

# HBP Benefits Summary

Benefit Program Features	TIER 1	TIER 2
	Cleveland Clinic Quality Alliance Network	MMO SuperMed <sup>1</sup> and Aetna <sup>®</sup> Open Choice <sup>®</sup> PPO Networks
<b>Annual Deductible</b>		
Single	None	\$500
Family	None	\$1,500
<b>Out-of-Pocket Maximum</b>		
Single	\$1,500	None
Family	\$3,000	None
<b>Medical Benefit Program Features</b>		
<b>PCP Office Visit</b> (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)	100% of Allowed Amount	\$25 co-pay, then 100% of Allowed Amount (after deductible)
<b>Specialist Office Visits</b>	100% of Allowed Amount after \$35 copay (no referral required)	\$50 co-pay, then 100% of Allowed Amount (after deductible)
<b>Maternity Care</b>	\$250 co-pay/admission, then 100% of Allowed Amount	\$250 co-pay/admission, then 70% of Allowed Amount (after deductible)
<b>Routine (Annual) Physical Exam by Primary Care Physician</b>	100% of Allowed Amount	Not Covered
<b>Routine (Annual) Vision Exam</b>	100% of Allowed Amount	Not Covered
<b>Inpatient Hospital Services<sup>2</sup></b>	\$250 co-pay/admission, then 100% of Allowed Amount	\$250 co-pay/admissions, then 70% of Allowed Amount (after deductible)
<b>Outpatient Hospital Services</b>	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Radiology –	100% of Allowed Amount	70% of Allowed Amount (after deductible)
MRI/CT Scans (non-emergent) <sup>2</sup>	\$50 co-pay	\$50 co-pay, then 70% of Allowed Amount (after deductible)
<b>Laboratory/Diagnostic Tests</b>	100% of Allowed Amount	70% of Allowed Amount (after deductible)
<b>Emergency Department</b>		
Emergency Care	100% after \$250 co-pay	100% after \$250 co-pay
Urgent Care	100% after \$50 co-pay	100% after \$50 co-pay
<b>Medical Supplies and Durable Medical Equipment</b>	80% of Allowed Amount	80% of Allowed Amount (after deductible)
<b>Skilled Nursing Care<sup>2</sup></b>	\$250 co-pay/admission, then 100% of Allowed Amount	\$250 co-pay/admission, then 70% of Allowed Amount (after deductible)
60 Days per Benefit Year		
<b>Acute Inpatient Rehab</b>	\$250 co-pay/admission, then 100% of Allowed Amount	\$250 co-pay/admission, then 70% of Allowed Amount (after deductible)
60 Days per Benefit Year		
<b>Long-Term Acute Care</b>	\$250 co-pay/admission, then 100% of Allowed Amount	Not Covered
60 Days per Benefit Year		
<b>Hospice<sup>2</sup></b>		
Symptom Management – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount
Respite Care – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount
<b>Home Health Care<sup>2</sup></b>	100% of Allowed Amount	70% of Allowed Amount (after deductible)
60 Visits per Benefit Year		
<b>Acupuncture</b>	50% of Allowed Amount	Not Covered
Maximum of 10 Visits/Benefit Year		
<b>Chiropractic</b>	First 10 visits: 100% of Allowed Amount after \$35 co-pay; Second 10 visits: 50% of Allowed Amount (Children under 12 require prior authorization)	Not Covered
Maximum of 20 Visits/Benefit Year		

## HBP Benefits Summary (continued)

Medical Benefit Program Features	TIER 1	TIER 2
	Cleveland Clinic Quality Alliance Network	MMO SuperMed <sup>1</sup> and Aetna <sup>®</sup> Open Choice <sup>®</sup> PPO Networks
<b>Therapy Services</b> Occupational/Speech/Physical 35 Visits per Therapy per Benefit Year	First 20 visits: 100% of Allowed Amount after \$10 co-pay; Second 15 visits: 50% of Allowed Amount	First 20 visits: 100% of Allowed Amount after \$10 co-pay and after deductible. Second 15 visits: 50% of Allowed Amount
<b>Dental</b> – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
<b>Family Planning<sup>3</sup></b>	100% of Allowed Amount	Not Covered
<b>Infertility</b> – Diagnostic Only	100% of Allowed Amount	Not Covered
<b>Hearing Aids</b>	50% of Charge up to \$3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
<b>Organ Transplant<sup>2</sup></b> Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
<b>Behavioral Health Benefit Program Features</b>		
<b>Outpatient Coverage</b> Outpatient (OP Visits) <sup>4</sup>	\$35 co-pay, then 100% of Allowed Amount	\$50 co-pay, then 100% of Allowed Amount (after deductible)
Psychological and Neuro-Psychological Testing <sup>5</sup>	100% of Allowed Amount	Not Covered
<b>Inpatient Coverage<sup>2</sup></b>	\$250 co-pay/admission, then 100% of Allowed Amount	\$250 co-pay/admission, then 70% of Allowed Amount (after deductible)
<b>Intensive Outpatient (OP)<sup>2</sup></b>	100% of Allowed Amount	70% of Allowed Amount (after deductible)
<b>Partial Hospitalization Programs (PHP)<sup>2</sup></b>	100% of Allowed Amount	70% of Allowed Amount (after deductible)
<b>Residential Treatment<sup>2</sup></b> 60 Days per Benefit Year	\$250 co-pay/admission, then 100% of Allowed Amount	Not Covered
<b>Transcranial Magnetic Stimulation (TMS)<sup>2</sup></b> 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	70% of Allowed Amount (after deductible)

For Tier 1, co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for bariatric surgery, hearing aids and Autism School.

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

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

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

4. The Outpatient coverage for the Behavioral Health Benefit Program includes any outpatient services provided by a behavioral health practitioner for chronic pain management, sleep disorder, aftercare groups for substance abuse, and/or pre and post gastric surgery visits. There is no coverage for school meetings by outpatient behavioral health practitioners.

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

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

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

# HBP Prescription Drug Benefit

Administered Through CVS/caremark

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

Categories	TIER 1	TIER 2	TIER 3	TIER 4	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
	Preferred Generics	Preferred Brands	Non-Preferred Brands (Non-Formulary)	Specialty Drugs (Hi-Tech)		
<b>Annual Deductible</b>	\$200 Individual \$400 Family	<i>(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)</i>			No	No
<b>Member % Co-insurance Cleveland Clinic Pharmacies:</b> up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
<b>Member % Co-insurance CVS Store Pharmacies:</b> 30-Day Supply <b>Mail Service Program:</b> 90-Day Supply	20%	30%	50%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
<b>Cleveland Clinic Pharmacies including Specialty &amp; Home Delivery:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$3 Minimum/ \$50 Maximum per Month Supply	Yes \$3 Minimum/ \$50 Maximum per Month Supply	No	Yes No Minimum/ \$50 Maximum per Month Supply	No	No
<b>Retail Pharmacies:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$5 Minimum/ \$50 Maximum per Month Supply	Yes \$5 Minimum/ \$50 Maximum per Month Supply	No	N/A	No	No
<b>CVS/caremark Mail Service Program:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$15 Minimum/ \$150 Maximum 90-Day Supply	Yes \$15 Minimum/ \$150 Maximum 90-Day Supply	No	Yes No Minimum/ \$100 Maximum per Month Supply	No	No
<b>Is there an Annual Out-of-pocket Maximum?</b>	<b>After Deductible Has Been Met:</b> \$1,500 Individual / \$4,500 Family Combined Maximums for Retail, Specialty and Home Delivery				No	No
<b>Components of Each Category</b>			<b>Brand Name Drugs</b> See the <b>EHP Prescription Drug Benefit Handbook</b>	<b>Specialty Drugs<sup>6,7</sup></b> Complete list of Specialty Drugs and Copay Card Assistance Program in the <b>EHP Prescription Drug Benefit Handbook</b>	<b>Lifestyle Drugs</b> See the <b>EHP Prescription Drug Benefit Handbook</b>	<b>Over-the-Counter Drugs</b> See the <b>EHP Prescription Drug Benefit Handbook</b>
<b>Prior Authorization Required</b>	See the <b>EHP Prescription Drug Benefit Handbook</b> for list of pharmaceuticals requiring prior authorization				No	N/A
<b>Diabetic Supplies<sup>8</sup> Asthma Delivery Devices<sup>3</sup> and Prescription Vitamins<sup>4</sup></b>	Co-insurance 20%			No	No	N/A
<b>Pharmacies<sup>10</sup> in the Retail Network</b>	Cleveland Clinic Pharmacies (listed on pages 33, 34 and 35), Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Home Delivery Pharmacy, CVS store pharmacies (including CVS pharmacies located in Target stores), CVS/caremark Mail Service, CVS/specialty Pharmacy					

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

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

7. There are 3 options for obtaining medications in the category listed above. The options are: 1. *Cleveland Clinic Pharmacies listed on pages 33, 34 and 35*, 2. *Cleveland Clinic Specialty Pharmacy*, and 3. *CVS/caremark Specialty Drug Program*. **Specialty Drug prescription orders (first fill and refills) are limited to a one month supply.**

8. Diabetic Supplies – All diabetic supplies covered, except for insulin pumps and insulin pump supplies

(which are covered under the medical benefit). Diabetic supplies covered under the prescription drug benefit include: needles purchased separately, test strips, lancets, glucose meters, syringes, lancing devices, and injection pens. Members with type 1 diabetes who are under 18 years of age will have no out-of-pocket expense for their insulins and diabetic supplies covered under the prescription drug benefit.

Asthma Delivery Devices – Includes spacers used with asthma inhalers.

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

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