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 after $35 copay	Not Covered Not Covered
Inpatient Hospital Services[1]	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent)[1]	100% of Allowed Amount 100% of Allowed Amount $75 co-pay , then 100% of Allowed Amount	Not Covered Not Covered Not Covered
Laboratory/Diagnostic Tests	100% of Allowed Amount	Not Covered
Emergency Department Emergency Care / ER Hospital Admission Urgent Care	100% after $250 co-pay/$350 if admitted 100% after $50 co-pay	100% after $250 co-pay/$350 if admitted 100% after $50 co-pay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	Not Covered
Skilled Nursing Care[1] 60 Days per Benefit Year	$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Acute Inpatient Rehab 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[2]	100% of Allowed Amount	Not Covered
Infertility Treatment[2]	100% of Allowed Amount LTM: ($15,000 Medical, $6,000 Pharmacy)	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 and the Autism School.

1. Prior authorization required.

2. Marymount employees are subject to family planning exclusions including infertility treatment, 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 Prescription Drug Benefit

Administered Through CVS/caremark

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

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 Program: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes $15 Minimum/ $150 Maximum 90-Day Supply	Yes $15 Minimum/ $150 Maximum 90-Day Supply	No	Yes No Minimum/ $100 Maximum per Month Supply	No	No
Is there an Annual Out-of-pocket Maximum?	**After Deductible Has Been Met:** $3,950 Individual / $7,900 Family Combined Maximums for Retail, Specialty and Home Delivery				No	No
Components of Each Category			**Brand Name Drugs** See the ***EHP Prescription Drug 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, 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, 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.***

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.