplan.clevelandclinic.org**. Click on the "Retiree" tab. Medications are listed in the *Formulary* by both their brand and generic names.

Prescription drugs in both the *Handbook* and SilverScript's *Formulary* are categorized in four tiers:

Generic Medications (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 (Tier 2) – FDA-approved brand name medications of proven therapeutic effectiveness and safety considered essential for patient care and approved for inclusion in the *Handbook*.

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

Specialty 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 he/she chooses 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" (see page 13) 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, prior authorization guidelines, the Caring for Caregivers Program, pharmacy programs, and options for filling your prescription medications.

* Medicare eligible and approved SilverScript members have a separate *Formulary* which is provided by SilverScript. It is also available on our website at **employeehealthplan.clevelandclinic.org**. Click on the "Retiree" tab. Updates to the *Formulary* will be sent to members by SilverScript.

HBP Benefits Summary

Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance Network	*TIER 2* MMO SuperMed[1] and Aetna® Open Choice® PPO Networks
Annual Deductible		
Single	None	$500
Family	None	$1,500
Out-of-Pocket Maximum		
Single	$3,950	None
Family	$7,900	None
Medical Benefit Program Features		
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)	100% of Allowed Amount	$25 co-pay, then 100% of Allowed Amount (after deductible)
Specialist Office Visits	100% of Allowed Amount after $35 copay (no referral required)	$50 co-pay, then 100% 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 Services[2]	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admissions, then 70% of Allowed Amount (after deductible)
Outpatient Hospital Services	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Radiology –	100% of Allowed Amount	70% of Allowed Amount (after deductible)
MRI/CT Scans (non-emergent)[2]	$75 co-pay	$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	100% after $250 co-pay	100% after $250 co-pay
Urgent Care	100% after $50 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 Care[2] 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 Rehab 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Long-Term Acute Care 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Hospice[2]	100% of Allowed Amount	100% of Allowed Amount
Symptom Management – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount
Respite Care – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount
Home Health Care[2] 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 20 Visits/Benefit Year	First 10 visits: 100% of Allowed Amount after $35 co-pay; Second 10 visits: 50% of Allowed Amount (Children under 12 require prior authorization)	Not Covered

HBP Benefits Summary (continued)

Medical Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance Network	*TIER 2* MMO SuperMed[1] and Aetna® Open Choice® PPO Networks
Therapy Services Occupational/Speech/Physical 35 Visits per Therapy per Benefit Year	First 20 visits: 100% of Allowed Amount after $10 co-pay; Second 15 visits: 50% of Allowed Amount	First 20 visits: 100% of Allowed Amount after $10 co-pay and after deductible. Second 15 visits: 50% of Allowed Amount
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[3]	100% of Allowed Amount	Not Covered
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[2] Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	70% of allowed amount (after deductible) None None
Behavioral Health Benefit Program Features		
Outpatient Coverage Outpatient (OP Visits)[4] Psychological and Neuro-Psychological Testing[5]	$35 co-pay, then 100% of Allowed Amount 100% of Allowed Amount	$50 co-pay, then 100% of Allowed Amount (after deductible) Not Covered
Inpatient Coverage[2]	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 70% of Allowed Amount (after deductible)
Intensive Outpatient (OP)[2]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Partial Hospitalization Programs (PHP)[2]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Residential Treatment[2] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[2] 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, hearing aids and Autism School..

1. MMO SuperMed for the state of Ohio and Aetna® Open Choice® PPO outside the state of Ohio.

2. Prior authorization required for all IOP and PHP services in Tier 2 network (exception Tier 1 providers psychiatric and chemical dependency). Eating disorders require prior authorization for IOP/PHP in Tier 1 and Tier 2.

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

4. 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.

5. Psychological and Neuro-Psychological Testing: Up to 16 hours of testing are automatically reimbursed without prior authorization. Testing is covered in Tier 1 only, by trained Behavioral Health Specialists.

Note: Prior authorization, precertification, predetermination 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 HBP Prescription Drug Benefit

Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2021 (Retirees under 65)

Categories	*TIER 1* Preferred Generics	*TIER 2* Preferred Brands	*TIER 3* Non-Preferred Brands (Non-Formulary)	*TIER 4* Specialty 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: 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?	No	No	No	No	No	No
Components of Each Category			**Brand Name Drugs** See the ***EHP Prescription Drug Benefit Handbook***	**Specialty Drugs**[6, 7] Complete list of Specialty Drugs and Copay Card Assistance Program in the ***EHP Prescription Drug Benefit Handbook***	**Lifestyle Drugs** See the ***EHP Prescription Drug Benefit Handbook***	**Over-the-Counter Drugs** See the ***EHP Prescription Drug Benefit Handbook***
Prior Authorization Required	See the ***EHP Prescription Drug Benefit 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 (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.

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

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

8. 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.

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.

Medicare Eligible and Approved HBP Prescription Drug Benefit

Administered Through SilverScript®

The Following Is a Summary Overview of the Prescription Drug Benefit for 2021

Categories	*TIER 1* Generic Rx	*TIER 2* Preferred Brands (Formulary)	*TIER 3* Non-Preferred Brands (Non-Formulary)	*TIER 4* Specialty Drugs (Hi-Tech)
Annual Deductible	$100 Individual *(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)*			
Member % Co-insurance Cleveland Clinic Pharmacies: Outpatient: up to 90-Day Supply Specialty & Home Delivery: up to 90-Day Supply	15%	25%	45%	20%
Member % Co-insurance CVS/caremark Retail: up to 90-Day Supply **Mail Service Program:** up to 90-Day Supply	20%	30%	50%	20%
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
CVS/caremark Retail up to 90-Day Supply: 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
CVS/caremark Mail Service: 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
Is there an Annual Out-of-pocket Maximum?	No	No	No	No
Components of Each Category	Generic Drugs	Brand Drugs		Specialty Drugs
	You will be sent a copy of the SilverScript's *Preferred Drug List*. You may also contact SilverScript to request a copy of the *Preferred Drug List* **by calling the toll-free number on your SilverScript card.** **Medicare Part B vs. Medicare Part D** **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.**			
Major Chains in the Retail Network	ACME, Cleveland Clinic Pharmacies, 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.			

Note: Diabetic Supplies - Insulin and all diabetic supplies covered. Includes: needles purchased separately, test strips, lancets, glucose meters, syringes and injection pens.

Asthma Delivery Devices - Includes spacers used with asthma inhalers.

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

Accurate Registration

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 page 46 in 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 page 42 in Section Four: "Third-Party Administrator – Mutual Health Services" for details. Additional information about claim types and benefit determination for claims can be found in Section Six: "HBP Members' Rights and Responsibilities" on page 49.

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, through the local hospital newsletter, and through the centralized ONE HR Service Center available during business hours. See the Quick Reference Guide on page 8 for appropriate contact information.

EHP Customer Service Unit

The EHP Customer Service Unit is open Monday through Friday from 7 a.m. to 5 p.m. A trained representative is available to answer health plan benefit questions. The Customer Service Unit will be able to assist you with medical, behavioral health/substance abuse, and prescription drug questions and issues. If you have questions regarding any other benefit coverage you must contact the ONE HR Service Center.

The EHP Customer Service Unit is responsible for providing key information regarding HBP benefits. You can contact us by:

Phone: 216.448.CCHR (2247) or toll-free at 877.688.CCHR (2247)
Fax: 216.448.2053

Email: **cehpao@ccf.org**

Mailing address:

Cleveland Clinic Health Benefit Program
EHP Customer Service
3050 Science Park Drive / AC332B
Beachwood, OH 44122

EHP Medical Management

Find out about Cleveland Clinic programs designed to assist members with complex medical and behavioral health needs.

Life Event Changes

Certain changes that affect you and/or your dependents – such as a marriage, birth, divorce, or qualifying for Medicare – **and may result in the need to make changes to your benefit elections** (see page 43 in Section Five: "Administrative Information").

HBP Quick Reference Guide

CLEVELAND CLINIC ONE HR SERVICE CENTER
Phone: 216.448.2247 Toll-free: 877.688.2247

Health Benefit Program – Option 2

- Benefit Determination
- Eligibility Verification
- Network Provider Questions
- Referral/Claims Issues

Eligibility fax number: 216.448.2054
General fax number: 216.448.2053
Email address: cehpao@ccf.org
Web address *(Internet)*: employeehealthplan.clevelandclinic.org

Total Rewards Department – Option 1

- Life Events
- ONE HR Workday and Portal
- Retirement/Pension

Fax number: 216.448.0645

MUTUAL HEALTH SERVICES CUSTOMER SERVICE
(Cleveland Clinic HBP TPA)

- Mailing address: P.O. Box 89472, Cleveland, OH 44101-6472
- Phone number: toll-free 800.451.7929

EHP MEDICAL MANAGEMENT AND PHARMACY DEPARTMENT
(Medical, Behavioral Health, and Pharmacy Services)

- Case Coordination
- Formulary Drug Review
- Pharmacy Management Programs
- Prior Authorization for Clinical Appropriateness and Notification

Phone numbers:
216.986.1050
or toll-free: 888.246.6648

EHP Medical Management
Fax number: 216.442.5791

Emergency Room Transfer Line:
866.721.9803

Pharmacy Fax number:
216.442.5790

TIER 2 NETWORK

- Medical Mutual SuperMed (inside the state of Ohio)
- Aetna® Open Choice® PPO (outside the state of Ohio)
- Web address: MutualHealthServices.com/CCHS

PRESCRIPTION DRUG BENEFIT

- ***Cleveland Clinic Home Delivery Pharmacy***
  Phone numbers: 216.448.4200
  or toll-free: 855.276.0885
  Fax number: 216.448.5603
- ***Cleveland Clinic Home Infusion Pharmacy***
  (injectables only)
  Phone numbers: 216.444.HOME (4663)
  or toll-free: 800.263.0403
- ***Cleveland Clinic Pharmacy Information Hotline***
  Phone numbers: 216.445.MEDS (6337)
  or toll-free: 866.650.MEDS (6337)
  Web address:
  clevelandclinic.org/pharmacy
- ***Cleveland Clinic Specialty Pharmacy***
  Phone numbers: 216.448.7732
  or toll-free: 844.216.7732
  Fax number: 216.448.5601
- ***CVS/caremark***
  Phone number: 866.804.5876
  Email address:
  customerservice@caremark.com
  Web address: caremark.com
- ***SilverScript***
  Phone number: 866.693.4617
  Web address:
  https://c/evelandclinic.silverscript.com

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 consist of the Cleveland Clinic Quality Alliance (QA) network. The QA is comprised of Cleveland Clinic and regional hospitals, including participating physicians credentialed by the Cleveland Clinic Community Physician Partnership (CPP). The Tier 1 Network of Providers includes Primary Care Providers (PCP), Specialist Providers (SP), Behavioral Health Providers, and Ancillary Services Providers. Ancillary services are services such as dialysis, ambulance, 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 PCP's 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 vision examinations, therapy services (Occupational (OT)/Physical (PT)/Speech (ST)), chiropractic services, maternity services, custom orthotics, sclerotherapy for symptomatic varicose veins, 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 reimbursed at 80%.

Note: HBP members who have Medicare Part B as their primary health plan (age 65 and older) are not subject to the co-payment when the HBP pays as secondary. However, for services not covered by Medicare and the service is a covered benefit by the HBP, the HBP then pays as primary. In this instance, you could be responsible for the applicable co-payment.

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, hearing aids and Autism School.

It is important to understand that not all physicians on the Cleveland Clinic and Regional hospital medical staff are in the Quality Alliance. **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 theEHP website at **employeehealthplan.clevelandclinic.org** Information about special arrangements with additional Tier 1 providers for employees who work at Cleveland Clinic locations outside of Cuyahoga and Lorain Counties can be obtained by visiting the Cleveland Clinic Health Benefit Program website at **employeehealthplan.clevelandclinic.org**.

The HBP does not print a hardcopy Provider Directory. If you do not have access to a website you can either call Mutual Health Services toll-free at 800.451.7929 or the Health Benefit Program Customer Service Unit at 216.448.CCHR (2247) or toll-free at 877.688.CCHR (2247) 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.

Tier 1 Hospitals in the Cleveland Clinic HBP Network

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

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

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

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

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

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

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

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

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 ..... **euclidhospital.org**

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

Tier 1 Hospitals in the Cleveland Clinic HBP Network (continued)

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

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

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

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

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

Cleveland Clinic Florida[11]
3100 Weston Road
Weston, FL 33331.....954.689.5000 ..... **ccf.org/florida**

Martin North Hospital[11]
200 SE Hospital Avenue
Stuart, FL 34974.....772.287.5200 ..... **martinhealth.org**

Martin South Hospital[11]
2100 SE Salerno Road
Stuart FL 34997.....772.223.2300 ..... **martinhealth.org**

Indian River[11]
1000 36th Street
Vero Beach, FL 32960 .....772.567.4311 ..... **indianrivermedicalcenter.com**

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

11. If you choose to see a physician at Cleveland Clinic Florida, you must see a physician who is employed by the hospital.

Other Cleveland Clinic Ambulatory Facilities

Akron General Health & Wellness Center, Montrose
Cleveland Clinic Beachwood Ambulatory Surgery Center
Cleveland Clinic Lorain Ambulatory Surgery Center
Cleveland Clinic Outpatient Surgery Center
Cleveland Clinic Richard E. Jacobs Health Center
Cleveland Clinic Stephanie Tubbs Jones Health Center
Cleveland Clinic Strongsville Ambulatory Surgery Center
Fairview Surgery Center
Marymount Ambulatory Surgery Center
Twinsburg Family Health Center
Wooster Clinic
Wooster Clinic Specialty Center (Endoscopy)

Tier 2

The following two provider networks comprise the Tier 2 network:

- MMO SuperMed network (within the state of Ohio)
- Aetna® Open Choice® PPO network (outside the state of Ohio).

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

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 19.

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).

Note: The University Hospital System and their employed physicians are not considered in the MMO wrap network.

The Health Benefit Program 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 these networks. 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 19.)

Section Three
HEALTH BENEFIT PROGRAM COVERAGE

Cleveland Clinic Retiree 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 clinical appropriateness.

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:

- Prior Authorization for Clinical Appropriateness and Notification
- Case Coordination – EHP Medical Management Department
- Formulary Drug Review – EHP Pharmacy Management Department
- Pharmacy Management Program – EHP Pharmacy Management Department

Although you may choose to use a provider from either the Tier 1 or Tier 2 provider networks, 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:

1. Preventive healthcare
2. Care if you become ill
3. 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 care, to name a few. Behavioral Health includes all services for mental health and substance abuse.

The Prescription Drug Benefit Summary charts on pages 5 and 6 outline drug categories, such as generic and formulary. The *Retiree Prescription Drug Benefit Handbook* provides detailed information on prescription drug delivery options which include Cleveland Clinic Pharmacies, CVS/caremark Retail, and home delivery programs. These delivery options apply to both SilverScript and CVS/caremark members.

Read this section of the *Summary Plan Description (SPD)* in its entirety so that you have a thorough under standing of your medical, behavioral health, and prescription drug benefits. HBP services, managed care programs, prior authorization/clinical appropriateness 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 clinically appropriate 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 maybe 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. Mutual Health Services is the Third-Party Administrator (TPA) that will reimburse medical and behavioral health claims (See Section Four: "Third-Party Administrator – Mutual Health Services" on page 39). If you are not certain that a claim paid/reimbursed correctly, you should contact Mutual Health Services for review. If you still disagree, contact EHP Customer Service at 216.448.CCHR (2247) or toll-free at 877.688.CCHR (2247).

Medical Management includes five elements:

1. **Utilization Management** to establish prior authorization and determine clinical appropriateness of requested services.
2. **Case Coordination** for assistance with complex medical and behavioral health needs.

UTILIZATION MANAGEMENT

In order to ensure that provided services are clinically appropriate, the EHP 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 "Prior Authorization and Concurrent Review for Clinical Appropriateness" section that follows below.

A service is ***NOT*** considered clinically appropriate 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, is 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 clinically appropriate 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 clinically appropriate. 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. Experimental or Investigational – Generally, experimental or investigational refers to the medical use of a service or supply still under study and the service or supply is not yet recognized throughout the Physician's profession in the United States as safe or effective for diagnosis and 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. Experimental or investigational procedures are usually identified by those procedures that have no CPT code and are therefore coded into a "NOC – not otherwise classified" category. These will require prior authorization for clinical appropriateness.

   The Cleveland Clinic Health Benefit Program reserves the right for final determination of clinical appropriateness.
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.

PRIOR AUTHORIZATION AND CONCURRENT REVIEW FOR CLINICAL APPROPRIATENESS

The EHP Medical Management and Pharmacy Departments have prior authorization and clinical review processes to help ensure quality and cost-effective medical care for HBP members.

Prior Authorization

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

Member Responsibility for Prior Authorization

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

- Bariatric Surgery – see details on page 22.

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 prior authorization/clinical appropriateness 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 prior authorization process before obtaining the service there will be ***NO REIMBURSEMENT*** for the service.

Concurrent Review

This is a clinical appropriateness 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 clinically appropriate. 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.

Prior authorization for clinical appropriateness 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 issues 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 care.

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

EHP Medical Management and Pharmacy Departments
6000 West Creek Road, Suite 20 • Independence, OH 44131
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 Prior Authorization

For the most current list of services requiring prior authorization, please see the online version of the *Summary Plan Description* – **employeehealthplan.clevelandclinic.org**.The following list includes those medical services that must receive prior authorization for clinical appropriateness, by the provider of service, prior to being rendered except for emergency/urgent situations:

All Inpatient Hospitalizations[12] – In/Out Network (both Medical and Behavioral Health)

- Acute Rehabilitation Admission
- All Inpatient Behavioral Health
- Elective Hospital Admission[13]
- Inpatient Maternity stays over 48 hours (normal delivery) or 96 hours (c-section)
- Long Term Acute Care (LTAC) Admissions
- Tissue Transplants
- Out-of-Network and Out-of-Area Care (All) – See Emergency Care on page 26.
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission

Outpatient Services – In/Out Network

- **Behavioral Health**
  - Intensive Home-Based Treatment
  - Intensive Outpatient (IOP)[13]
  - Partial Hospitalization Programs (PHP)[13]
  - Residential Treatment
  - Transcranial Magnetic Stimulation (TMS)
- **Medical**
  - Anesthesia for dental procedures
  - Bariatric Surgery
  - Blepharoplsty
  - Botox
  - Breast Enhancements – with diagnosis of breast cancer
  - Breast Reductions
  - Capsule Endoscopy
  - Capsule Motility device
  - Cell Free DNA Screening – fetal Aneuploidy testing
  - Chiropractic services for patients under 12
  - Dental implants needed as a result of an underlying medical condition or recent severe trauma or a congenitally missing tooth
  - Gamma Knife procedures
  - Gender affirming surgery
  - Some Genetilc testing
  - Heart implant devices
  - Home Healthcare
  - Hospice
  - Injectable or Infused medications covered under the medical benefit
  - LVAD
  - Maxillofacial Surgery
  - MRI/MRA/CT scans
  - Negative pressure wound therapy
  - Nerve stimulators
  - Orthognathic Surgeries
  - Panniculectomy
  - Removal of lesions
  - Resigam/Synagis (if approved, up to 5 injections per session are covered)
  - Septoplasty
  - Temporomandibular Joint Syndrome (TMJ)
  - Certain medications

12. May be subject to concurrent review.
13. Prior authorization required for all Tier 2 providers for any diagnosis; Tier 1 & 2 treatment of eating disorders.

- **Medical (continued)**
  - Durable Medical Equipment (DME)[14]:
    (Purchases over $1,500 and/or rentals over $500 per month – see below for examples)
    - Cochlear implants
    - Continuous glucose monitor
    - Continuous passive motion machines
    - Crutch substitute, lower leg platform, with or without wheels
    - Electric wheelchairs
    - Extension/Flexion (dynamic and bi-directional) devices
    - Fully automatic beds
    - High-end (hinged) braces
    - High-end prosthetics
    - High frequency chest wall oscillation system
    - Home oxygen therapy
    - Home CPAP or BiPap
    - Insulin pumps
    - Low air loss beds
    - Non-standard size wheelchairs – lightweight/ heavyweight
    - Prosthetics over $5,000
    - Osteogenesis stimulators
    - Pneumatic compression devices
    - Scooters
    - Speech assistance devices

Special Services

These services require prior authorization whether inpatient or outpatient:

- Bariatric restrictive procedures or malabsorptive procedures for weight reduction
- Experimental or Investigational treatments or procedures
- Hospice (Respite Care)
- Human Organ or Bone Marrow Transplant
- Potential Cosmetic Services.

Pharmaceuticals

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

Care Outside of Tier 1 Cleveland Clinic HBP Network of Providers

In some cases, your Cleveland Clinic physician may wish to refer you for care outside of the Cleveland Clinic Tier 1 network. This is appropriate for coverage under HBP only when medical or behavioral healthcare cannot be provided within the Tier 1 Network of Providers. These services will be covered as a Tier 1 benefit if:

- The Cleveland Clinic HBP Chief Medical Officer authorizes the service **before** it is received.
- The service is determined to be clinically appropriate.
- The service is not available within the Cleveland Clinic Tier 1 network.
- **Note:** some University Hospital and Summa Health System facilities are not covered.

You and/or your physician should contact the Medical Management Department prior to the service being scheduled for further information.

14. 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.

Services That Must Be Provided by HBP Tier 1 Providers

The following services are covered benefits ***ONLY*** when provided within the Tier 1 Network of Providers ***AND*** Benefit Guidelines are met. There is ***NO*** coverage outside of the Tier 1 Network of Providers.

1. Acupuncture.
2. Acute Inpatient Rehab.
3. Autism Program (Cleveland Clinic Center for Autism).
4. Bariatric surgery.
5. Botox for migraine.
6. Breast reconstruction in connection with a mastectomy due to breast cancer.
7. Chiropractic services.
8. Cleveland Clinic Summer Treatment Program.
9. Dental implants for accidents or certain medical conditions.
10. Family planning services.
11. Genetic testing/counseling.
12. Left Ventricular Assist Device (LVAD).
13. Long-Term Acute Care (LTAC) – requests for services outside Northeast Ohio may be reviewed for geographical location, extenuating circumstances, and medical necessity.
14. Neurofeedback and Biofeedback.
15. Nutritional counseling.
16. Outpatient cardiac rehabilitation programs.
17. Protein Sparing Modified Fast (PSMF) diet.
18. Psychological and Neuro-psychological testing.
19. RAST (allergy blood) testing.
20. Residential Care.
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 routine eye and hearing examinations.
25. Services for Strabismus repair.
26. Services for treatment of sleep apnea.
27. Hearing aids and services provided for the evaluation and conformity of hearing aids.
28. Surgical extractions for soft/bony dental impactions.
29. Temporomandibular Joint Syndrome (TMJ), treatment and appliances.
30. Transcranial Magnetic Stimulation (TMS)
31. Transgender services (Behavioral Health visits, gender affirmilng surgery and hormonal treatment).
32. Treatment for reduction mammoplasty.
33. Vestibular testing battery.

Coverage Clarification

The following pages (20 through 29) 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 22 to 29), are defined and include additional information about coverage criteria and co-payments.

BEHAVIORAL HEALTH SERVICES

ADHD Summer Treatment Program

Full benefit coverage applies only if the child and parent each complete their designated portions of the program. Prior authorization and a clinical appropriateness 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)

20 hours per week of 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. Coverage is limited to enrollees under age 14.

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.

Full Spectrum Light Boxes
For Seasonal Affective Disorder. Prior authorization and a clinical appropriateness review are required. Coverage is 80%. One light box is covered every five years, no bulb replacement is included. The member is responsible for all shipping and handling charges. Call the Medical Management Department regarding supplier information. HBP does not provide coverage for full spectrum light boxes for the purpose of treating a primary sleep disorder.

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. Prior authorization is required.

Pain Management
Members in pain management programs that have a psychiatric component should contact the Medical Management Department for prior authorization if the program is in Tier 2.

Psychological and Neuro-psychological Testing

Up to 16 hours of testing are automatically reimbursed without prior authorization. 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.

Approval for Residential Treatment will be determined by Medical Management on an individual case basis, following a review for clinical appropriateness. This level of care is only available to those members who have been referred to the Medical Management Department. If approved, there is a 60-day limit. Tier 1 reimbursement is 100% after the applicable co-payment. There is no coverage in Tier 2 or out-of-network.

Transcranial Magnetic Stimulation (TMS)

Annual limit of 36 combined therapy related visits which includes (1) initiation of treatment, (33) repeat delivery and management treatments and (2) threshold re-evaluation treatments. Continued maintenance therapy is an excluded benefit.

MEDICAL SERVICES

Acupuncture

Maximum of 10 visits per benefit year. Coverage is 50% of Allowed Amount (remaining 50% is member responsibility). Coverage is for specific pain management related diagnoses only.

Bariatric Surgery

To be eligible for this benefit, a member must be a participant in the HBP for a minimum of two consecutive years (see page 16). **Laproscopic band placement (lap band surgeries) are not a covered benefit.**

- Prior authorization is required through the EHP Medical Management Department. The member must call the Medical Management Department when the workup begins to initiate the prior authorization process.
- To be eligible for surgery, the member must meet the HBP's established clinical criteria. A member may qualify for surgery through the Bariatric Center, ***BUT NOT*** meet HBP clinical criteria. In this instance the surgery will not be authorized for reimbursement.
- Member must have a BMI greater than 40 for at least the preceding full year.
- Members with a BMI of 35 to 40 will be reviewed by the Medical Management Department and approval will require significant co-morbidity(ies) such as hypertension, diabetes, hyperlipidemia, or sleep apnea which are not amenable to maximum conservative treatment.
- Members with a BMI between 30 and 35 will require the following: Diabetes under the care of an endocrinologist and on at least three diabetic medications. Must have hemoglobin A1c level of >7.5%. The duration for all requirements is at least six months.
- If a member with a BMI of 35 to 40 does not meet the above criteria and gains weight to reach a BMI of 40, he or she will not be considered for surgery for one year.
- If approved, service is covered only when provided by Cleveland Clinic.
- If approved, all pre-workup physician visits require a $35 co-payment. Workup visits include diagnostic and laboratory tests, assessments by endocrinology, psychiatry/psychology, nutrition, general surgery, and possibly other specialists such as cardiology. It is estimated the total co-payment cost for physician workup visits will be $300 to $400.
- An upfront $2,750 co-payment is required for the surgical procedure. This co-payment **does not** accrue to the out-of-pocket maximum.

Botox for Migraine

Botox for chronic migraine requires prior authorization. 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.

Breast Feeding Equipment

Breast pumps are covered at 100% if obtained through a Tier 1 Durable Medical Equipment provider or a Cleveland Clinic Pharmacy. One pump is covered every five years and new tubing and bottles are covered yearly if needed. A prescription from your physician is required and the pump must be obtained in the third trimester or within 4 months after the infant's birth.

Breast Reconstruction

Breast reconstruction is covered at 100% for a member who elects a breast reconstruction in connection with a mastectomy due to cancer or as prophylaxis. Services include the initial reconstruction of the removed breast or breasts, and surgical revisions as needed on the reconstructed breast or breasts. In the case where only one breast is affected (with cancer), coverage for surgery on the "unaffected" breast (without cancer) is limited to one surgery if needed for symmetry and alignment. EHP follows Medicare guidelines which may not cover every kind of breast reconstruction surgery. For example, if the purpose of surgery is to create a more balanced appearance, additional surgery might not meet the criteria for coverage if

a previous surgery was already completed for the same purpose. Services must be provided in the Tier 1 network. Coverage includes treatment for postoperative complications of mastectomy and reconstruction surgeries.

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 20 visits are covered per calendar year within the Tier 1 Network of Providers only. There is a $35 co-payment attached to the first 10 visits. The second 10 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for 50%. X-rays done at the chiropractor's office are a non-covered benefit. Patients under age 12 require prior authorization through the Medical Management Department. 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, regardless of the member's age, ordered by a Chiropractor require prior authorization by the Medical Management Department. If prior authorization 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 clinically appropriate 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 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 50% 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 member is responsible for submitting a letter from the servicing physician 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, emergency contraceptives, generic oral contraceptives, generic injectables (medroxypro- gesterone) 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 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.
- Members who are employed at Marymount Hospital are excluded from this coverage.
- 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 Clinically Appropriate Surgery

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

- The **professional** fee for the cosmetic surgery will ***NOT*** be covered.
- The patient/member is responsible for 50% of the Allowed Amount for all technical/facility fees AND the anesthesia professional fee.

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

- If the usual course of the clinically appropriate procedure requires hospitalization, hospital days will be covered at 100%.
- If the usual course of the clinically appropriate 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.

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 ONE HR Service Center. ***All Services in this Section must be provided in the Tier 1 Network.***

1. Dental procedures such as 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 clinically appropriate 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 clinical appropriateness is determined due to an accident or within one year of major trauma resulting in mandibular/maxillary fractures (see #1) 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.
   - Prior authorization is required through the Medical Management Department.

   If these conditions are met, the surgery (implant) and the prosthodontics (crown, bridge, etc.) will be covered under the HBP. The implant will be covered at 100%. The coverage under HBP will be 60%, up to a maximum of $1,500 annually. The prosthodontics coverage under the HBP is the identical level of coverage as offered under the Cleveland Clinic Enhanced Dental Benefit Program.

3. **Surgical Extraction for Soft or Bony Dental Impactions:**
   - Surgical extraction for impacted teeth surgically removed is covered at 100%. Treatment for non-impactions, which entails pulling of the teeth, is covered by the member's Dental Benefit Program. For example, if all four of an employee's wisdom teeth need removed, and only two are impacted, the HBP covers the two teeth that are surgically removed. The other two are covered under the Dental Program. We recommend that you consult with your dentist and/or doctor before receiving treatment.
   - Emergent surgical extractions follow Emergency/Urgent Care guidelines.
   - Surgical extractions must first be billed to your dental plan. Any remaining balance is then claimed with the EHP.

Note: If your dentist is sending a specimen to pathology, it must be sent to a Tier 1 provider.

4. Anesthesia for dental procedures for adults is ***NOT*** a covered benefit under the HBP unless the dental procedure is one of the two procedures listed above. The only exceptions are cases where anesthesia is necessary to do dental work that is required because of a specific ***Underlying Medical Condition*** as determined by our Medical Directors. These cases will be subject to prior authorization through the Medical Management Department. If approved, the anesthesia will be reimbursed under the HBP but the dental work will not. Anesthesia for pediatric cases where extensive restoration is required may be covered for children under age seven and will require prior authorization to meet medical necessity criteria. ***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 clinically appropriate.

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 Care/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" on pages 62 and 64 respectively. A co-payment is required for any emergency department visit. If the visit results in an admission, ER 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 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 requires members to contact the Cleveland Clinic Transfer Center at 866.721.9803 or EHP Medical Management at 216.986.1050 or 888.246.6648 if the member requires admission (including unplanned admissions). These numbers are also on the back of your medical ID card.

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 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 prior authorization.

Failure to contact the Transfer Center or EHP Medical Management, if it was feasible prior to admission, or refusal to accept a transfer to a Cleveland Clinic facility when indicated by either the Transfer Center or EHP Medical Management, may result in Tier 2 coverage or no coverage for the admission.

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.

Genetic Testing/Counseling

Genetic testing must be done by a Tier 1 provider; and some genetic testing requires prior authorization to ensure clinical appropriateness (see prior authorization list on page 16). 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

Reimbursement will be made up to a $250 lifetime maximum for a cranial protheses (wig) and only as a result of hair loss due to chemotherapy or radiation treatments. The wig can be purchased from the provider of choice. Receipts may be submitted to Mutual Health Services.

Hearing Aids

Hearing aids are covered at 50% of billed amount up to $3,500 per ear; one aid per ear every three years within the Tier 1 Network of Providers. Evaluation, consulting, and dispensing fees are covered at 100% within the Tier 1 Network of Providers. Repair of hearing aids ***ARE NOT*** covered. There is ***NO*** coverage of the hearing aids, evaluation, consultation, or dispensing fees ***OUTSIDE*** of the Tier 1 Network of Providers.

Hospice

To be eligible to receive the hospice benefit, patients must have a life expectancy that is less than six 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. Notification to the Medical Management Department is required for coordination of care. Hospice Respite or inpatient symptom management care is limited to 10 days per calendar year. Inpatient stays are subject to applicable co-payments.

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 the day before the child turns age eight. 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 covered, but is excluded for travel purposes. Caregivers themselves should have them done through Occupational Health; dependents should go through their primary care physician.

Infertility

Coverage for infertility is limited to diagnostic services only.

Maternity Care

A $350 co-payment for each confinement for delivery is required. Prenatal care, which includes physician visits and ultrasounds as needed, are covered at 100% in the Tier 1 Network. Visits to a specialist will require a co-payment.

The HBP does not restrict benefits for any hospital length of stay in connection with childbirth for mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, the HBP will not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the HBP will NOT require that a provider obtain authorization from the Medical Management Department or the Third-Party Administrator for prescribing a length of stay not in excess of 48 or 96 hours. Doula services are ***NOT*** considered clinically appropriate 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 on page 46.

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 nbe waived and the inpatient admission co-pay will be applied.

Orthotics

- **Custom-made:** covered at 80% of Allowed Amount after $50 co-payment in Tier 1.
- **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.

Pain Management

Treatments, such as injections, are covered up to three injections per specific anatomical site per benefit year. Members in programs that have a psychiatric component should contact the Medical Management Department for prior authorization of that component of their pain management program if the program is in Tier 2. Tier 2 Behavioral Health counseling sessions require prior authorization through the Medical Management Department.

PAP/HPV Testing

Pap smears are indicated when any of the following are met:

Screening Pap:

- Over age 18 and under age 30.
- After hysterectomy for cancer.

Screening Pap/HPV tests are covered once every 3 years over age 30.

Diagnostic Pap smears are covered as needed for one of the following:

- Previous abnormal Pap.
- Previous positive high risk HPV subtype.

A Pap/HPV is not needed if the cervix has been removed during a hysterectomy and will not be covered. Screening Pap smears will be covered once every three years and diagnostic Pap smears will be covered as needed. Members will be financially responsible if they receive the tests more frequently without a medical condition.

Pediatric Eye Exams

Coverage allows for two exams per calendar year for patients under the age of 18. Must use Tier 1 ophthalmologists only.

Pediatric Type 1 Diabetes

Related co-pays, medications and supplies for pediatric type 1 diabetes are covered at 100%. 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.

Routine (Annual) Vision Examination

One routine (annual) vision 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% after a $50 co-payment per session; and
  - Vein stripping for symptomatic varicose veins is a covered benefit in the Tier 1 Network of Providers only.

Telemedicine and Express Care Online Coverage

Coverage for real-time interactive **Telemedicine** includes visits for routine and follow-up visits for services such as behavioral health and chronic conditions such as diabetes, hypertension and cholesterol. Members are required to have a PCP treating them for the condition and to have seen the PCP in person at least once. These visits have no co-payment.

Coverage for **Express Care Online** is available by downloading the app. ***Express Care Online*** includes non-emergency care such as sprains, rashes, and other minor ailments. This service is free for EHP members and their dependents (ages 2+). Visit **ccf.org/eco** to download the free app on your mobile device. Select "***CCF Employee Health Plan***" when asked for insurance and enter your ID number from your health plan card.

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 prior authorization is required.

Therapy

Occupational[16]

A maximum of 35 visits are covered per calendar year. A $10 co-payment is required for the first 20 visits. The remaining 15 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for the remaining 50%.

Physical[16]

A maximum of 35 visits are covered per calendar year. A $10 co-payment is required for the first 20 visits. The remaining 15 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for the remaining 50%.

Speech[16]

A maximum of 35 visits are covered per calendar year. A $10 co-payment is required for the first 20 visits. The remaining 15 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for the remaining 50%.

Transgender Services

Transgender services are covered in Tier 1 only. Coverage is 100% of allowed amount for behavioral health visits, gender affirming surgery and hormonal treatment and subject to any applicable co-payments.

16. 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 Prior Authorization and Concurrent Review for Clinical Appropriateness rules on page 15 for more information.

CASE COORDINATION

The Health Benefit Program (HBP) is committed to helping you and your family stay healthy. However, 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 Coordination 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.

Case Coordination Programs for medical conditions include End-Stage Renal Disease, high-risk maternity, and complex care needs, among others. Behavioral Health Case Coordination Programs include anxiety disorders, childhood disorders, dual diagnoses, eating disorders, mood disorders, psychotic disorders, and substance abuse.

Case Coordinators also make courtesy calls to members who have repeat emergency room visits, repeat inpatient stays within 90 days or have an inpatient stay with a length-of-stay of five or more days to assess for any post discharge care needs.

If you have a medical or behavioral health question related to a Case Coordination Program, the Medical Management Department can be reached at 216.986.1050 or toll-free at 888.246.6648 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.

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.

Cleveland Clinic Retiree Health Benefit Program (HBP) 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 HBP 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 plan 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 (800.633.4227). TTY users should call 877.486.2048.

Contact Health Benefit Program Customer Service Unit with further questions about SilverScript at 216.448.CCHR (2247) or toll-free at 877.688.CCHR (2247).

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.

Medicare Part D Chart

If your filing status and yearly income in 2019 was			You Pay Each Month (in 2021)
File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	
$88,000 or less	$176,000 or less	$87,000 or less	your plan premium
above $88,000 up to $111,000	above $176,000 up to $222,000	not applicable	$12.30 + your plan premium
above $111,000 up to $138,000	above $222,000 up to $276,000	not applicable	$31.80 + your plan premium
above $138,000 up to $165,000	above $273,000 up to $326,000	not applicable	$51.20 + your plan premium
above $165,000 and less than $500,000	above $330,000 and less than $750,000	above $88,000 and less than $412,000	$70.70 + your plan premium
$500,000 or above	$750,000 and above	$412,000 and above	$77.10 + your plan premium

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 Dor 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).

Prescription Drug Benefit

The Health Benefit Program (HBP) Prescription Drug Benefit is administered through CVS/caremark under the guidance of the Pharmacy Coordination Department and is divided into two groups: Non-Medicare and Medicare eligible and approved.

The non-Medicare retirees are insured under CVS/caremark. The Medicare eligible retirees are insured under SilverScript Insurance Company. SilverScript is an affiliate of CVS/caremark and is an approved Medicare Part D Prescription Drug Plan provider.

Both CVS/caremark and SilverScript have dedicated toll-free Customer Service phone numbers email or website addresses available 24 hours a day, seven days a week:

- **CVS/caremark**
  866.804.5876
  Email: customerservice@caremark.com
- **SilverScript**
  866.693.4617
  Website: https://clevelandclinic.silverscript.com

Both websites provide information for your applicable plan such as:

- Prescription Refills for CVS/caremark Mail Service
- Frequently Asked Questions
- Order Status
- 13 Month Drug History
- Pharmacy Locations
- Additional Health Information
- Benefit Coverage
- Drug Formulary (List of covered drugs)
- Request Forms

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

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

The Retiree Health Plan *Prescription Drug Benefit Handbook* provides detailed information on prescription drug delivery options which include Glyxambi (empagliflozin/linagliptin), CVS/caremark Retail, and home delivery programs for both SilverScript members and CVS/caremark members.

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 clinically appropriate by your physician.
- Care which is not clinically appropriate and/or has not received prior authorization. **If prior authorization 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-clinically appropriate 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 clinically appropriate;
  - 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.
- Services provided by a hospital or institution maintained by the U.S. government.
- 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, domicillary, 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 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.

- Marymount Hospital employees are subject to family planning exclusions, including all abortions, vasectomy, Norplant, Depo-Provera, IUD, tubal ligation, and oral contraceptives unless clinically appropriate.
- 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

- Expenses solely for cosmetic procedures or complications from cosmetic procedures.
- Expenses for the treatment of obesity, with the exception of registered dietician services, unless treatment has received prior authorization 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.
- Costs associated with the acquisition of donor sperm or donor.
- Costs associated with cryopreservation of sperm, eggs, or embryos for any reason.
- Any new technology used in an experimental or investigational program.
- Drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not clinically appropriate based on current medical standards, including but not limited to IVIG.
- 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.
- Coverage for infertility is limited to diagnostic services only.
- 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 unless member has received prior authorization by the Medical Management Department.
- 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.
- Services for treatment of infertility.
- 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

- Treatment, testing, or forensic evaluations that are Court ordered or recommended as a condition of probation or parole or for any other reason including child custody. This applies to residential, inpatient, PHP, IOP, or outpatient levels of care. Approval may be considered for first time treatment episodes only with prior authorization from the Medical Management Department. Repeat treatment episodes in this category are not covered.
- Services for mental illnesses that cannot be treated; however, services to determine if the mental illness is treatable are covered.
- 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 clinically appropriate and have received prior authorization 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 continued maintenance therapy for Transcranial Magnetic Stimulation (TMS).
- 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 prior authorization from the Medical Management Department.
- Residential level of care solely for the purpose of treating nicotine and/or smoking addictions (excluding marijuana).
- Halfway houses.
- There is no coverage for school meetings by outpatient behavioral health practitioners.

Prescription Drug Benefit Exclusions

- The replacement of lost or damaged prescriptions.[17] Stolen medications will be covered at the Health 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 that can be purchased without a prescription.
- Drugs used for cosmetic purposes.
- Drugs used for the treatment of infertility and/or the preservation of fertility.
- 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).
- See Durable Medical Equipment Benefit on page 26.
- 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.
- Viscosupplementation products such as Euflexxa, Gel-One, Synvisc, or Synvisc One.

Refer to the Prescription Drug Benefit chart on pages 5 and 6 to see the Drugs & Items at Discounted Rate and Non-covered Drugs & Items for additional exclusions.

17. 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.

Section Four

THIRD-PARTY ADMINISTRATOR – MUTUAL HEALTH SERVICES

Cleveland Clinic Retiree Health Benefit Program
Third-Party Administrator (TPA) Mutual Health Services (MHS)

The Retiree Health Benefit Program (HBP) is partnered with Mutual Health Services (MHS) to administer your health benefit program benefits accurately and efficiently. Mutual Health Services 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

Information regarding contacting Mutual Health Services is available in the Quick Reference Guide on page 8.

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 Ohio law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). 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.

Medicare Coordination

When you or your covered dependent become Medicare eligible and retire, it is important for you to enroll in Medicare Part B. The Health Benefit Program (HBP) becomes the secondary insurance once you become Medicare eligible. This means that if you do not enroll in Medicare Part B, you will be responsible for 80% of your physicians’ bills (out of your pocket) because HBP pays only 20% (what Medicare does not pay) as the secondary insurance.

In order for this claims payment process to work correctly, it is *EXTREMELY IMPORTANT* that you bring both your Medicare and RHP ID cards to all visits and inform the registrar that you are covered by two health plans. If you have more than these two plans, bring ALL the health plan cards you have to the visit so that coordination of benefits can be done correctly.

Medical plan benefits provided are also subject to the following **non-duplication** provision:

- The combined payments of all healthcare plans will not exceed the actual amount of your bills. In other words, you cannot expect to receive benefits in excess of 100% of the cost you incur and receive reimbursement on claims through both the HBP and any other company sponsored plan where you have coverage.

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: Cleveland Clinic Retiree Health Plan reimburses claims according to its plan rules (i.e., network requirements must be adhered to even if a court decree dictates the Cleveland Clinic retiree'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 byyour health plan as if you had no other coverage, provided it is a covered benefit under the HBP and all Network Provider and EHP 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. The TPA will pay only for services covered under your primary health plan only if you followed all of their procedural requirements including prior authorization and network provider rules.**
- **If a member seeks services from a Tier 2 or Tier 3 provider, before the Health Benefit Program will reimburse as secondary, the deductible must be met.**

When the retired 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 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 51). 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.

Claims Information

Using Tier 1 or Tier 2 (see Section Two beginning on page 9) 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 MHS website 24/7, by signing up for online access to their benefit claims. You can register via the ONE HR Workday and Portal or directly from the TPA website. You can also register to receive electronic EOB's via email. Details on how to register can be found on our website at **employeehealthplan.clevelandclinic.org**.

Explanation of Benefits (EOB)

① **Cleveland Clinic Employee Health Plan**
Administered by Mutual Health Services
PO Box 89472
Cleveland, OH 44101-6472

Cleveland Clinic

Questions?
Call Customer Service
800-451-7929
Behavioral Health
888-246-6648 or 216-986-1050

② JANE DOE
60 ELM ST
SOMEWHERE OH 41234

③ Group 0000123456
Your ID Number EHP012345
Benefits Provided by
Cleveland Clinic Employee Health Plan

SAMPLE

④ Date: December 5, 2017

EXPLANATION OF BENEFITS - THIS IS NOT A BILL

⑤ ***Provider Name:*** CLEVELAND CLINIC FOUNDATION ⑥
Claim Number : 161234234-F ***Patient Number***: P98765432109 ***Patient Name:*** JOHN DOE ***Insured Name:*** JANE DOE ***Insured ID***: EHP012345

Line No	Type of Service	Proc Code	Amount Billed ($)	Excluded Amount	Co-Pay	Deductible	Amount Allowed	Paid at	Balance Paid By Plan
⑦ 1	Date of Service 11/22/2017 - 11/22/2017 OFFICE/OUTPATIENT VISIT EST PAT **Note:** AD	99213	135.00 ⑧	58.04 ⑨	0.00 ⑩	0.00 ⑪	76.96 ⑫	100%	76.96
Total for this Claim			135.00	58.04	0.00	0.00	76.96		76.96

Amount Payable: 76.96 ⑬
Patient Responsibility: 0.00

Check was issued to CLEVELAND CLINIC FOUNDATION in the amount of $76.96 ⑭

Note(s):

⑮ **AD -** Contractual adjustment.

Claims must be submitted within one year of the date of service in order to be paid. Claim forms and bills for services received should be sent to:

Mutual Health Services, P.O. Box 89472, Cleveland, OH 44101-6472

Questions about your claim should be directed to MHS' Customer Service at 800.451.7929.

The Coded Explanations for EOB Sample Above:

1. Mutual Health Services Customer Service address.
2. Member's name and address.
3. Group Number and EHP I.D.
4. Date claim paid.
5. Name of Provider.
6. Name of Patient.
7. Date of Service.
8. Total amount billed by provider.
9. Difference between billed amount and contracted amount and any denied services.
10. Co-payment/co-insurance member is responsible for paying.
11. Deductible amount member is responsible for paying.
12. Allowed Amount.
13. Total amount paid to provider.
14. The total of co-payment, deductible, co-insurance and non-covered services that the member may owe to the provider of service.
15. Claim remarks and explanation.

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
- Retiree 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.**

Eligibility

You are eligible to participate in the Cleveland Clinic Health Benefit Program (HBP) if, at the time of retirement, you are at least age 55 with a minimum of 10 years of continuous service or age 65 with a minimum of five years of continuous service. In addition, you must be a current participant in one of the HBP offerings immediately prior to retirement and begin your pension benefit immediately. (Deferred vested participants of the Cleveland Clinic Retirement Plan are not eligible for Retiree Medical Benefits.)

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.[18]

18. 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 ONE HR Service Center at 216.448.2247 or toll-free at 877.688.2247.

Coverage Options

1. **Individual**: Only the retiree is covered under the Cleveland Clinic Retiree 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 Enrollees

All new hires and/or existing employees enrolling themselves and/or their dependents for the first time are contacted by our consultant, Willis, 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

Eligibility Verification

New Enrollees

Retirees enrolling a dependent for the first time are contacted by our consultant, Willis, 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

Eligible employees have the opportunity to enroll in the Cleveland Clinic Retiree Health Benefit Program (HBP) at the same time they apply for their retirement benefits. If you do not enroll in the Cleveland Clinic HBP when you apply for retirement benefits, you will never be eligible to apply for the health plan again. If you terminate coverage, you will not be able to re-enroll in the Cleveland Clinic HBP.

Retiree Contributions

A retiree will pay a portion of the cost for coverage under the HBP. The Cleveland Clinic pays the remainder of the cost for coverage. Information on retiree contributions is available through the ONE HR Service Center.

Benefit Program Identification Card

Your Cleveland Clinic Retiree Health Benefit Program (HBP) Identification (ID) card(s) will be mailed to your home directly from the Third-Party Administrator (TPA). See Section Four for TPA information beginning on page 39. Each HBP member will receive an ID card listing his/her name and personal identification number followed by the two digit suffix oo.

For example:

EHP123456-oo

Your ID card(s) contains the following information:

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

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 8 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 oflegal 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 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 retiree, spouse or dependent qualifies for Medicare or Medicaid. (If this happens, health plan 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 is a change in status if 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 ONE HR Workday and Portal and click on the "Benefits" worklet. If you need assistance, contact the ONE HR Service Center at 216.448.2247or toll-free at 877.688.2247.

Retirees/ 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 ONE HR 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 ONE HR Service Center.

Termination of Coverage

Cleveland Clinic will initiate Termination of Coverage if you stop premium payments for more than two months.

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
- 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 lay person 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 not 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 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.

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, a Mutual Health Services (MHS) Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Customer Service representative will telephone the employee with the response. If attempts to telephone the employee are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the employee 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

Expedited Review Process

A request for an expedited 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 Medical Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted 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 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, call the Customer Service telephone number on your identification card. You may also 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:

Mutual Health Services
Member Appeals Unit
P.O. Box 89472
Cleveland, OH 44101-6472
Fax: 440.878.5451

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 MHS 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.

First Level Mandatory Appeal

The Benefit Program offers all members a first level **mandatory** appeal. You must complete this first level of appeal before any additional action is taken.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by calling Customer Service or in writing as described on page 51.

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 an Appeals Coordinator, 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 healthcare professionals who review 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. 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.

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 you received notice of 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 claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the 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 is a voluntary appeal level and is filed with the Health Benefit Program to be reviewed by the Health Plan Advisory Committee (HPAC). The member is not required to follow this internal procedure before going to the External Review Process on page 54.

The HPAC members 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.

- Members who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Members or their Personal Representative must submit a written request for a second review within 180 calendar days following the date they received the TPA's 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 the TPA sends 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 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 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. The review will be conducted by individuals 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 file suit under ERISA after they have completed all mandatory appeal levels described in this *SPD*.

Regarding voluntary appeal level on page 53, 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 52. 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 affect 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 HBP. Refer to the ERISA Statement of Rights section on page 58 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:
Mutual Health Services Member Appeals Unit
P.O. Box 89472
Cleveland, OH 44101-6472
Fax: 440.878.5451

Send Pharmacy Appeals to:
Health Benefit Program Pharmacy Appeals
6000 Westcreek, Suite 10
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/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 only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- ***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:*** Before treatment ends or is reduced.

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 first-level mandatory internal appeal. 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 MHS's Member Appeals Unit at the address listed on page 51.

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 Mutual Health Services at the number on the back of your identification card. You may also request an external review for urgent or cxpedited claims 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*.

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 attorneys 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 motorists 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.

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 change in life status.
- 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 ONE HR 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 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 Mutual Health Services, 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 a 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
3050 Science Park Drive / AC332B
Beachwood, OH 44122
216.448.CCHR (2247) or toll-free at 877.688.2247

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, 2021.

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 care immediately for a life-threatening emergency.
- ***Emergent*** is defined as having access to emergency care 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 Charges – Negotiated charges for allowed healthcare services as described in this *SPD*. 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 21 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 Ancillary Services.

Cleveland Clinic consists of the following group of hospitals:

Cleveland Clinic Florida Hospital in Weston, 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, South Pointe Hospital, Union Hospital, and Cleveland Clinic Nevada.

Clinical Appropriateness – A service, supply, and/or prescription drug that is required to diagnose or treat conditions which the Cleveland Clinic Health Benefit Program (administered through the TPA) determines is:

- Appropriate with regard to the standards of good medical practice;
- Not primarily for your convenience or the convenience of a provider or another person; and
- The most appropriate supply or level of service that can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to prescription drugs, this means the prescription drug is cost effective compared to alternative prescription drugs that produce comparable effective clinical results. (See page 15 for complete information.)

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.

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.

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

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 lay person, 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.

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.

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

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.

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 and Medical Assistants, Social Workers and Counselors to provide education and follow-up to employees to assure the delivery of clinically appropriate, high quality, and cost-effective healthcare in the most appropriate setting. The Medical Management Department provides Case Coordination and Utilization Management programs.

Medical Necessity – See Clinical Appropriateness.

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 their respective companies.

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.

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.

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

Precertification – See prior authorization.

Predetermination – See prior authorization.

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 prior authorization.

Prior Authorization – The process of verifying member eligibility and benefit coverage under the HBP. Prior Authorization also includes the process of determining whether or not a patient has met the clinical appropriateness 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, predetermination and prior approval are often used interchangeably.

Provider – A person or organization responsible for furnishing 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.**

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

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.

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

Please use this page to keep a record of contact dates and names of correspondence for your personal records.

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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.

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