Cleveland Clinic
Weston Hospital

Employee Health Plan

Summary Plan Description

Calendar Year 2022

Your Guide to Quality Healthcare Services and Healthier Living

Welcome to the Cleveland Clinic Florida Employee Health Plan, hereafter referred to as the "Health Benefit Program" (HBP). As a Health Benefit 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 which is updated as necessary.

The *Cleveland Clinic Florida EHP SPD* is the health benefit program document. There are no other documents to reference when determining health benefit program coverage. We encourage you to take the time to read it carefully and to file for future reference. *Summary Plan Description* information is also available on the Intranet.

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

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

Refer to the back of this booklet for detailed definitions of the terms used throughout the *SPD*. If you have any questions, refer to the Florida HBP Quick Reference Guide on page 8 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. HBP looks forward to assisting you with your healthcare needs.

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Section One
GETTING STARTED

Cleveland Clinic Florida Health Benefit Program Mission

To manage the employee health plan benefits 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 (HBP).

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

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

This section also addresses the importance of accurate registration, updating life event changes, claims processing information, and customer service. A Quick Reference Guide is on page 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 UMR, our Third-Party Administrator (TPA), to administer your health plan benefits and provide claims processing for healthcare services.

Each year, you are responsible for providing the HBP with information pertaining to additional medical benefits that you or any of your participating dependents are eligible to receive. This is done through UMR by following the COB process described below.

Coordination of Benefits (COB)/Employee Questionnaire

Coordination of Benefits (COB) and Employee Questionnaire both mean the same thing. For the purposes of this *Summary Plan Description (SPD)*, we will use the term Coordination of Benefits.

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 health plan, the TPA follows rules established by state law to decide which health plan pays first (primary plan) and how much the other healthcare plan (secondary plan) must pay. You must provide the TPA with COB facts and information necessary to apply order-of-benefit determination provisions of the HBP. The combined payments of all healthcare plans will not exceed the actual amount of your bills.

COB Process

1. All members are required to complete a COB form upon initial enrollment and in January of each year. The form is available at **UMR.com**.
2. Life Event Change(s) require the completion of a COB form at the time of the event.

3. If the member does have other insurance, you can update the other insurance at **umr.com** or complete the form and either fax or mail to UMR.

   Fax number: 877.293.4926

   Mailing address: UMR
   P.O. Box 30541
   Salt Lake City, UT 84130-0541

4. If the member **does not** have other insurance, he or she can call UMR toll-free at 800.826.9781 and the information will be updated at the time of the call or you can complete the first section and sign the bottom of the form and return to UMR via Fax or U.S. mail.

If the process is not completed, the TPA will not process claims for your dependents. You will be sent an Explanation of Benefits (EOB) form by the TPA explaining the denial. Employees have one year from the date of service to complete the COB process. After one year, claim payment will be the responsibility of the member.

Two-Tiered Provider Network

Cleveland Clinic Florida providers, the Cleveland Clinic Florida Integrated Network, as well as the Cleveland Clinic Network of Providers in Cleveland, comprise the Tier 1 provider network. UMR UnitedHealthcare Choice Plus is the Tier 2 provider network. The tier you select, however, determines the amount of coverage you will receive. Your EHP Identification (ID) card reflects these relationships by displaying the Cleveland Clinic logo on the front of the card with the written words "Cleveland Clinic Florida Employee Health Plan." The UMR (TPA) logo is on the back of your ID card. See page 46 in Section Five: "Administrative Information" for ID card details.

As a Florida EHP member, you can use either provider tier at anytime throughout the benefit 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 both tiers and the benefits of each.

HBP Benefits

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

Medical and Behavioral Health Benefit Program

The Benefits Summary chart on pages 4 and 5 summarizes Tier 1 and Tier 2 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 chart on page 6 summarizes drug categories, lists prescription drug delivery options, including Cleveland Clinic Pharmacies, and lists annual deductibles and co-insurance amounts.

The Prescription Drug Benefit provides coverage for FDA-approved prescription drugs that are included in the *Cleveland Clinic HBP Prescription Drug Benefit Formulary*. The online version of the *Formulary* is updated four times a year and can be accessed at the Intranet. Medications are listed in the Formulary by both their brand and generic names.

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

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

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

Specialty Brand/Generic Drugs (Tier 4) – These medications are only available through the Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Pharmacies or the CVS/specialty Pharmacy. ***Please note***: The member may have higher out-of-pocket expenses if 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 Health Benefit Program. More detailed information is addressed on HBP services, coordinated care programs, prior authorization guidelines, the Caring for Caregivers Program, options for filling your prescription medications, and pharmacy programs.

CVS/caremark is a trademark of CVSHealth Inc.

HBP Benefits Summary

Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance Network[1]	*TIER 2* UMR United Healthcare Choice Plus Network *(All Tier 2 services are subject to deductible unless othewise stated)*
Annual Deductible (Medical only) Single Family **Out-of-Pocket Maximum[4] (Medical only)** Single Family	 None None $3,950 $7,900	 $500 $1,500 $3,950 $7,900
Medical Benefit Program Features		
PCP Office Visit (Family Practice, Internal Medicine and Gynecology)	100% of Allowed Amount	$25 co-pay, then 100% of Allowed Amount (after deductible)
PCP Virtual Visits	100% of Allowed Amount	$25 co-pay, then 70% of Allowed amount (after deductible)
OB/GYN, Nutritionists and Pediatrics[2] (includes *Routine* care by OB-GYN or GYN)	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
Specialist Office Visits – Dermatology, Ophthalmology and Otolaryngology (ENT)	100% of Allowed Amount after $35 co-pay (no referral required) 100% of Allowed Amount after $35 co-pay	$50 co-pay, then 70% of Allowed Amount (after deductible) $35 co-pay, then 100% of Allowed Amount (not subject to deductible)
Specialty Virtual Visits	100% of Allowed Amount	$25 co-pay, then 70% of Allowed amount (after deductible)
Maternity Care	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 100% of Allowed Amount (not subject to deductible)
Routine (Annual) Vision Exam	$35 co-pay/admission, then 100% of Allowed Amount	$35 co-pay, then 100% of Allowed Amount (not subject to deductible)
Inpatient Hospital Services[2] OB/GYN and Pediatrics[2]	$350 co-pay/admission, then 100% of Allowed Amount $350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 70% of Allowed Amount $350 co-pay/admission, then 100% of Allowed Amount (not subject to deductible)
Outpatient Hospital Services OB/GYN, Opthalmology and Pediatrics[2] Radiology – MRI/CT Scans (non-emergent)[2]	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed amoung after $75 co-pay	70% of Allowed Amount (after deductible) 100% of Allowed Amount (not subject to deductible) 70% of Allowed Amount (after deductible) $75 co-pay, then 70% of Allowed Amount (after deductible)
Laboratory/Diagnostic Tests	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Emergency Department Emergency Care Urgent Care	 100% after $250 co-pay 100% after $50 co-pay	 100% after $250 co-pay 100% after $50 co-pay
Ambulance	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	80% of Allowed Amount
Skilled Nursing Care[3] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 100% of Allowed Amount (not subject to deductible)
Acute Inpatient Rehab 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)

1. Tier 1 includes Cleveland Clinic providers in Florida, the Cleveland Clinic Florida Integrated Network, and the Quality Alliance Network in Cleveland.
2. Pediatric services defined as patient age 0–18 regardless of the provider specialty. The $350 co-pay/admission also applies to Pediatric Behavioral Health services.
3. Prior authorization required for Tier 1 and Tier 2.
4. Co-pays for hearing aids and Bariatric surgery **do not** accrue to the out-of-pocket maximum.

HBP Benefits Summary (continued)

Medical Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance Network	*TIER 2* UMR United Healthcare Choice Plus Network *(All Tier 2 services are subject to deductible unless othewise stated)*
Long-Term Acute Care[3] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 100% of Allowed Amount
Hospice[3] Symptom Management – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
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	70% of Allowed Amount
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)	First 10 visits: 100% of Allowed Amount after $35 co-pay; Second 10 visits: 50% of Allowed Amount (Children under 16 require prior authorization)
Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	100% of Allowed Amount
Home Health Care 60 Visits per Benefit Year	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
Infertility Treatment[3]	100% of Allowed Amount LTM: ($15,000 Medical, $6,000 Pharmacy) Network: UMR/Optum Centers of Excellence Facilities & Providers	
Hearing Aids[4]	50% of Charge up to $3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
Custom Orthotics	80% of Allowed Amount after $50 co-pay (not subject to deductible)	80% of Allowed Amount after $50 co-pay (not subject to deductible)
Organ Transplant[3] Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
Behavioral Health Benefit Program Features		
Outpatient Coverage	100% of Allowed Amount	100% of Allowed Amount
Inpatient Coverage[2]	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission then100% of Allowed Amount (not subject to deductible)
Physician Services	100% of Allowed Amount after $35 co-pay	100% of Allowed Amount after $35 co-pay (not subject to deductible)
Residential Treatment[3] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	$350 co-pay/admission, then 100% of Allowed Amount
Transcranial Magnetic Stimulation (TMS)[3] 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	100% of Allowed Amount

1. Tier 1 includes Cleveland Clinic providers in Florida, the Cleveland Clinic Florida Integrated Network, and the Quality Alliance Network in Cleveland.
2. Pediatric services defined as patient age 0–18 regardless of the provider specialty. The $350 co-pay/admission also applies to Pediatric Behavioral Health services.
3. Prior authorization required for Tier 1 and Tier 2.
4. Co-pays for hearing aids and Bariatric surgery **do not** accrue to the out-of-pocket maximum.

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

HBP Prescription Drug Benefit

Administered Through CVS/caremark

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

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

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

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

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

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

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

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

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 41 in Section Four: "Third-Party Administrator – UMR" 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 50.

UMR Case and Disease Management

Find out about Cleveland Clinic programs designed to assist members with complex medical and behavioral health needs; self-management care needs for those with chronic illnesses; health promotion programs; and rare disease management for uncommon conditions. See page 13 in Section Three: "Health Plan Coverage."

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 47 in Section Five: "Administrative Information").

HBP Quick Reference Guide

CLEVELAND CLINIC WESTON HOSPITAL

Health Benefit Program: 216.986.1050 (see options below)

- No Benefit Determination (Opt 1)
- Billing (Opt 1)
- EHP Wellness/Healthy Choice (Opt 3)
- Eligibility Verification (Opt 1)
- Referral/Claims Issues (Opt 1)

EHP Wellness fax number.: 216.448.2055

Eligibility fax number: 216.448.2054

General fax number: 216.448.2053

Email address: cehpao@ccf.org

Web address (*Internet*): **employeehealthplan.clevelandclinic.org**
or via the intranet by clicking on the "Employee Health Plan" link.

ONE HR Service Center Phone: 216.448.2247 • Toll-free: 877.688.2247

Option 1: Benefits
Option 2: Leave of Absence
Option 3: Payroll
Option 4: Workday Password Reset
Option 5: Employment Verification
Option 6: Occupational Health

Fax number: 216.448.0645

UMR (CLEVELAND CLINIC FLORIDA HEALTH BENEFIT PROGRAM TPA)

- Prior Authorization for Clinical Appropriateness and Notification

NurseLine
Phone: 800.808.4424 (toll-free)

- ***All Questions – Customer Service***

Claims, Benefits
Phone number: 800.826.9781 (toll-free)

Claims Address:
UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541

Web address: **umr.com**

CLEVELAND CLINIC FLORIDA

- ***Human Resources Department –***
  Phone: 954.659.6055
- ***Employee Assistance Program (EAP)***
  Available 24/7
  Phone number: 800.624.5544 (toll-free)
  Web address: **https://eap.ndbh.com**
  Code: CCFL

PRESCRIPTION DRUG BENEFIT

- ***Florida Outpatient Pharmacy Information***
  Phone numbers:
  954.659.MEDS (6337)
  866.2WESTON (293.7866) (toll-free)
- ***Cleveland Clinic Pharmacy Information Hotline***
  Phone numbers:
  216.445.MEDS (6337)
  866.650.MEDS (6337) (toll-free)
  Web address: **clevelandclinic.org/pharmacy**
- ***Cleveland Clinic Home Delivery Pharmacy***
  Phone numbers:
  216.448.4200
  855.276.0885 (toll-free)
  Fax number: 216.448.5603
- ***Cleveland Clinic Home Infusion Pharmacy***
  (injectables only)
  Phone numbers:
  216.444.HOME (4663)
  800.263.0403 (toll-free)
- ***Cleveland Clinic Specialty Pharmacy***
  Phone numbers:
  216.448.7732
  844.216.7732 (toll-free)
  Fax number: 216.448.5601
- ***CVS/caremark***
  Phone number:
  866.804.5876
  Email address: **customerservice@caremark.com**
  Web address: **caremark.com**

EHP MANAGEMENT AND PHARMACY DEPARTMENT

- Coordinated Care Programs
- Formulary Drug Review
- Pharmacy Management Programs

Phone numbers:
216.986.1050 or
888.246.6648 (toll-free)

Fax numbers:

Coordinated Care:
216.442.5795

Pharmacy Management:
216.442.5790

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

Section Two
TIERED NETWORK OF PROVIDERS

Two-Tier Network

Cleveland Clinic Florida providers in the Cleveland Clinic Florida Integrated Network and the Cleveland Clinic Quality Alliance (QA) Network of Providers in Cleveland, comprise the Tier 1 provider network. UMR UnitedHealthcare Choice Plus is the Tier 2 provider network. As a Cleveland Clinic Florida HBP member, you can use either provider tier at anytime throughout the year and may see providers in both tiers 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 – includes all Cleveland Clinic Florida providers, who are credentialed through Cleveland Clinic Florida providers in the Cleveland Clinic Florida Integrated Network and the Cleveland Clinic Quality Alliance Network of Providers in Cleveland, credentialed through the Cleveland Clinic Community Physician Partnership (CPP).

Tier 2 – consists of UMR UnitedHealthcare Choice Plus providers/facilities.

All Emergency services are covered at 100% after a $250 co-payment regardless of the provider of service. Urgent Care services are covered at 100% after a $50 co-payment.

Tier 1

If you seek services from a Tier 1 provider, you are covered at 100%. Physician specialties considered primary care include Family Practice, Internal Medicine, OB/GYN and Pediatrics (see special provisions for Pediatrics, Ophthalmology, Dermatology, Nutritionists, Chiropractors and Behavioral Health in boxed area below). All other specialties are reimbursed at 100% after a $35 co-payment per visit. You do not require a referral to see a specialist.

Pediatrics, OB/GYN, Ophthalmology, Dermatology, Nutritionists, Chiropractic, Otolaryngology (ENT), Oral Surgery and Behavioral Health services are not available at Cleveland Clinic Florida. As a result, special network arrangements have been made. Only these services, when obtained at/by UMR UnitedHealthcare Choice Plus providers/ facilities will be reimbursed at the Tier 1 benefit level.

Pediatrics is defined as a dependent child ages 0–18. If your child requires treatment from a specialist, a Pediatric specialist must be seen. Otherwise, coverage would be at the Tier 2 benefit level.

For Tier 1 **OB/GYN** coverage, your provider's specialty can be OB, OB/GYN, or GYN. The Tier 1 benefit for these specialties covers all "routine" care for medical, obstetric, and gynecological services. If you are seeing one of these specialists for any other services, such as abdominal pain or an abnormal pap, coverage will be at the Tier 2 benefit level.

In addition to Specialty Care, co-payments will also be applied to other services such as therapy services (Occupational (OT)/ Physical (PT)/Speech (ST), chiropractic services, custom orthotics, sclerotherapy for symptomatic varicose veins, out patient MRI/MRA/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%.

For all other services not available at Cleveland Clinic Florida, members can utilize Cleveland Clinic Tier 1 providers in Cleveland for services and still be reimbursed at the Tier 1 benefit level or they can use UMR Tier 2 UnitedHealthcare Choice Plus providers/facilities. **Please note UMR services are not reimbursed at the Tier 1 benefit level.** These services will be reimbursed at the Tier 2 benefit level. See the Summary chart on pages 4 and 5 for benefit coverage.

It is the member's responsibility to verify the provider's most current Tier participation each time services are obtained.

You have a maximum out-of-pocket (OOP) expense per year of $3,950 individual/$7,900 family. In Tier 1, all co-payments accrue to your annual OOP maximum with the exception of co-payments and coinsurance for hearing aids and bariatric surgery.

The HBP does not print a hardcopy provider directory. To obtain a complete list of Tier 1 providers for Cleveland Clinic Florida, you can call UMR toll-free at 800.826.9781 or visit their website at **UMR.com**. Once registered, enter your user ID and password to access the Cleveland Clinic Tier 1 provider network.

Tier 1 Hospitals in the Florida Cleveland Clinic HBP Network

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

Martin North Hospital
200 SE Hospital Avenue
Stuart, FL 34974 ..... 772.287.5200 ..... **www.martinhealth.org**

Martin South Hospital
2100 SE Salerno Road
Stuart FL 34997 ..... 772.223.2300 ..... **www.martinhealth.org**

Martin Tradition Hospital
10000 SW Innovation Way
Port St. Lucie, FL 34987 ..... 772.345.8100 ..... **www.martinhealth.org**

Indian River Hospital
1000 36th Street
Vero Beach, FL 32960 ..... 772.567.4311 ..... **www.indianrivermedicalcenter.com**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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)

If you are seeking a Tier 1 provider, visit the **UMR.com** portal and register with your UMR ID number. Once registered, click on the "Find a provider" button.

Tier 2

The Tier 2 Network of Providers includes UMR UnitedHealthcare Choice Plus providers throughout the United States. Tier 2 benefits include an annual deductible of $500 Individual/$1,500 Family. After your deductible is met, services will be reimbursed at 70%. The maximum out-of-pocket expense is $3,950 Individual/$7,900 Family.

Out-of-Area Coverage Provisions

College Students

College students living outside the state of Florida can utilize the UMR UnitedHealthcare Choice Plus Provider Network should they require urgent care, acute care and follow-up pertaining to an acute injury or illness. Should this option be utilized, all covered services will be reimbursed at the Tier 2 benefit level. The Tier 2 deductible and co-insurance will apply. Preventive or routine services should continue to be rendered by a Cleveland Clinic Florida HBP Tier 1 provider so that the maximum benefit coverage can be received.

Note: All Emergency services are covered at 100% after a $250 co-payment regardless of the provider of service. Urgent care services are covered at 100% after a $50 co-payment.

If you would like to choose a provider from the Tier 2 network, you can obtain provider information on their website at **umr.com**. You can also contact UMR Customer Service toll-free at 800.826.9781.

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

Out-of-Network Billing

When covered health services are received from a non-network provider as a result of an emergency or as arranged by your Plan Administrator, eligible expenses are amounts negotiated by your Plan Administrator or amounts permitted by law. Please contact your Plan Administrator if you are billed for amounts in excess of your applicable Plan participation, co-pays or deductibles. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Section Three
HEALTH BENEFIT PROGRAM COVERAGE

Cleveland Clinic Florida Health Benefit Program (HBP) Benefits

The 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.

Along with UMR, the EHP Pharmacy Management Department utilizes scientifically evidence-based criteria to authorize covered services for the employee population accessing services. They oversee the following:

- Prior Authorization for Clinical Appropriateness and Notification – UMR
- Case Coordination – UMR
- Disease Management Programs – UMR
- 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 (as explained in Section Two), we encourage you to develop a relationship with a Primary Care Provider (PCP). Physician practices considered primary care include most Family Practice, Internal Medicine, Gynecology, Obstetrics, and Pediatrics. This will provide you with the advantage of having a physician knowledgeable about your healthcare and can provide:

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 Benefits Summary chart on pages 4 and 5 summarizes Tier 1 and Tier 2 provider coverage for medical and behavioral health services, as well as deductible and out-of-pocket maximum information. Medical Plan 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 chart on page 6 summarizes drug categories, such as generic and formulary; lists prescription drug delivery options, including Cleveland Clinic Pharmacies, Cleveland Clinic Specialty Pharmacy, CVS/caremark Retail, and home delivery programs (detailed in this section), and lists annual deductibles and co-insurances.

Read this section of the *Summary Plan Description (SPD)* in its entirety so that you have a thorough understanding of your medical, behavioral health, and prescription drug benefits. HBP services, 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 UMR and/or the EHP Pharmacy Management Department 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 themselves or family members. 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.

UMR Care Management

The following pages detail your health benefits coverage. UMR is the Third-Party Administrator (TPA) that will reimburse medical and behavioral health claims. If you are not certain that a claim paid/reimbursed correctly, you should contact UMR for review.

UMR and Care Management includes the following elements:

1. **Utilization Management** to establish prior authorization and determine clinical appropriateness of requested services. This section also includes detailed benefits coverage clarification information.
2. **Case Coordination** for assistance with complex medical and behavioral health needs.
3. **Disease Management** addresses self-management care needs of members with chronic illnesses.

UTILIZATION MANAGEMENT – UMR

The HBP is designed to provide coverage for members that is clinically appropriate. In order to ensure that provided services are clinically appropriate, UMR Care Management has established criteria for members to follow so that clinically appropriate care is reimbursed appropriately and efficiently. These 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 unless they are deemed clinically appropriate 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. 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.

PRIOR AUTHORIZATION AND CONCURRENT REVIEW FOR CLINICAL APPROPRIATENESS

UMR has a prior authorization feature that requires clinical appropriateness approval 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. Concurrent review is a clinical appropriateness review for continued use of services, and 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).

Prior authorization for clinical appropriateness and concurrent reviews are performed on 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 the consistency of application of criteria 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.

UMR's business hours are from 7 a.m. until 5 p.m. Monday through Friday. If an urgent or emergency situation occurs, a Case Coordinator is on call after business hours and can be reached by calling the phone number below. This phone number is also on the back of your HBP ID card.

UMR Phone Toll-Free at: 800.808.4424

Member Responsibility for Prior Authorization

As soon as a member learns from a physician that the services listed below and on page 17 are being recommended, he or she MUST call UMR. The member is required to participate in the prior authorization process to ensure the member's 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.

Prior authorization for clinical appropriateness is also the responsibility of the provider of service ***EXCEPT*** for the one service noted below:

- Bariatric Surgery – see details on page 20.

It is to the member's benefit to remind their physician/provider that this is a requirement so that claims payment issues can be avoided.

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.

Medical and Behavioral Health Services That Require Prior Authorization

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:

Inpatient Hospitalizations – In/Out Network (both Medical and Behavioral Health)

- Acute Rehabilitation Admission
- All Inpatient Behavioral Health
- Elective Hospital Admission[11]
- 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 24.
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission

11. May be subject to concurrent review.

Outpatient Services – In/Out Network

- **Behavioral Health**
  - ABA Therapy
  - Intensive Home-Based Treatment
  - Intensive Outpatient (IOP)[12]
  - Partial Hospitalization Programs (PHP)[12]
  - 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 surgeries
  - Genetic Testing[12]
  - Heart implant devices
  - **Durable Medical Equipment (DME)**[12]: *(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
  - Home Healthcare
  - Hospice
  - Infertility Treatment
  - 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
    - > 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

12. Prior authorization required for all Tier 2 providers for any diagnosis; Tier 1 & 2 treatment of eating disorders.

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.

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 Formulary* for a list of medications that require prior authorization. This comprehensive list includes medications covered under the medical and/or prescription drug benefit. Prior authorized drugs approved for coverage under the medical benefit are only covered when administered by Tier 1 providers for members 19 years of age and older.

BENEFITS COVERAGE CLARIFICATION

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. Bariatric surgery.
2. Botox for migraine.
3. Breast feeding equipment.
4. Breast reconstruction in connection with a mastectomy due to breast cancer.
5. Dental implants for accidents or certain medical conditions.
6. Genetic testing/counseling.
7. Gender affirming surgeries.
8. Heart transplant.
9. Hearing aids and services provided for the evaluation and conformity of hearing aids.
10. Left Ventricular Assist Device (LVAD).
11. Long-Term Acute Care (LTAC).
12. Outpatient cardiac rehabilitation programs.
13. Protein Sparing Modified Fast (PSMF) diet.
14. Routine care costs for qualifying clinical trials.
15. Routine health maintenance tests, routine screening tests, and standard immunizations unless pediatric.

Coverage Clarification

The following pages (19 through 27) provide detailed benefit coverage clarification information about HBP behavioral health and medical services. This information complements and further explains the Benefits Summary Chart on pages 4 and 5. Behavioral health, which is listed first, includes all services for mental health and substance abuse. For behavioral health care level information, see Behavioral Health Levels of Care in Section Seven, Definition of Terms (page 61). Medical services (pages 20 to 27), are defined and include additional information about coverage criteria and co-payments.

BEHAVIORAL HEALTH SERVICES

Mental Health Services

Mental Health/Substance Abuse Services will be covered similar to the special arrangement for Dermatology, Opthalmology, Nutritionists, Chiropractors, Pediatrics and OB/GYN. When these services are received from a UMR UnitedHealthcare Choice Plus provider/facility, the services will be reimbursed at the Tier 1 benefit level and are subject to applicable co-payments.

Comprehensive Mental Health services include diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy provided to a HBP member by a physician, psychologist, or mental health professional for the treatment of a Mental and Nervous Disorder. Covered services are available from Tier 2 UMR UnitedHealthcare Choice Plus providers only. These healthcare services include inpatient, outpatient, and physician services as listed on the HBP Benefits Summary chart on pages 4 and 5.

Substance Dependency Services

Care and treatment of Substance Dependency includes healthcare (inpatient, outpatient, and physician services) provided to a HBP member by a physician or psychologist in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the State of Florida for Detoxification or Substance Dependency. Covered services are available from Tier 2 UMR UnitedHealthcare Choice Plus providers only. See the HBP Benefits Summary chart on pages 4 and 5.

Intensive Home-Based Treatment

Approval for Intensive Home-Based Treatment (IHBT) is given on a case by case basis following a review with UMR. 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. Members are required to participate in Case Coordination to obtain this benefit.

Pain Management

Members in pain management programs that have a psychiatric component should contact UMR for prior authorization.

Psychological and Neuro-psychological Testing

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

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 UMR.

Approval for Residential Treatment will be determined by UMR 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 UMR. If approved, there is a 60-day limit per calendar year.

Applied Behavioral Analysis (ABA)

Prior authorization is required. 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 18.

MEDICAL SERVICES

Bariatric Surgery

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

- Prior authorization is required through UMR Care Management. The member must call UMR Care Management 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 Care Management 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 must be enrolled in appropriate Disease Management Programs and must be in both for six months prior to surgery.
- 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 be enrolled in the HBP Diabetes Disease Management Program. 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 is a covered benefit under UMR and requires prior authorization. Botox for cosmetic use is not a covered benefit.

Breast Cancer Prevention Coverage

Under the provisions of the Affordable Care Act regarding breast cancer preventive health services, generic raloxifene and tamoxifen are covered under the Benefit Program's prescription drug benefit with no out-of-pocket expense for female members age 35 or older; a valid prescription from the member's healthcare provider is required.

Breast Feeding Equipment

Breast pumps are covered at 100% if obtained through a Tier 1 Durable Medical Equipment provider. 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 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 UMR Care Management. 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 UMR Care Management. 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.

Contact Lenses and Lens Fittings

Contact lenses and lens fittings are only covered when an ophthalmologic condition that cannot be corrected by glasses, such as Keratoconus, is present. Services must be provided by a Tier 1 provider. The member is responsible for submitting a letter from the servicing physician to UMR Care Management 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 (medroxyprogesterone) will be covered with no out-of-pocket expense for the member. However, a prescription from your health care provider is required.
- Brand name oral contraceptives that are not available generically require prior authorization. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the brand name oral contraceptive will not be covered.
- Members who receive a brand name formulation of a contraceptive that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name contraceptive product and the generic alternative.
- Contraceptive products that do not require a prescription to be purchased are not covered under the HBP Prescription Drug Benefit.
- Mirena and other intrauterine devices (IUDs) are not covered under the HBP Prescription Drug Benefit. Rather, they are covered under the medical benefit and no co-payment will be charged.

Cosmetic Surgery Combined with 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 UMR Care Management.

Removal of lesions is a covered benefit when medically necessary. If upon review they are deemed to be cosmetic or medically inappropriate they may be adjusted accordingly. If there is any question if a procedure would be covered, the provider can call UMR for a predetermination.

In addition, UMR Care Management 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 HBP, ***NOT*** the Dental Benefit Program. Questions about dental coverage should be directed to the Human Resources help line. ***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. Care Management will review cases of severe trauma resulting in mandibular/maxillary fractures, in which major
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 (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.

- The definition of major trauma for the purpose of this policy is trauma that required an inpatient hospital stay directly related to trauma or the fracture of one or more facial bones.
- Prior authorization is required through UMR.

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 $1500 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 bill to the dental plan. Any remaining balance is then claimed with the health plan.

   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 UMR Care Management. 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)

(Purchases over $1,500 and/or rentals over $500 per month.)

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. Please refer to page 17 for a list of equipment that may require prior authorization.

Emergency Care

Emergency and 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 Six, Definitions of Terms pages 62 and 64 respectively. A co-payment is required for any emergency department visit. Observation stays in the hospital are ***not*** considered admissions and are subject to the ER co-payment. If an observation stay results in an admission, the admission co-payment would apply and the ER co-payment will be waived.

Emergency transport to an emergency room is always covered. Air ambulance coverage is limited to $25,000.

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.

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 pages 16 and 17). Genetic testing/counseling is covered only for Health Benefit Program members. It is not covered when the service does not benefit the member.

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 the HBP.

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. Note: The 50% co-insurance **does not** accrue to the out-of-pocket maximum.

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 home care, continuous home care, inpatient respite care, and general inpatient care. Inpatient respite care provides rest and relief for the patient's primary caregivers. General inpatient care provides 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 UMR is required for coordination of care. Hospice Respite Care is limited to 10 days per calendar year.

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 Treatment

Coverage for infertility is limited to a lifetime maximum of $15,000 for Medical and $6,000 Pharmacy. Prior authorization by UMR is required for eligibility and provider determination. Contact Optum Fertility Solutions at 866.774.4626 to obtain detailed information. If an Optum Centers of Excellence provider does not exist within 60 miles, Optum will provide a gap exception. Prior authorization is required by Optum.

Sperm, Oocytes, or Embryo Cryopreservation

- With prior authorization, coverage for the harvest, procurement, and storage of sperm, oocytes, or embryos for eligible members who have no prior history of sterilization, and said storage is in association with ongoing infertility care (infertility treatment within 90 days of the cryopreservation) when the definition of infertility is met.
- The plan may prior authorize coverage for the harvest, procurement, and short term storage (<90 days) of sperm, oocytes, or embryos for eligible members who have no prior history of sterilization, in the presence or absence of ongoing infertility care, when the eligible member requires medical treatment that may render them sterile. Examples of such treatment include, but are not limited to, chemotherapy and/or radiation therapy for cancer and medically necessary gender confirming treatment. A letter of medical necessity from the treating physician is required. Coverage for this indication is limited to one cycle.
- **Limitations:**
  - Long-term sperm, oocyte or embryo storage, defined as greater than 360 days, as long as the eligible member is actively receiving infertility treatment (see above) or storage is following medical treatment that rendered them sterile (see above).
  - Coverage beyond 90 days after the last cycle of infertility treatment ends, or if a pregnancy occurs.
  - Sperm cryopreservation as a routine procedure for sperm backup in the absence of a confirmed physical or psychological diagnosis requiring cryopreservation.

Maternity Care

Prenatal care, which includes physician visits and ultrasounds as needed, are covered at 100% in the Tier 2 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 UMR Care Management 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 Events Changes on page 47.

Observation Stays

Observation stays in the hospital are not considered admissions and are subject to the $250 ER co-payment. If the observation stay results in an admission, the ER co-payment will be waived and the $350 admission co-payment would be applied.

Orthotics

- **Custom-made:** covered at 80% of Allowed Amount after $50 co-payment.
- **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 UMR 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 by UMR.

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 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.

Refractive Surgery

Coverage for refractive surgery includes services for the LASIK, PRK and SMILE procedures. Services must be provided by a United Healthcare Choice Plus or Cleveland Clinic provider in Cleveland. An assessment is usually required to determine if you are a candidate for the procedure. The assessment fee is the responsibility of the health plan member. Once determination is made, the surgery and after care up to a year is covered at 100%. This benefit has a lifetime maximum of one surgery per eye. Note: In some cases, the provider may request the member to pay up front. If this is the case, you would need to complete a claim form and submit with the receipt to the Third Party Administrator.

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 and Virtual Visit 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-payment/visit. Services and appliances must be received within the Tier 1 Network of Providers and prior authorization is required.

13. 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.

Therapy

Occupational[13]

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[13]

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[13]

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

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

Transplant Travel Expenses

If the covered person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to $5,000 total for both the recipient and donor. Provisions include:

- Applies to a designated transplant facility only (Cleveland Clinic in Cleveland or Florida)
- Applies to a covered person who is a recipient or to a covered or non-covered donor if the recipient is a covered person under the plan
- Expenses will be paid for the covered person and: one or two parents of the covered person (if covered person is a dependent child, as defined in this Plan); or one adult to accompany the covered person
- Type of expenses include, airfare, tolls and parking, gas/mileage, apartment/hotel rental (at or near the transplant facility)
- This benefit must be coordinated through the applicable facility's transplant team.

CASE COORDINATION (ADMINISTERED BY UMR)

Case Management Services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified from the Notification review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR's Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the member's care. UMR's philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The member can request that UMR provide services and UMR may also contact the member if the Plan believes case management services may be beneficial.

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to participate. The standard incentive is a gift card. Members who enroll via the UMR's website receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/

13. 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.

gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

UMR's NurseLine service is a 24/7 health information line that assists members with medical-related questions and concerns. NurseLine gives members access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their dependents. UMR's toll-free NurseLine is 800.808.4424.

DISEASE MANAGEMENT PROGRAM (ADMINISTERED BY UMR)

The Disease Management Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with Covered Persons to help them improve their chronic diseases and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and depression. We use medical and pharmacy claims to identify Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates may be initially identified using a Health Condition Survey. The survey is a general screening questionnaire available to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referrals, other Care Management programs, the employer, or the Covered Person's Physician.

If it is unreasonably difficult due to a medical condition for an individual to achieve the standards for the incentive under this program, or if it is medically inadvisable for an individual to attempt to achieve the standards for the incentive under this program, that individual should call the number on the back of his or her identification card. UMR Care Management will work with the individual to develop another way for him or her to qualify for the reward.

In addition to the telephonic services, UMR disease management also provides HealtheNotes. These targeted mailings are sent to Covered Persons' homes and their health care providers via U.S. mail. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs. Opportunities or gaps in care are identified through medical and/or pharmacy data.

HealtheNotes provides useful, personalized information based on an individual Covered Person's health care utilization, including information on provider visits, Prescriptions, and health screenings.

HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall health care costs.

Employee Assistance Program (EAP)

Occasionally, everyone is challenged by personal problems and issues. The Employee Assistance Program (EAP) offers **private and confidential** assessment, short-term counseling, and follow-up services to employees and their immediate family members. **You/your dependents do NOT need to be enrolled in the Cleveland Clinic Florida Employee Health Plan (HBP) in order to utilize the EAP benefit. You may want to consider the EAP program before using the comprehensive Cleveland Clinic Florida Employee Health Plan Mental Health Services benefit** (see Mental Health Services Benefits on pages 19–20 and refer to the Health Plan Summary chart on pages 4 and 5). **To access EAP please call toll-free at 800.624.5544 (24/7)**.

Common problems may include family or relationship issues, work-related problems, the death or illness of a close family member or friend, concerns about alcohol or drug use, depression, or an array of other personal challenges. Employees and families can utilize this benefit **without charge** up to six sessions per calendar year. No co-payment or co-insurance is required.

All EAP clinical practitioners are licensed mental health professionals and have a variety of specialized areas of training and interest. The EAP clinicians conduct thorough assessments and are trained in providing short-term counseling. Mental Health Services provided by the Cleveland Clinic Florida HBP is also available if more extensive treatment is needed.

Prescription Drug Benefit

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

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

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

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

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

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

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

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

Prescription Drug Benefit Program Overview

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

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

Understanding the *EHP Prescription Drug Formulary*

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

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

14. The Cleveland Clinic Home Delivery Pharmacy is only available to members within the states of Florida, Indiana, Nevada, Pennsylvania and West Virginia. All other members can utilize the CVS/caremark Mail Service Program.

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

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

Filling Your Prescriptions

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

Cleveland Clinic Outpatient Pharmacies and Specialty/Home Delivery Pharmacy

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

You may pick up your prescriptions at any of the locations listed below or you can have your prescription(s) mailed to your home by using the Cleveland Clinic Specialty/Home Delivery Pharmacy. There is a turnaround time of up to ten business days for all specialty/home delivery pharmacy orders. **Please note:** You cannot drop off or pick up prescription orders at the Cleveland Clinic Specialty/Home Delivery Pharmacy. See page 37 for details.

Cleveland Clinic Pharmacies, Specialty, or Home Delivery Pharmacy

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

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

Cleveland Clinic Pharmacies – Locations and Hours of Operation

• Cleveland Clinic Pharmacies in Florida:

Cleveland Clinic North Pharmacy ..... 772.288.5813, Fax: 772.221.2064
200 SE Hospital Ave., Stuart FL 34995 — Monday–Friday, 7:30 a.m.–6 p.m.

Cleveland Clinic Tradition Retail Pharmacy ..... 772.345.8166, Fax: 772.345.8167
10080 SW Innovation Way, Suite 102 — Monday–Friday, 7:30 a.m.–6 p.m.
Port Lucie, FL 34987

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

• Akron General Medical Center Location

Akron General Medical Center ..... 330.344.7732, Fax: 330.344.2927
Ambulatory Care Pharmacy — Monday–Friday, 8 a.m.–6:30 p.m.
1 Akron General Avenue, Akron, OH 44307

Cleveland Clinic Pharmacies (continued)

• Cleveland Clinic Pharmacies On Main Campus:

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

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

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

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

• Cleveland Clinic Family Health Centers

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

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

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

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

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

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

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

Cleveland Clinic Pharmacies (continued)

Willoughby Hills Family Health Center Pharmacy .....
2570 SOM Center Road, Willoughby, OH 44094
216.445.MEDS (6337), Fax: 440.516.8629
Toll-free: 866.650.MEDS (6337)
Direct Dial: 440.516.862
Monday–Thursday, 8 a.m.–8 p.m.; Friday 8 a.m.–6 p.m.

• Cleveland Clinic Regional Hospital Locations

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

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

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

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

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

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

Mercy Professional Pharmacy.....
1330 Mercy Drive NW, Canton, OH 44708
330.489.1400, Fax: 330.489.1175
Monday–Friday, 7 a.m.–5 p.m.

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

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

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

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

Cleveland Clinic Specialty/Home Delivery Pharmacy Ordering Instructions

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

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

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

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

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

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

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

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

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

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

- *Lower cost:* You will pay less for prescription co-insurance. In addition, your deductible will be waived for prescriptions filled with a generic medication at these pharmacies.
- *Convenience:* You may request a 90-day supply of non-specialty medications at any Cleveland Clinic Outpatient Pharmacy. **Note: The prescription must be written for a 90-day supply.**
- *Peace of mind:* You will have access to a toll-free hotline number for questions ad pharmacist consultation services during regular business hours.

- *Healthy Choice Coordinated Care program medication reimbursement:* If the EHP member is enrolled in the Healthy Choice Coordinated Care program and is eligible for medication reimbursement, the member must utilize a Cleveland Clinic Outpatient Pharmacy to qualify for medication reimbursement. Medications obtained from CVS Caremark Mail Service program or CVS/pharmacy retail stores are **not** reimbursable as part of the EHP coordinated care program. Appropriate documentation must be submitted with the request, which includes both the tax receipt and cash register receipt. Please communicate with your EHP Care Coordinator to learn if your medication qualifies for reimbursement. Additional information can be found in the Reimbursement Guidelines of the Coordinated Care program on page 30.

CVS Caremark Retail Pharmacy Network

Members have the option of picking up acute care prescriptions such as antibiotic therapy or pain medications or the first fill of any maintenance medication (limited to a 30-day supply) at any Cleveland Clinic Outpatient Pharmacy or CVS store pharmacy. Refills of maintenance medications must be obtained through one of the three options identified in the Mandatory Maintenance Drug Program section on page 42. A complete list of these pharmacies can be found on the CVS Caremark website at **https://www.caremark.com**. Please note that when using a CVS store pharmacy or the CVS Caremark Program, member co-insurance is higher when compared to obtaining your prescriptions from a Cleveland Clinic Outpatient Pharmacy. In addition, prescriptions obtained from a non-Cleveland Clinic Pharmacy are not eligible for reimbursement through the Coordinated Care Program.

CVS Caremark Mail Service Program

New Prescriptions

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

1. For new maintenance medications, ask your doctor to write two prescriptions;
   - One for up to a 90-day supply, plus refills, to be ordered through the Mail Service Program; and
   - A second to be filled immediately at any Cleveland Clinic Outpatient Pharmacy or CVS store pharmacy for use until you receive your prescription from the Mail Service Program.
2. Complete a Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate payment for each prescription. Be sure to include your **original prescription**, not a photocopy. Forms are available on CVS Caremark's website at **https://www.caremark.com**.

Mail Service Refills

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

Prescription Drug Benefit Guidelines

Deductible

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

Note: The annual deductible is waived if:

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

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

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

Deductible and Out-of-Pocket Maximum

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

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

Generic Medical Policy

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

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

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

Prior Authorization

Prior authorization is required for coverage of certain medications. These medications are listed in the Pharmacy Management Program section of the EHP Prescription Drug Formulary. This list may change during the year due to new drugs being approved by the FDA or as new indications are established for previously approved drugs. A Prior Authorization, Formulary Exception and Appeal form must be completed or sufficient documentation must be submitted by the member's provider before a case will be reviewed. Please refer to the Formulary Failure Review Process on page 39 for information about obtaining a form. Completed forms can be faxed to 216.442.5790.

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

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

Formulary Failure Review Process

The *EHP Prescription Drug Formulary* is designed to meet the needs of the majority of HBP members. However, if it is determined that you require treatment with a medication not included in the *EHP Prescription Drug Formulary,* your physician may request a review for preferred coverage of a Non-Formulary medication. To start the review process,

your physician should call the EHP Pharmacy Management Department at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 and request a *Prior Authorization, Formulary Exception and Appeal Form.* The form is also available online at **https://employeehealthplan.clevelandclinic.org**.

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

All requests must be in writing and signed by the prescribing physician. If a Non-Formulary brand name drug is approved, the member will be responsible for a 30% co-insurance, with no monthly maximum out-of-pocket. If a Non-Formulary generic drug is approved, the member will be responsible for 20% co-insurance, with no monthly maximum out-of-pocket. Most requests will be processed within one to two business days from the time of receipt. A response will be faxed to the requesting physician, and we will also inform the member of the request and the decision via mail.

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

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

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

   OR

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

Exception Process – Once received, requests will be processed within 72 hours. Expedited requests may be made by calling EHP Pharmacy Management at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4. In most cases, these requests will be reviewed and processed the same business day; however, calls received after 4 p.m. or during the weekend will be handled the next business day. One of the following criteria must be met to file an expedited request:

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

Pharmacy Benefits Coverage Clarification

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

Breast Cancer Prevention Coverage

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

Two medications used in the prevention of breast cancer, generic anastrozole and generic exemestane, will also be covered at not member cost. If the member's individual medical condition meets the criteria set forth by the United States Preventive Services Task Force. Members or providers can obtain the *Aromastase Inhibitor for Breast Cancer Risk Reduction Formulary Exception form* located on our website at **https://employeehealthplan.clevelandclinic.org** to request coverage of these medication at no member cost.

Contraceptive Coverage

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

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

Oral Medications for Onychomycosis (Nail Fungus)

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

Over-the-Counter (OTC) Medications

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

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

- **Aspirin:** Prior authorization required
- **Iron Supplements:** Covered at 100% for members 0-12 months
- **Oral Fluoride Products:** Covered at 100% for members age 0-5 years

- **Folic Acid:** Covered at 100% for **female** members age 40 and under
- **Tobacco Cessation Medications:**
  - Must be prescribed by an EHP approved Tobacco Cessation provider (in person) or EHP Tobacco Cessation eCoaching program provider (online only)
  - Coverage includes generic bupropion, brand Chantix, generic nicotine gum, generic nicotine lozenges, and generic nicotine patches.
  - **Prescriptions must be filled at any Cleveland Clinic Outpatient Pharmacy**

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

Pre-exposure Prophylaxis (PrEP) Coverage

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

Statin Medications for Prior Prevention of Cardiovascular Disease

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

1. Members are between 40 and 75 years of age.
2. Members on generic formulary low to moderate dose statins require prior authorization in order to receive their medication at no member out-of-pocket expense. To begin this process, please have the prescribing provider submit a *USPSTF Copay Free Statin Coverage Request Form* (available on our website at **https://employeehealthplan.clevelandclinic.org**) to the EHP Pharmacy Management Department. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the standard plan benefits will apply regarding statin coverage.
3. Members who receive a brand name formulation of a formulary statin that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name statin product and the generic alternative.
4. For members who do not go through the prior authorization process, the standard plan benefits will apply regarding statin coverage.
5. Statin products that do not require a prescription to be purchased are not covered under the Prescription Drug Benefit (i.e. red yeast rice).

Pharmacy Management Programs

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

Mandatory Maintenance Drug Program

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

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

- **Cleveland Clinic Pharmacy Home Delivery Service** – Home delivery enables you to order up to a 90-day supply of your maintenance medication refill prescriptions, which are delivered to your home, saving you a trip to the pharmacy. There is

no extra charge for home delivery and you will save 5% on your co-insurance compared to using the CVS Caremark mail Service Program (see page 37 for details).

- **Cleveland Clinic Outpatient Pharmacies** – Drop off your maintenance prescriptions for refill at any of the Cleveland Clinic Outpatient Pharmacy locations in northeast Ohio or the Weston Pharmacy in Florida. You can obtain up to a 90-day supply of medication and you will save 5% on your co-insurance (see page 34 for details).
- **CVS Caremark Mail Service Program** – You can order up to a 90-day supply of your maintenance medication prescription to be delivered to your home, but you not get the same 5% discount available when you order your prescription from a Cleveland Clinic Outpatient Pharmacy or the Home Delivery Pharmacy.

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

Medications Limited by Provider Specialty

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

Quantity Level Limits

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

Split Fill Program

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

Step Therapy Program

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

Specialty Drug Benefit

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

Members will be responsible for their co-insurance for all drugs that are determined to be self-administrable by the member. Self-administrable medications are defined as medications that are typically administered orally or subcutaneously (SC) and have patient instruction for use in the package insert (PI). Some intramuscular injections are also considered self-administrable due to frequency of injection and PI instructions for the patient on how to self-administer the drug. A co-insurance applies at all locations where the drug can be obtained. If a self-administrable drug is administered in a doctor's office, the member will be responsible for the office copayment as well as the drug co-insurance. If administered in the physician's office, the co-

insurance is not applied to the pharmacy deductible or out-of-pocket maximum, unless stated otherwise in the list of specialty drugs in the EHP Prescription Drug Formulary as being a medication that is white-bagged. White-bagging refers to a specialty pharmaceutical that is not intended to be self-administered being shipped or delivered by an in-network specialty pharmacy directly to the location where it will be administered by the member's chosen health care provider.

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

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

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

Specialty Drug Copay Card Assistance Program

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

In the event the manufacturer discontinues a specialty medication's copay assistance card, the member's cost share will revert back to the benefit design outlined on page 5.

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

Prescription Drug Benefit Exclusions

1. The replacement of lost or damaged prescriptions.* Stolen medications will be covered at the benefit program rate when accompanied by a police report.
2. Drugs prescribed for the treatment of sexual dysfunction.
3. Drugs to enhance libido function.
4. Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.
5. Drugs used for experimental or investigational purposes.
6. Drugs used for cosmetic purposes.
7. Drugs not included in the Patient Protection and Affordable Care Act that can be purchased without a prescription.
8. Medicinal foods (regardless of whether they require a prescription or not).
9. Insulin pumps and insulin pump supplies.
10. Prescriptions ordered or provided by a member of your immediate family.
11. Histamine H2 Receptor Antagonist (H2RA) drugs for members one year of age or older.
12. Proton Pump Inhibitor (PPI) drugs for members one year of age or older.
13. Nasal corticosteroid drugs.
14. Medical devices approved via the FDA 510(k) Premarket Notification review process.
15. Unapproved prescription drugs that do not have FDA approval such as drugs grandfathered, DESI, or GRAS/E.
16. Viscosupplementation and intra-articular hyluronate products.
17. Aduhelm

18. Amondys 45
19. Emflaza
20. Exondys 51
21. Makena
22. Vyondys 53

Refer to the Pharmacy Management Program section of the *EHP Prescription Drug Formulary* to see Lifestyle Medication (i.e. Drugs and Items at Discounted Rate) and Non Covered Drugs.

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

Prescription Drug Coverage Under Medicare

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

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

Members potentially eligible for Medicare Part D include:

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

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

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

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

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

Detailed information about the Medicare prescription drug plans that offer prescription drug coverage is available on Medicare's website at medicare.gov or by calling Medicare at 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

Exclusions

Cleveland Clinic Florida 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 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, 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 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.

- 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 TPA.
- Services or expenses incurred for a second bariatric surgery.
- Charges associated with teeth or periodontia unless specifically defined elsewhere in this *Summary Plan Description*.
- Reversal of voluntary infertility.
- 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.
- 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 Care Management.
- Any new technology used in an experimental or investigational program.
- Cost associated with the acquisition of donor sperm or donor.
- 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.
- 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 is less than five years old or 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*** an HBP member.
- Hypnosis.
- Charges for acupuncture treatment.
- 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 Utilization Department at UMR.
- Nasal flu vaccine, FluMist for members greater than 18 years of age. (FluMist is covered for members ages 2 to 18.)
- Travel Clinic and related services (e.g., immunizations, medications).
- Sclerotherapy for spider veins.
- Unattended electrical stimulation.
- Cervical home traction units.
- Ambulance transport to home from any healthcare facility or to/from physician or outpatient care visits.
- Viscosupplementation products such as Euflexxa, Gel-One, Synvisc, or Synvisc One.

Behavioral Health Coverage Exclusions – UMR Review

- 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 Utilization Department at UMR.. 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 Care Management.
- 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 Care Management.
- 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 Care Management.
- 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.[15] 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.

15. 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.

- 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 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 24.
- 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 *Cleveland Clinic EHP Prescription Drug Formulary* to see the Drugs and Items at Discounted Rate and Non-covered Drugs & Items for additional exclusions.

Section Four
THIRD-PARTY ADMINISTRATOR – UMR

Cleveland Clinic Florida HBP Third-Party Administrator (TPA) UMR

UMR functions as the Third-Party Administrator (TPA) for Cleveland Clinic Florida Health Benefit Program (HBP). In this role, they are responsible for:

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

Information regarding contacting UMR is available in the Quick Reference Guide on page 8 and on your member ID card.

Coordination of Benefits (COB)

Coordination of Benefits (COB) and Employee Questionnaire both mean the same thing. For the purposes of this *Summary Plan Description (SPD),* we will use the term Coordination of Benefits.

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 health plan, the TPA follows rules established by Florida law to decide which health plan pays first (primary plan) and how much the other healthcare plan (secondary plan) must pay. You must provide the TPA, UMR with COB facts and information necessary to apply order-of-benefit determination provisions of the Cleveland Clinic Florida HBP. The combined payments of all healthcare plans will not exceed the actual amount of your bills.

Process for Determining Which Health Plan Is Primary

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

1. **Non-Coordinating Plan:** If you have another group plan that does not coordinate benefits, it will always be primary.
2. **Employee:** The plan that covers you as an active employee is always primary and pays before a plan covering the person as a dependent, laid-off employee or retiree.
3. **Children:**
   - **Birthday Rule** – When your children's healthcare expenses are involved, the TPA follows the "birthday rule." The birthday rule states that the health plan of the parent with the first birthday in the calendar year is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your health plan will be primary for all of your children.
   - **Gender Rule and other Health Plan Rules** – Sometimes a spouse's health plan has some other coordination of benefits rule, such as a gender rule, which states that the father's health plan is always primary. In cases of the gender rule or other specific health plan coordination of benefits rules for children, the TPA will follow the rules of that health plan.

4. **Children (Parents Divorced or Separated):**

   - If the court decree makes one parent responsible for healthcare expenses, that parent's plan is primary.

     Note: The Cleveland Clinic Florida Health Benefit Program reimburses claims according to its plan rules (i.e., network requirements must be adhered to even if a court decree dictates Cleveland Clinic Florida employee's health insurance is primary for children living outside of the Network of Providers).

   - If the court decree gives joint custody and does not mention healthcare, the TPA follows the birthday rule.
   - If neither of those rules applies, the order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

5. **Other Situations:** For all other situations not described previously, the order of benefits will be determined in accordance with the Florida Department of Insurance rule on coordination of benefits.

How the Cleveland Clinic Florida HBP TPA Pays as Primary

As primary, the TPA will pay the full benefit provided by your health plan as if you had no other coverage, provided it is a covered benefit under the Florida HBP and all network provider and UMR Health Program rules have been followed.

How the Cleveland Clinic Florida HBP TPA Pays as Secondary

Based on Coordination of Benefits (COB), if the Florida HBP is secondary, it will pay only if the services are provided by a HBP network provider – Tier 1 or Tier 2 (refer to Section Three). 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 UMR Health Program and network provider rules.**
- **If a member seeks services from a Tier 2 Provider, before Cleveland Clinic Florida HBP will reimburse as secondary, the deductible must be met.**

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 plan.

In order to apply and enforce this provision or any provision of similar purpose of any other healthcare plan, 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 plan 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 50).

Workers' Compensation

If a Cleveland Clinic Florida employee has a work related injury or illness, the following reporting guidelines should be adhered to.

- Immediately report any injury sustained by you on the job to your supervisor.
- During business hours, notify Employee Health Nursing (EHN) or the Nursing Supervisor (NS), if after hours.
- If injury is life or limb threatening, visit Cleveland Clinic Florida emergency department for emergency treatment.
- EHN will assist with the report of the injury to Cleveland Clinic Florida's workers' compensation third-party administrator, Multi Line Claims Service (MLCS)/Managed Medical Equipment (MME).
- Obtain authorization from MLCS/MME prior to seeking medical services for work-related illness/injuries.

More detailed administrative guidelines are available on the Cleveland Clinic Florida Intranet. Click on "Department Sites," "Human Resources," then "Workers' Compensation Handbook."

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

Claims Information

Tier 1 and 2 (see Section Two) of Cleveland Clinic Florida Health Benefit Program (HBP) allows you, in most instances, to receive care without sending any claims or paperwork to the Third-Party Administrator (TPA).

Explanation of Benefits (EOB)

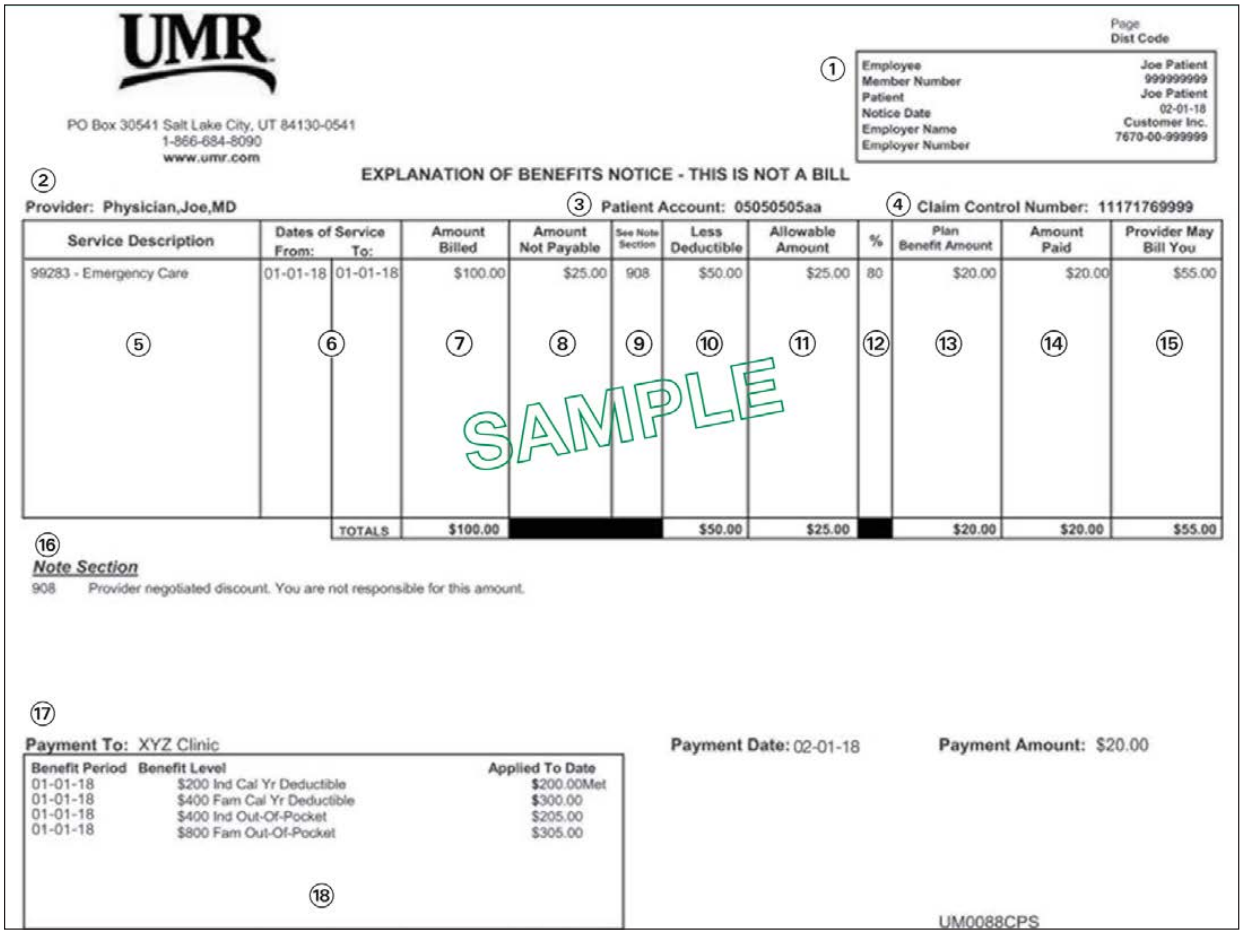
After a claim is processed, an EOB is created. An EOB is a statement that explains how the bill was paid by the TPA. An example is provided on the following page. The TPA only mails copies of the EOB if there is a payment to be made by the member other than a co-payment. You can view all your claims and EOB's on UMR's website at **umr.com** by following these instructions:

1. Visit **umr.com** and select Members
2. Enter your member ID located on your UMR ID card.
3. Click **go to my online services**. Their website will take you to your home page.
4. If you have previously registered, enter your username and password.
5. If you are not registered, click **Need a Username? Register here**.

To review electronic copies of your EOB, click on **myHome** page. You can also view your EOB's by clicking on the **myClaimCenter** tab.

If you do not have access to the intranet, simply contact UMR at the customer service number on the back of your ID card and a customer representative can assist you.

Explanation of Benefits (EOB) *Sample*



UMR

PO Box 30541 Salt Lake City, UT 84130-0541
1-866-684-8090
www.umr.com

Page
Dist Code

① Employee: Joe Patient
Member Number: 999999999
Patient: Joe Patient
Notice Date: 02-01-18
Employer Name: Customer Inc.
Employer Number: 7670-00-999999

② EXPLANATION OF BENEFITS NOTICE - THIS IS NOT A BILL

Provider: Physician,Joe,MD ③ Patient Account: 05050505aa ④ Claim Control Number: 11171769999

Service Description	Dates of Service From:	To:	Amount Billed	Amount Not Payable	See Note Section	Less Deductible	Allowable Amount	%	Plan Benefit Amount	Amount Paid	Provider May Bill You
99283 - Emergency Care	01-01-18	01-01-18	$100.00	$25.00	908	$50.00	$25.00	80	$20.00	$20.00	$55.00
⑤	⑥		⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮
		TOTALS	$100.00			$50.00	$25.00		$20.00	$20.00	$55.00

SAMPLE

⑯ *Note Section*
908 Provider negotiated discount. You are not responsible for this amount.

⑰ Payment To: XYZ Clinic
Payment Date: 02-01-18 Payment Amount: $20.00

Benefit Period	Benefit Level	Applied To Date
01-01-18	$200 Ind Cal Yr Deductible	$200.00Met
01-01-18	$400 Fam Cal Yr Deductible	$300.00
01-01-18	$400 Ind Out-Of-Pocket	$205.00
01-01-18	$800 Fam Out-Of-Pocket	$305.00

⑱

UM0088CPS

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:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

Questions about your claim should be directed to UMR's Customer Service at 800.826.9781.

The Coded Explanations for EOB Sample Above:

1 Fields include member information under which the claim was processed.

2 Hospital, physician or other healthcare provider that performed the services.

3 Account number assigned by the hospital, physician or other healthcare provider.

4 UMR assigns a unique claim control number to each claim received.

5 Services and/or procedures that were performed by the hospital, physician or other healthcare provider.

6 Date(s) services were performed by the hospital, physician or other healthcare provider.

7 Amount charged for the services by the hospital, physician or other healthcare provider.

8 Charges not allowed according to the Plan – see comment code.

9 Refers to codes used to explain charges that were not allowed – see Notes Section.

10 Amount applied to the deductible.

11 Charges allowed for payment – this is the difference between the "Amount Billed" and the "Amount Not Payable" and/or "Less Deductible" columns.

12 Percentage at which the Allowable charges are paid.

13 Amount actually payable by the Plan.

14 Amount that UMR paid to the provider.

15 Only amount you are responsible to pay to the hospital, physician or other healthcare provider, if applicable.

16 Explains codes provided in the "See Notes Section" column. Lists the specific code and its definition.

17 List of individuals or organizations to whom checks were issued.

18 Provides benefit period and benefit levels, amounts applied to individual/family deductibles, out-of-pocket and lifetime maximums, if applicable.

Section Five
ADMINISTRATIVE INFORMATION

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

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

The Registration Process

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

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

Eligibility

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

Note: If both employees (spouses) work for Cleveland Clinic or a Cleveland Clinic hospital, they cannot carry any family member twice.

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.[16]
- 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 your Human Resources Department.

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

Coverage Options

1. Employee Only – Covers only the employee.
2. Employee + One Child – Covers the employee and one child.
3. Employee + Spouse – Covers the employee and his or her spouse.
4. Family I – Covers the employee and up to three dependents (the three dependents can be a spouse and two children or all children).
5. Family II – Covers the employee and four or more dependents (the dependents can be a spouse and children or all children).

Dependents Eligible for Coverage

Dependents eligible for the Employee Health Plan 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.

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

Dependent Eligibility Verification

New Hires or New Enrollees

All new hires and/or existing employees enrolling themselves and/or their dependents for the first time need to provide the supporting documentation for verification of dependent eligibility to Human Resources during enrollment.

Spouse

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

Children under age 26

Natural born children:

- Copy of birth certificate or one of the following:
  - Copy of page one of your most recent tax return (you may cross out wage information)
  - Copy of court-issued qualified medical child support order (QMCSO)
  - Copy of divorce decree

Stepchildren/Custodial:

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

Adopted Children:

- Adoption papers

Health Benefit Enrollment Process

New Hires

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

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

If you ***do NOT*** take advantage of any of these opportunities to elect coverage for yourself or your dependents, you will not receive health benefit program coverage and will not be entitled to health benefit program coverage until the **next open enrollment offering unless you experience a life event change**, which is described in the Life Event Changes section on page 47. Open enrollment takes place annually, at which time benefit-eligible employees have the opportunity to elect coverage for the upcoming calendar year.

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

If you have further questions on how to apply for coverage, contact your Human Resources Department.

Coverage-Effective Date

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

Current Employees

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

At the time of open enrollment, you may take advantage of several options to help you defray the cost of your benefits:

1. **The Flexible Spending Account (FSA)** – Helps save money on healthcare related expenses, such as front-end deductibles and co-payments/co-insurance for medical, prescription drugs, dental services, eyeglasses and contact lenses. You will pay no Federal, State or Social Security tax on the money reimbursed to you.
2. **PTO Trade-in** – Can be applied toward your portion of the premiums for benefits you choose. Detailed information about the FSA and PTO programs can be obtained from the ONE HR Service Center.

Employee Contributions

Cleveland Clinic makes considerable effort each year to effectively manage the cost of your medical and pharmacy benefits. To maintain this important benefit, however, the employee contributes up to 30 percent of the cost for coverage. Cleveland Clinic pays the remaining 70 percent of the cost for you and your family's coverage.

Information about employee contributions is also available in the annual Open Enrollment Benefit packet and through Human Resources.

Plan Identification Card

Your Cleveland Clinic Florida Health Benefit Program (HBP) Identification (ID) card(s) will be mailed to your home directly from the Cleveland Clinic Florida HBP Third-Party Administrator (TPA) within approximately 20 business days of your enrollment date. See Section Two of this *Summary Plan Description* for TPA Information. Promptly submitting your selections reduces delays in receiving your ID cards and helps avoid possible claims issues.

Your ID card(s) contain the following information:

1. Florida Group Name
2. Florida Subscriber Name
3. Member ID
4. Group Number
5. Co-payment Requirements
6. HBP Customer Service and UMR's Nurseline and Care Management Telephone Number
7. Admission Certification Phone Number
8. UMR Claim Submission Mailing Address

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 Florida 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 **"Life Event Change"** and permit you to change certain elections:

1. Changes in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
2. Changes in the number of dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death.
3. Employment status changes, meaning an employee, spouse or dependent starts a new job or loses a current job.
4. Work schedule changes, meaning a reduction or increase in hours of employment for the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or the beginning or end of an unpaid leave of absence.
5. Changes in work location, meaning a change in the place of residence or work of an employee, spouse, or dependent.
6. A dependent satisfies – or no longer satisfies – the benefit program requirements for unmarried dependents because of age, job status or other circumstances.
7. A qualified medical child support court order (QMCSO), or other similar order, that requires health coverage for an employee's child.
8. The employee, spouse or dependent qualifies for Medicare or Medicaid. (If this happens, Health Benefit Program coverage may be cancelled for that individual.)
9. If there is a loss of coverage or significant increase or decrease in the cost of a benefit or a significant coverage curtailment (e.g., a significant increase in cost-sharing) or coverage improvement during a plan year you may be able to change certain benefit elections.
10. In addition, the Dependent Care Flexible Spending Account (FSA) has additional status change events which permit you to change your election during the year.
    a. For example, if you are participating in the Dependent Care Flexible Spending account and there 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, contact Human Resources.

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

Qualifying Events: Who, When, and for How Long

If your Florida 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 your ONE HR Service Center.

Veteran Reemployment

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

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

Retirement

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

- Continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). See COBRA section on page 47 for more information.

Please check with your Human Resources Department to determine if you are eligible for the Retiree Health Benefit Program.

Medical Leave/Disability Status

If you are on an approved medical leave of absence for more than six months, you may be eligible for Medical Leave/Disability Status. If you are approved for Medical Leave/Disability Status, your coverage may be extended. You must make arrangements for continuation of coverage directly with Human Resources.

Leave of Absence

If you go on an approved leave of absence, your coverage may continue. You must make arrangements for continuation of coverage directly with Human Resources.

Outplacement

If you are outplaced, Cleveland Clinic Florida HBP deductions continue at the active employee rate during your severance benefit period.

Termination of Coverage

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

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

You may elect to extend coverage if the Florida HBP coverage is lost due to one of the COBRA-related provisions beginning on page 47.

Section Six
HBP MEMBERS' RIGHTS AND RESPONSIBILITIES

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

- 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

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of 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 UMR 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

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 plan or health insurance coverage; or
- A decision to rescind your coverage, unless it is due to your 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:

Claims Appeals Unit
UMR
P.O. Box 30546
Salt Lake City, UT 84130-0546

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 UMR 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 UMR may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.

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 UMR Care 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.

Adverse Benefit Determination (Denied Claims)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the member is no longer eligible to participate in the Health Benefit Program.

If a claim is being denied in whole or in part, and the member will owe any amount to the provider, the member will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form. The EOB form will:

- Explain the specific reason for the denial.
- Provide a specific reference to pertinent Benefit Program provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the member to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the member can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Clinical Appropriateness for coverage or experimental treatment, the TPA will notify the member of that fact. The member has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

Appeals Procedure for Denied Benefit Determinations

If a member disagrees with the denial of a claim or a rescission of coverage determination, the member or his/her Personal Representative can request that the TPA review its initial determination by submitting a written request to the TPA as described on the next page. An appeal filed by a provider on the member's behalf is not considered an appeal under the Health Benefit Program unless the provider is a Personal Representative.

First Level of Appeal

This is a **mandatory** appeal level and is filed with UMR. The member must exhaust the following internal procedures before any outside action is taken.

Note: Pharmacy appeals are not subject to the mandatory appeal level. Pharmacy appeals should start at the second appeal level.

- Members must file the appeal within 180 days of the date they received the EOB form from the TPA showing that the claim was denied. The Benefit Program will assume that the member received the EOB form five days after the TPA mailed the EOB form.
- Members or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Members may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a 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 review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information 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 and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the TPA 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, nor be supervised by the healthcare professional who was involved. If the TPA has obtained medical or vocational experts in connection with the claim they will be identified upon the member's request, regardless of whether the TPA 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. The notification will provide members with the information outlined under the Adverse Benefit Determination section on page 51. 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*.

Second Level of Appeal

This is a **voluntary** appeal level and is filed with UMR. The member is not required to follow this internal procedure before going to the External Review Process on page 54.

- 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 60 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 the above voluntary appeal level, the HBP agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the member has followed the mandatory appeal level as required above. 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 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:

First Level **Mandatory** Appeals
UMR Claims Appeal Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

Second Level **Voluntary** Appeals
UMR Claims Appeal Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

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.

Right to External Review

Following completion of the internal appeals process, you may be eligible to submit a request for external review, which will be conducted by an independent physician external review group. Your request for external review will have no effect on other benefits available under your Benefit Program. Your request must be submitted within four months of the last adverse determination.

If you wish to pursue an external review, please send a written request to the following address:

UMR
External Review
Appeal Unit
P.O. Box 8048
Wausau, WI 54402-8048

Your written request should include: (1) your specific request for an external review; (2) the Employees' name, address, and member ID number; (3) your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive your request.

Contact UMR at the telephone number shown on your ID card for more information on the Federal external review program.

Reimbursement and Subrogation Rights of the Plan

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.

- Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as

required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

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
25900 Science Park Drive / AC242
Beachwood, OH 44122
216.986.1050, option 1 or toll-free at 888.246.6648, option 1

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.....65-0003177

Benefit Program Effective Date.....The Plan is effective as of January 1, 2013 and the provisions of the Benefit Program are effective January 1, 2022.

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 19 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.

Care 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. Care Management provides Case Coordination, Coordinated Care and Utilization Management programs.

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, Mercy 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 Care Management approval.

Contracted Rate – The hospital rate and physician fee schedule that is paid by the Third-Party Administrator (TPA) for the Cleveland Clinic Florida 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 Florida 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 at Cleveland Clinic Florida provided that you enrolled in Cleveland Clinic Florida HBP.

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 Florida 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 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 Cleveland Clinic Florida 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 UMR.

Non-Contracting – The status of a hospital or other facility provider which does not meet the definition of a contracting Cleveland Clinic Florida 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 Care Management 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 Florida Health Benefit Program TPA with respect to customary charges or costs for services of comparable complexity and difficulty.

Every life deserves world class care.

9500 Euclid Ave., Cleveland, OH 44195

Cleveland Clinic is a nonprofit, multispecialty academic medical center integrating outpatient and hospital care with research and education for better patient outcomes and experience. More than 4,500 staff physicians and researchers provide services through 20 patient-centered institutes. Cleveland Clinic is a 6,026-bed healthcare system with a main campus in Cleveland, 18 hospitals and over 220 outpatient locations. The health system includes five hospitals in Southeast Florida with more than 1,000 beds, a medical center for brain health in Las Vegas, a sports and executive health center in Toronto and a 364-bed hospital in Abu Dhabi. Cleveland Clinic London, a 184-bed hospital, will open in 2022. Cleveland Clinic is currently ranked as one of the nation's top hospitals by *U.S. News & World Report.*
clevelandclinic.org

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