

HBP Benefits Summary

Benefit Program Features	TIER 1	TIER 2
	Cleveland Clinic Quality Alliance Network ¹	UMR United Healthcare Choice Plus Network (All Tier 2 services are subject to deductible unless otherwise stated)
Annual Deductible		
Single	None	\$500
Family	None	\$1,500
Out-of-Pocket Maximum		
Single	\$3,950	\$3,950
Family	\$7,900	\$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)
Obstetrics, Pediatrics² and Dieticians (includes <i>Routine</i> care by OB-GYN or GYN)	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
Specialist Office Visits Dermatology and Ophthalmology	100% of Allowed Amount after \$35 copay (no referral required) Not Available	\$50 co-pay, then 70% of Allowed Amount (after deductible) \$35 co-pay, then 100% of Allowed amount (not subject to 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, then 100% of Allowed Amount	\$35 co-pay, then 100% of Allowed Amount (not subject to deductible)
Inpatient Hospital Services² Obstetrics 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 Obstetrics, Ophthalmology and Pediatrics ² Radiology – MRI/CT Scans (non-emergent) ²	100% of Allowed Amount Not Available 100% of Allowed Amount 100% of Allowed amount after \$75 copay	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 (not subject to deductible)
Skilled Nursing Care³ 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)
Long-Term Acute Care³ 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)
Hospice³ Symptom Management – 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount (not subject to 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.

HBP Benefits Summary (continued)

Medical Benefit Program Features	TIER 1	TIER 2
	Cleveland Clinic Quality Alliance Network	UMR United Healthcare Choice Plus Network <i>(All Tier 2 services are subject to deductible unless otherwise stated)</i>
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)	70% of Allowed Amount
Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	70% of Allowed Amount
Home Health Care 60 Visits per Benefit Year	100% of Allowed Amount	100% of Allowed Amount (not subject to deductible)
Infertility – Diagnostic Only	100% of Allowed Amount	Not Covered
Hearing Aids	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 Transplant³ 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 after \$35 co-pay	100% of Allowed Amount after \$35 co-pay
Inpatient Coverage³	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission then 100% 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 Treatment³ 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

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3. Prior authorization required for Tier 1 and Tier 2.

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)		
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^{4,5} 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 Supplies⁶ Asthma Delivery Devices⁶ and Prescription Vitamins⁷	Co-insurance 20%			No	No	N/A
Pharmacies⁸ in the Retail Network	Cleveland Clinic Pharmacies (listed on pages 33 and 34), 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.

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

5. There are 3 options for obtaining medications in the category listed above. The options are: 1. *Cleveland Clinic Pharmacies listed on pages 33 and 34*, 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.**

6. 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.

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

8. 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.