Cleveland Clinic Florida

My EHP Health Connection™

From the Employee Health Plan

Cleveland Clinic Employee
Health Plan Bulletin
Issue 1 FL, May 2017

In This Issue

New Name, Same Trustworthy Source: *My EHP Health Connection* 1
Healthy Choice Participation Continues to Increase 1
A Message from the CEO: 2
2017 Benefit Change Reminders and Updates 2
Effective January 1 2
Member Responsibility for Co-Payment . . 2
EHP Prescription Drug Benefit Reminders 3
EHP Coordinated Care Updates 3
Coordinated Care Reimbursement Guidelines Change 3
Bariatric Surgery Follow-up Visits 3
Using Tier 1 Providers Saves You Money . . 4
Reminders from Revenue Cycle Management 4

Cleveland Clinic Tier 1 Network Hospitals

- Cleveland Clinic Florida
- Cleveland Clinic Main Campus
- Cleveland Clinic Children's Hospital
- Cleveland Clinic Children's Hospital for Rehabilitation
- Akron General Hospital
- Ashtabula County Medical Center
- Euclid Hospital
- Fairview Hospital
- Hillcrest Hospital
- Lutheran Hospital
- Marymount Hospital
- Medina Hospital
- South Pointe Hospital
- Cleveland Clinic Nevada

New Name, Same Trustworthy Source: *My EHP Health Connection*

What's in a name? Apparently a lot.

We're introducing the first issue of *My EHP Health Connection*. It continues to be the exclusive newsletter from Cleveland Clinic's Employee Health Plan to all plan members.

The name change coincides with Cleveland Clinic's rebranding of all compensation and benefits programs under **My Pay + Benefits**. The branding is more personalized. It's all about how much we support you and your family's well-being.

Learn more about all our **My Pay + Benefits** offerings at the ONE HR Portal. ■

Healthy Choice Participation Continues to Increase

There are 33,000 Employee Health Plan members taking charge of their well-being. And earning a discount on their premiums.

Are you participating in Healthy Choice? It's not too late — and it's easy to get started. You can still earn a partial discount while improving your health.

1. **Create an account in the Healthy Choice Portal.** Access the portal via the Employee Health Plan website at *www.clevelandclinic.org/healthplan*. Click the orange "Healthy Choice Portal" button. Once registered, view your current health status and you can begin to take action.
2. **View your "Personal Program Requirements"** in the Healthy Choice Portal.
   - If it says "Healthy" or "Chronic Condition," follow the program requirements.
   - If it asks you to submit a *Health Visit Report Form*, schedule a health visit with your primary care provider immediately and bring the form with you.
3. **Participate!** All that means is following your program requirements according to your health status.

Yes, you can still earn a discount if you did not begin participating by our March deadline. Join before June 30, 2017, to earn a partial discount if you meet program requirements by September 30. Questions? Call the ONE HR Service Center at 216.448.2247 or toll-free at 877.688.2247. ■

A Message from the CEO:
You Have the Power to Improve Your Health

It isn't easy to consistently make healthy food choices — who doesn't enjoy an occasional chocolate chip cookie? As a physician, I have seen the consequences of consistently eating a high-fat, sugar diet, leading a sedentary lifestyle and smoking. They all contribute to many diseases that can be prevented, including heart disease, high blood pressure and some forms of cancer.

Through our Healthy Choice program, I have also seen caregivers taking control of their health by losing weight, quitting smoking and in many cases eliminating or reducing the need for medications to manage chronic disease. As a result, our family health plans for caregivers are less expensive than the national average.

Healthy Choice shows us caregivers stay well by participating and even become healthier when they join our coordinated care programs. More importantly, it shows that when you, our caregivers, have the resources to make changes, you are using them to improve your health and life.

I encourage you and your spouse to continue participating in Healthy Choice. There is no greater benefit than good health.

Toby Cosgrove, MD
CEO and President ■

2017 Benefit Change Reminders and Updates

Effective January 1

- Emergency co-payment increased to $150.
- All inpatient admissions require a $150 co-payment. This includes extended care/skilled nursing, long-term acute care, hospice and residential treatment, which are all considered inpatient.
- The maximum number of days for home care, residential treatment, long-term care and acute rehab decreased from 75 to 60 days.
- The chiropractor co-payment increased to $35.
- The number of visits for physical, occupational and speech therapy decreased from 45 to 35 visits.
- Temporomandibular Joint Syndrome (TMJ) is now covered at 100 percent of allowed amount after a $35 co-payment. Services must be within the Tier 1 network of providers. Prior authorization is required.
- The pharmacy deductible increased to $200 per individual and $400 for families. The deductible is waived if you use a Cleveland Clinic pharmacy and the prescription is filled with a generic medication.
- All brand and generic medication in the H2 Antagonist, Proton Pump Inhibitor and Nasal Steroid medications are no longer covered. Please refer to our website for a list of these medications.

Note: EHP does not perform annual mailings of the *Summary Plan Description* or the *Prescription Drug Benefit and Formulary Handbook*. These documents are available for reference at *www.clevelandclinic.org/healthplan* and are updated as changes occur. Contact us to request a hard copy. If you are new to the health plan, you will receive hard copies of these documents at your home address on file with Human Resources. ■

Member Responsibility for Co-Payment

Like most health benefit programs, the Employee Health Plan requires co-payments for certain services, which are due at the time the service is rendered. Federal and state insurance laws state that physicians can refuse to see patients if they do not pay their co-payment or if they have an open balance that payments are not being made on. Co-payments can be made by cash, check or credit card. ■

EHP Prescription Drug Benefit Reminders

- EHP members have an annual deductible of $200 for individuals or $400 for families before their pharmacy benefit begins to cover prescription medications. The deductible is waived if your prescription is filled with a generic medication and the medication is filled at a Cleveland Clinic pharmacy.
- The amount you have paid toward the annual deductible is reset to $0 each year on January 1.
- We have a list of maintenance medications that can be found on our website.
- You are required to refill maintenance medications from a Cleveland Clinic outpatient pharmacy, the Cleveland Clinic Home Delivery Pharmacy or from Caremark Mail Service.
- You cannot obtain refills of maintenance medications at CVS store pharmacies under the EHP Pharmacy Benefit Program.
- The outpatient pharmacy on the main campus of Akron General Medical Center is considered a Cleveland Clinic pharmacy. The EHP member discounts that apply at all other Cleveland Clinic pharmacies also apply at the Akron General Medical Center outpatient pharmacy.
- Effective March 1, 2017 the EHP drug benefit program's pharmacy network was changed to include the Cleveland Clinic and CVS pharmacies only. Members are able to obtain prescription medications from the following:
  - Cleveland Clinic pharmacies (including Akron General Medical Center)
  - Cleveland Clinic Home Delivery Pharmacy
  - Cleveland Clinic Specialty Pharmacy
  - CVS store pharmacies (including CVS pharmacies located in Target stores)
  - Caremark Mail Service
  - Caremark Specialty Pharmacy
- Effective April 1, 2017, the EHP Pharmacy Benefit Program will require prior authorization for all GLP-1 receptor agonists, including:
  - Albiglutide (Tanzeum)
  - Dulaglutide (Trulicity)
  - Exanatide (Bydureon/Byetta)
  - Liraglutide (Victoza)
  - Lixisenatide (Adlyxin)
  - Insulin glargine/lixisenatide (Soliqua)

These medications will be covered for the treatment of diabetes mellitus only if they meet prior authorization criteria. The use of any of these products for the treatment of weight loss is not covered under the EHP Pharmacy Benefit Program. ■

EHP Coordinated Care Updates

Coordinated Care Reimbursement Guidelines Change

Effective January 1, 2017: If you are participating in a coordinated care program, the guidelines for reimbursement of co-payments/co-insurance changed. Refer to the FAQs sent to you by your care coordinator or visit our website at *www.clevelandclinic.org/healthplan* for more detailed information. ■

Bariatric Surgery Follow-up Visits

The required follow-up visits with Bariatric Surgery has recently been updated. Please work with your EHP Care Coordinator to review what you need to do to qualify for reimbursements. ■

Using Tier 1 Providers Saves You Money

The EHP offers members many choices in healthcare providers, offering two networks to choose from — Tier 1 and Tier 2. Using Tier 1 providers maximizes your coverage and minimizes out-of-pocket expenses, while Tier 2 is subject to a deductible and a lower percentage of coverage (70 percent). The member is responsible for the remaining 30 percent.

As a reminder, there are providers who may have privileges at our hospitals, but they may not necessarily be in the Tier 1 network. The member is responsible for confirming which tier their provider participates in prior to making an appointment. It is recommended checking each time you make an appointment as providers do opt out of our network and do not always contact their patients.

Note: University Hospital System and their employed physicians are not considered in either Tier 1 or Tier 2.

To find out whether a provider is in the Tier 1 network, call UMR toll-free at 800.826.9781. You can also visit UMR's website at *www.umr.com.* ■

Reminders from Revenue Cycle Management

The following reminders impact the billing process:

- **Coordination of Benefits (COB)** — The COB process is an annual process conducted in January. It's critical for you to update your COB. Otherwise, all claims will deny until it's completed. Accounts that get billed and are denied for COB will begin to bill the patient immediately. After four months and 120 days of billing the patient, the balances will transfer out to a collection agency if the COB is still not updated.
- **Co-payments** — Paying your co-payments when you are present for an appointment is the most efficient way to meet your financial obligations. Providers expect co-payments to be paid at the point of service.
- **Patient Statements** — We often hear from plan members that they don't receive their patient statements. The most common reason why patients don't receive their statements is because they have opted into *MyAccount Electronically Delivered Statements*. When you opt into *MyAccount*, this disables delivery of paper statements. Your statements are instead delivered to an email address that you directed us to send your statement to. If all of your balances are pending with insurance and your patient amount due is $0, we generally do not send out statements for that scenario either. If you have any questions regarding your *MyAccount*, please email *myaccountsupport@ccf.org* for assistance. ■