Cleveland Clinic

My RHP Health Connection™

From the Employee Health Plan

Cleveland Clinic
Employee Health Plan Bulletin
September 2021 – Retirees

In This Issue

This issue of My RHP Health Connections is part of your 2022 Open Enrollment materials. It provides information about the 2022 medical and prescription drug offerings in addition to other health plan changes. To get the most value out of your health plan benefits, refer to your summary plan description located on the EHP website. This newsletter now includes information for retirees under age 65 and over age 65. Review the open enrollment material carefully as there are important changes in 2022.

Retiree Health Plan (RHP) partnering with Aetna in 2022

The Cleveland Clinic Employee Health Plan (EHP) partners with a third party administrator for claims processing, eligibility verification, explanation of benefits, and more. **Starting Jan. 1, 2022**, the Employee Health Plan (EHP) will transition from Mutual Health Services (MHS), a subsidiary of Medical Mutual of Ohio, to Aetna Select Open Access for these services. This change will apply to retirees currently enrolled in the retiree health plan.

For the remainder of 2021, Mutual Health Services remains as the third party administrator, so continue to use the same health insurance cards you have now. We are working closely with MHS and Aetna to ensure a smooth transition for our current plan members.

The EHP will be issuing new medical ID cards for 2022 to reflect the change to Aetna. Your new ID cards should arrive in late December. There will be no changes to the prescription drug benefit and new cards will not be issued in 2022. ■

Introducing More Choice for RHP Members

During open enrollment this year, there will be two medical plan options to choose from: EHP and EHP Plus. The benefit coverage (such as medical and prescription drug) are the same for both options. The difference will be in your ability to access providers nationwide and your premium cost. As always, emergency and urgent care services are covered at 100% (after applicable copay) no matter where the services are received.

EHP: This option will include one network – the Cleveland Clinic Quality Alliance. This includes Cleveland Clinic facilities and employed physicians as well as contracted community physicians and facilities in northeast Ohio. This plan excludes Akron Children's Hospital providers. There will no longer be a Tier 2 network, so you must use this network of providers if you elect this plan.

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Introducing More Choice for RHP Members CONTINUED

EHP Plus: This option includes the Cleveland Clinic Quality Alliance network above in addition to the Aetna Select Open Access network (a national network). There will not be any out of network coverage, so you must use Cleveland Clinic Quality Alliance providers or Aetna Select Open Access providers if you elect this plan.

The new medical plan option, EHP Plus, offers a choice for retirees whose medical needs may not be met by the Cleveland Clinic Quality Alliance **OR** because they may live outside of the EHP provider network.

You can view each network on the Aetna Preview Site. The site can be accessed via our website at clevelandclinic.org/healthplan. Click on the "Aetna 2022 Preview Site" at the top of the page. Then click on the "Retiree" link. There you can access a tutorial video on how to look up a provider for both the EHP and EHP Plus networks. You can also view frequently asked questions regarding the new options.

When your plan is active on Jan 1, 2022, you will be able to create an account and view your claims and explanation of benefits, as well as have access to the provider list for the plan you have chosen. To create an account on Jan. 1, visit MyAetnaWebsite.com. You can also make inquires by calling Aetna's customer service at 833.414.2331.

Full instructions on how to elect the plan that best fits your needs are included in this open enrollment packet. If you want to elect the **EHP Plus** option, you must complete the Opt-In Form and return it to the address on the form. If you do not complete and return this form, you will automatically be enrolled in the EHP option (local network).

Note: The prescription drug benefit is not affected by this change and will continue to be administered by CVS/Caremark.

If you have questions, contact the ONE HR service center at 216.448.2247. ■

RHP Coverage Changes for 2022

Medical Benefits

The following benefit changes will be effective Jan. 1, 2022 All co-pays and co-insurances will remain the same.

- Coverage for LASIK surgery
- Coverage for infertility treatment: $15,000 lifetime maximum

Pharmacy Benefits

There are no changes to either the CVS/Caremark (under 65) or SilverScript (over 65) pharmacy benefit for 2022.

Attention Medicare Recipients

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

HBP Benefits Summary

Benefit Program Features	*EHP* Cleveland Clinic Quality Alliance Network	*Out of Network*
Annual Deductible Single Family **Out-of-Pocket Maximum** Single Family	 None None $3,950 $7,900	
Medical Benefit Program Features		
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)	100% of Allowed Amount	Not Covered
Specialist Office Visits	100% of Allowed Amount after $35 copay (no referral required)	Not Covered
Maternity Care	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Routine (Annual) Physical Exam by Primary Care Physician **Routine (Annual) Vision Exam**	100% of Allowed Amount 100% of Allowed Amount	Not Covered Not Covered
Inpatient Hospital Services[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent)[1]	100% of Allowed Amount 100% of Allowed Amount $75 co-pay , then 100% of Allowed Amount	Not Covered Not Covered Not Covered
Laboratory/Diagnostic Tests	100% of Allowed Amount	Not Covered
Emergency Department Emergency Care Urgent Care	 100% after $250 co-pay 100% after $50 co-pay	 100% after $250 co-pay 100% after $50 co-pay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	Not Covered
Skilled Nursing Care[1] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Acute Inpatient Rehab 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Long-Term Acute Care 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Hospice[1] Symptom Management – 10 Days/Benefit Year Respite Care – 10 Days/Benefit Year	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	Not Covered Not Covered Not Covered
Home Health Care[1] 60 Visits per Benefit Year	100% of Allowed Amount	Not Covered
Acupuncture Maximum of 10 Visits/Benefit Year	50% of Allowed Amount	Not Covered
Chiropractic Maximum of 20 Visits/Benefit Year	First 10 visits: 100% of Allowed Amount after $35 co-pay; Second 10 visits: 50% of Allowed Amount (Children under 12 require prior authorization)	Not Covered

HBP Benefits Summary (continued)

Medical Benefit Program Features	*EHP* Cleveland Clinic Quality Alliance Network	*Out of Network*
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	Not Covered
Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning[3]	100% of Allowed Amount	Not Covered
Infertility Treatment	100% of Allowed Amount ($15,000 Lifetime Maximum)	Not Covered
Hearing Aids	50% of Charge up to $3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant[1] Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
Behavioral Health Benefit Program Features		
Outpatient Coverage Outpatient (OP Visits)[3]	$35 co-pay, then 100% of Allowed Amount	Not Covered
Psychological and Neuro-Psychological Testing[4]	100% of Allowed Amount	Not Covered
Inpatient Coverage[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Intensive Outpatient (OP)[1]	100% of Allowed Amount	Not Covered
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	Not Covered
Residential Treatment[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[1] 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	Not Covered

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

1. Prior authorization required.

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

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

4. Psychological and Neuro-Psychological Testing: Up to 16 hours of testing are automatically reimbursed without prior authorization. Testing must be done 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 Benefits Summary

Benefit Program Features	*EHP Plus* Cleveland Clinic Quality Alliance and Aetna Select Open Access Networks	*Out of Network*
Annual Deductible Single Family **Out-of-Pocket Maximum** Single Family	 None None $3,950 $7,900	
Medical Benefit Program Features		
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Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning[2]	100% of Allowed Amount	Not Covered
Infertility – Treatment	100% of Allowed Amount ($15,000 Lifetime Maximum)	Not Covered
Hearing Aids	50% of Charge up to $3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
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Inpatient Coverage[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Intensive Outpatient (OP)[1]	100% of Allowed Amount	Not Covered
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	Not Covered
Residential Treatment[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[1] 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	Not Covered

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

1. Prior authorization required.
2. Marymount employees are subject to family planning exclusions including abortion, vasectomy, Norplant, Depo Provera, IUD, tubal ligation, and oral contraceptives, except if clinically appropriate.
3. The Outpatient coverage for the Behavioral Health Benefit Program includes any outpatient servicesprovided by a behavioral health practitioner for chronic pain management, sleep disorder, aftercare groups for substance abuse, and/or pre and post gastric surgery visits. There is no coverage for school meetings by outpatient behavioral health practitioners.
4. Psychological and Neuro-Psychological Testing: Up to 16 hours of testing are automatically reimbursed without prior authorization. Testing must be done by trained Behavioral Health Specialists.

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

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

Non-Medicare HBP Prescription Drug Benefit

Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2022 (Retirees under 65)

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

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

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

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

3. 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.

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

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

Medicare Eligible and Approved HBP Prescription Drug Benefit

Administered Through SilverScript®

The Following Is a Summary Overview of the Prescription Drug Benefit for 2022 (Retirees 65 and over)

Categories	*TIER 1* Generic Rx	*TIER 2* Preferred Brands (Formulary)	*TIER 3* Non-Preferred Brands (Non-Formulary)	*TIER 4* Specialty Drugs (Hi-Tech)
Annual Deductible	$100 Individual *(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)*			
Member % Co-insurance Cleveland Clinic Pharmacies: Outpatient: up to 90-Day Supply Specialty & Home Delivery: up to 90-Day Supply	15%	25%	45%	20%
Member % Co-insurance CVS/caremark Retail: up to 90-Day Supply **Mail Service Program:** up to 90-Day Supply	20%	30%	50%	20%
Cleveland Clinic Pharmacies including Specialty & Home Delivery: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $3 Minimum/ $50 Maximum per Month Supply	Yes $3 Minimum/ $50 Maximum per Month Supply	No	Yes No Minimum/ $50 Maximum per Month Supply
CVS/caremark Retail up to 90-Day Supply: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $5 Minimum/ $75 Maximum per Month Supply	Yes $5 Minimum/ $75 Maximum per Month Supply	No	N/A
CVS/caremark Mail Service: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $15 Minimum/ $225 Maximum 90-Day Supply	Yes $15 Minimum/ $225 Maximum 90-Day Supply	No	Yes No Minimum/ $100 Maximum per Month Supply
Is there an Annual Out-of-pocket Maximum?	No	No	No	No
Components of Each Category	Generic Drugs	Brand Drugs		Specialty Drugs
	You will be sent a copy of the SilverScript's *Preferred Drug List*. You may also contact SilverScript to request a copy of the *Preferred Drug List* **by calling the toll-free number on your SilverScript card.** **Medicare Part B vs. Medicare Part D** **Please note: Most medications are covered under Medicare Part D, but there are some medications that can be covered under both Medicare Part B (i.e., the Medicare outpatient benefit) or Medicare Part D (i.e., the Medicare prescription drug benefit) depending on what the drug is used for and how it is administered. Please consult the SilverScript Prescription Drug Formulary or contact SilverScript using the toll-free phone number on the back of your SilverScript card for more information regarding Medicare Part B vs. Medicare Part D medications.**			
Major Chains in the Retail Network	ACME, Cleveland Clinic Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy), Costco, CVS, Discount Drug Mart, Giant Eagle, K-Mart, Marc's, Medicine Shoppe, Rite Aid, Target, Walgreens, Wal-Mart, plus other chains and independent pharmacies.			

SilverScript is a registered trademark of SilverScript Insurance Company.
Note: Effective January 1, 2018, diabetic testing supplies will no longer be covered under the Medicare Part D program. They will now be covered under Medicare Part B.

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

Other Important Information

Dependent Eligibility Processes

1. New Enrollees

After enrolling in the plan for the first time, all employees (new hires or those with longer service) need to provide documentation that proves dependent eligibility. The plan accepts these documents:

Spouse

- Copy of marriage license, or
- Copy of page 1 of your most recent tax return (make sure to cross out wage information)

Children under age 26

Natural born children:

- Copy of birth certificate or one of the following:
  - Copy of page 1 of your most recent tax return (make sure to cross out wage information)
  - Copy of court-issued qualified medical child support order (QMCSO) (if applicable)
  - Copy of divorce decree (if applicable)

Stepchildren/Custodial:

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

Adopted Children:

- Adoption papers

2. Coordination of Benefits (COB)

All members are expected to complete the COB process when they enroll, each year in January, or if they experience a life event change. Here's how the process works:

- If the employee/dependent(s) has other insurance, the COB form can be completed online via the Aetna website or the completed form can either be faxed or mailed to Aetna. The form is available on EHP's website at clevelandclinic.org/healthplan.
- If the employee/dependent(s) does not have other insurance, they can complete the information online via the Aetna website or they can call Aetna customer service at 833.414.2331 and the information will be updated during the call. Employees have one year to complete the COB process. As long as the COB process remains uncompleted, claims for covered dependents will be denied. The member will receive a COB form with each dependent's first claim statement until the COB process is complete. If a member does not respond within 45 days, Aetna will send an *Explanation of Benefits (EOB)* form explaining that all claims for dependents will be denied until the COB form is completed. If the member still has not completed the COB process by the end of the year, he or she will be financially responsible for all the dependent claims submitted that year.

Medicare Coordination

When you or your covered dependent become Medicare eligible, it is important for you to enroll in Medicare Part B. The Employee Health Plan (your health benefit plan) becomes the secondary insurance once you become Medicare eligible. This means that if you do not enroll in Medicare Part B, you will be responsible for 80% of your service costs because EHP pays only 20% (what Medicare does not pay) as the secondary insurance.

3. Life Event Changes

Members whose legal marital status changes (for example, through divorce or death of a spouse) or who have changes in the number of their dependents will need to verify the changes and dependent eligibility with the proper documentation. This ensures that only eligible dependents are enrolled in the plan. If you have questions, call the ONE HR Service Center at 216.448.2247 or toll-free at 877.688.2247.

Social Security Numbers are Required

Under Healthcare Reform, Cleveland Clinic is required to report to the government the Social Security numbers of each member on the health plan. When enrolling your dependents in the health plan, make sure to include their Social Security numbers. If already enrolled, you can update Social Security numbers for your health plan dependents on the ONE HR Workday and Portal.

Case Coordination

Case Coordination Programs give members telephone access to a registered nurse or a licensed social worker or counselor when they need help with a range of complex medical or behavioral health needs such as:

- Progressive neurological conditions
- Anxiety disorders

Other Important Information CONTINUED

- Childhood disorders
- Dual diagnoses (both psychiatric and chemical dependence)
- Eating disorders
- Mood disorders
- Psychotic disorders
- Substance abuse

Case coordination also can help members with network access issues and referrals to community services. Members can refer themselves or be referred by their physician or family for evaluation.

To get more information about case coordination, call the EHP Medical Management Department at 216.986.1050 or toll-free at 888.246.6648. ■

Pharmacy Management Programs (under 65 only – CVS Caremark)

The EHP Pharmacy Management Department administers four programs that assist members in using prescription medications safely and effectively.

- Quantity Level Limits
- Prior Authorization
- Step Therapy Program
- Specialty Drug Benefit

For details about each program, visit clevelandclinic.org/healthplan and click on "Plan Offerings." ■

Comparing RHP Rx with Medicare Part D

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

The Retiree Health Plan (RHP) has determined that your existing coverage with the RHP is, as good as standard Medicare coverage. In many cases, coverage under the RHP actually exceeds the standard Medicare coverage. It is important that you evaluate both the RHP Prescription Drug Benefit and the Medicare Prescription Drug Benefit to determine which plan best meets your needs. Compare your current RHP 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. RHP members who are Medicare eligible receive a "Creditable Coverage" letter upon the date of eligibility. This letter is important to keep because it serves as confirmation of your participation in an employer-based prescription drug plan. It also allows you to enroll in Medicare Part D in the future without increased monthly premiums if you decide to terminate your RHP coverage. If you misplace this letter, you may request a duplicate from your Total Rewards Department by contacting the ONE HR Service Center at 216.448.2247.

It is important to note that if you enroll in a different Medicare Part D plan, you may no longer participate in the Cleveland Clinic Retiree Health Plan. You will lose your Cleveland Clinic medical and pharmacy plans and will not be eligible to return to the Cleveland Clinic RHP in the future.

Medicare eligible RHP members include:

- RHP members age 65 or over enrolled in Medicare
- Retirees under age 65 who are disabled and eligible for Medicare
- Dependents, such as spouses, of RHP members who are enrolled in Medicare
- Disabled dependents (e.g., children) eligible for Medicare
- Active Medicare-eligible employees and their Medicare eligible dependents who are enrolled in Medicare
- Long-term disability (LTD) recipients eligible for Medicare

More detailed information about the Medicare prescription drug plans that offer prescription drug coverage is available at www.medicare.gov or by calling Medicare toll-free at 800.MEDICARE (800.633.4227). TTY users should call toll-free at 877.486.2048. Additional information about the RHP Prescription Drug Benefit and the Medicare Prescription Drug Benefit is included in the Retiree Summary Plan Description (SPD) and Prescription Drug Benefit and Formulary Handbook available on our website at clevelandclinic.org/healthplan. Contact the ONE HR Service Center with further questions at 216.448.2247 or toll-free at 877.688.2247. ■