Cleveland Clinic
Retiree Health Plan
Total Care
Summary Plan Description
Welcome to Cleveland Clinic Retiree Health Plan (RHP) Total Care. As a Cleveland Clinic or Regional hospital retiree, you have access to some of the very best healthcare services in the world. To help you understand the healthcare services and benefits available to you under this health plan, Cleveland Clinic Employee Health Plan Total Care developed this Summary Plan Description (SPD), which is updated as necessary.

The Cleveland Clinic RHP Total Care SPD is the health plan document. There are no other documents to reference when determining health plan coverage. We encourage you to take the time to read it carefully and to file for future reference. Summary Plan Description information is also available on the Cleveland Clinic Web site at www.clevelandclinic.org/healthplan. You will be required to log-in using the group number found on your RHP Identification Total Care (ID) card.

You will find helpful information about:
- Administrative and enrollment procedures;
- The Medicare prescription drug benefit and eligibility;
- The Third-Party Administrator and coordination of benefits;
- Network providers;
- Medical plan and behavioral health benefits;
- Medical and Behavioral Health Case Coordination;
- Prescription drug benefits and Pharmacy Coordination Programs; and
- Customer service.

Refer to the back of this booklet for detailed definitions of the terms used throughout the SPD. If you have any questions, refer to the RHP Total Care Quick Reference Guide on page 61 for appropriate phone numbers and addresses.

This is your guide to quality healthcare services and healthier living. Quality healthcare is everybody’s responsibility. We encourage you to pursue a lifestyle of healthy living. Cleveland Clinic Employee Health Plan Total Care looks forward to assisting you with your healthcare needs.
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Cleveland Clinic Retiree Health Plan (RHP) Total Care is partnered with Antares Management Solutions (Antares) to administer your health plan benefits accurately and efficiently. Antares provides claims processing for all members who receive healthcare services. For more information about Antares, see Section Two of the Summary Plan Description (SPD): “Third-Party Administrator (TPA) — Antares.”

Cleveland Clinic and Regional hospitals, including participating physicians, comprise the RHP Total Care Tier 1 provider network. The Tier 2 provider network consists of three different networks: Cleveland Health Network (CHN), Medical Mutual Traditional Network (MMO), and USA Managed Care Organization (USAMCO). Cleveland Health Network also services RHP Total Care with managing data analysis, case coordination, and network contracting. Tier 1 and CHN providers are credentialed through the Cleveland Clinic Community Physician Partnership (CPP). Providers in the MMO and USAMCO networks are credentialed through their respective companies. As a RHP Total Care member, you can use either provider tier at anytime throughout the benefit year. See page 14 for explanations of both tiers and benefits of each.

The EHP Medical Management Department provides optimal case management and coordinated care services for all RHP Total Care members.

Your RHP Total Care Identification (ID) card reflects these relationships by displaying the CHN logo on the front of the card with the written words “Cleveland Clinic Retiree Health Plan Total Care.” The Antares logo is on the back of your ID card.

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**At a Glance**

To help find information when you need it, and to ensure proper claim payment, remember these important items:

- **Coordination of Benefits (COB)** — The procedure used to pay healthcare expenses when you or an eligible dependent are covered by more than one health plan. Each year, you are responsible for providing Cleveland Clinic Employee Health Plan Total Care with information pertaining to additional medical benefits that you or any of your participating dependents are eligible to receive (see page 9).

- **Accurate Registration** — This ensures timely claim reimbursement. Make sure that registration information is correct for each family member every time you or any of your dependents receive healthcare services. Make sure the correct ID card is being used, the address information is up-to-date, and the date of birth information is accurate (see page 4).

- **Life Event Changes** — Certain changes that affect you and/or your dependents — such as a marriage, birth, or divorce — and may result in the need to make changes to your benefit elections (see page 5).

- **RHP Total Care Quick Reference Guide** — See page 61 for appropriate phone numbers and addresses.
Eligibility

You are eligible to participate in Cleveland Clinic Retiree Health Plan (RHP) Total Care if, at the time of retirement, you are at least age 55 with a minimum of 10 years of continuous service or age 65 with a minimum of five years of continuous service. In addition, you must be a current participant in one of the Cleveland Clinic Employee Health Plan offerings immediately prior to retirement and begin your pension benefit immediately. (Deferred vested participants of the Cleveland Clinic Retirement Plan are not eligible for Retiree Medical Benefits.)

Coverage Options

1. **Single:** Only the retiree is covered under the Cleveland Clinic Retiree Health Plan.
2. **Family:** Coverage is available to the retiree, his/her spouse and/or any eligible dependent child(ren).
   If coverage is elected, each family member will be covered under the contract holder and will have their own identification card.

Dependents Eligible for Coverage

Dependents eligible for coverage include:

1. Your lawful spouse (neither divorced nor legally separated).
2. Your or your spouse’s dependent, unmarried, natural, legally adopted children or stepchildren.
3. Unmarried children covered under an official court-appointed guardianship, who are under age 23.
4. Unmarried dependent children age 23 or older who were covered by a Cleveland Clinic Health Plan and considered disabled under Social Security before their 23rd birthday. Proof of disability must be provided to the Benefits Department within 31 days after the determination of disability.
5. Dependent children (age 19 to their 23rd birthday) who are enrolled in school part-time or full-time or who are primarily dependent on you for financial support.

Ineligible members include the retiree’s parents, grandchildren, nieces, nephews, ex-spouses, common-law marriage partners (after the year 1991) and foster children who have not been legally adopted.

Eligibility Verification

1. **Student/Dependent Verification**

   This verification process is common in the insurance industry and has been a requirement by many insurance companies for many years. Cleveland Clinic RHP Total Care reviews the status of dependents age 19 to their 23rd birthday to validate eligibility to participate in RHP Total Care. In order to remain on the health plan, dependents in this age group must either be a full-time or part-time student or must be financially dependent on you, the retiree. Cleveland Clinic RHP Total Care sends out communication twice a year (in February and August) for dependents age 19 to their 23rd birthday. Documentation required for this audit — such as current college schedule, tuition receipts, or a copy of your most recent tax return — is proof that your dependent is either enrolled in college or is being claimed on your income tax. College bursar’s/registrar’s offices are very familiar with this requirement by insurance companies and will provide verification. If you do not respond by the date specified with the correct documentation, your dependent’s benefit coverage will be terminated.

Michelle’s Law

This is a provision under your health plan that allows for college students who require a leave of absence from school for a medically necessary condition to retain their healthcare coverage. The medical condition must be certified by a Physician. The extension of the insurance begins while the child is “suffering from a serious illness or injury” that causes the child to lose “student status” for purposes of coverage under RHP Total Care. The extension can be up to one year. Cleveland Clinic Employee Health Plan Total Care cannot terminate coverage until the earlier of: 1) one year after the absence begins, and 2) the date coverage otherwise would terminate under RHP Total Care (e.g., upon the employee’s termination of employment).
2. New Enrollees

Retirees enrolling a dependent for the first time are contacted by our consultant, Willis, to provide supporting documentation for verification of dependent eligibility. Acceptable documentation for verification is as follows:

**Spouse**
- Copy of marriage license, or
- Copy of page one of your most recent tax return (you may cross out wage information)

**Children under age 19**

Natural born children:
- Copy of birth certificate or one of the following:
  - Copy of page one of your most recent tax return (you may cross out wage information)
  - Copy of court-issued qualified medical child support order (QMCSO)
  - Copy of divorce decree

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

Adopted Children:
- Adoption papers

**Children age 19 to their 23rd birthday**

- Copy of birth certificate and one of the following:
  - Copy of page one of your most recent tax return (you may cross out wage information)
  - Copy of dependent’s paid college tuition receipt or Office of Registrar confirmation of full-time or part-time status
  - Marriage license (if dependent is not your natural born child)
  - Disability award letter from Social Security

**Domestic Partners**

If you participate in the Health Plan, your same-gender domestic partner also is eligible to participate in the plan if all of these criteria are met:

1. You both are of the same gender.
2. You both are age 18 or older and mentally competent to enter into contracts.
3. You both reside in the same household.
4. You and your partner have been in a committed relationship with one another for at least six months and intend to remain in the relationship solely and indefinitely with one another.
5. You have joint responsibility for one another’s welfare and financial obligations.
6. You are not related by blood to a degree that would prohibit marriage under the law of the state in which you reside.
7. You are not currently married to any other person under either statutory or common law.

*Note: Domestic Partner Benefits are not available to Marymount Hospital retirees.*

*Dependent children of domestic partners also are eligible for coverage as long as they meet the eligibility requirements for dependents outlined above.*

In order to enroll your domestic partner in RHP Total Care, you and your domestic partner must sign an **Affidavit of Domestic Partnership**.
Health Benefit Enrollment Process

Eligible employees have the opportunity to enroll in Cleveland Clinic Retiree Health Plan (RHP) Total Care at the same time they apply for their retirement benefits. If you do not enroll in Cleveland Clinic RHP Total Care when you apply for retirement benefits, you will never be eligible to apply for the health plan again. If you terminate coverage, you will not be able to re-enroll in Cleveland Clinic RHP Total Care.

Retiree Contributions

A retiree will pay a portion of the cost for coverage under RHP Total Care. The Cleveland Clinic facility for whom the retiree was employed pays the remainder of the cost for coverage. Information on retiree contributions is available through the Benefits Department.

Plan Identification Card

Your Cleveland Clinic Retiree Health Plan (RHP) Total Care Identification (ID) card(s) will be mailed to your home directly from the Third-Party Administrator (TPA). See Section Two for TPA information. Members with Single coverage will receive an ID card with their name and 9-character number plus the two-digit suffix 00. For Family coverage, each member of the family will receive an ID card listing his or her name and the contract holder’s 9-character number, followed by a two-digit suffix to identify each family member. The contract holder’s suffix will always be 00, with each additional member’s suffix number ascending by one.

For example:
- EHP123456–00 Contract Holder’s ID Number
- EHP123456–01 Spouse’s ID Number
- EHP123456–02 Oldest Child’s ID Number
- EHP123456–03 Second Oldest Child’s ID Number

Your ID card(s) contains the following information:
1. Name of RHP Total Care Enrollee
2. Member ID Number (contract holder’s 9-character ID number + suffix)
3. Group Name
4. Group Number
5. Co-payment Requirements
6. Antares Claim Submission Phone Number/Mailing Address
7. EHP Medical Management Department Precertification for Medical Necessity Phone Number for Medical, Behavioral Health, and Case Coordination programs
8. Information Regarding Tier 2 Networks

If your ID card(s) are lost or stolen, you may contact the Third-Party Administrator (TPA) for a replacement card. Please have the contract holder’s Social Security Number available for the Customer Service Representative. See the Quick Reference Guide on page 61 for appropriate phone numbers/contacts.
Life Event Changes

To help Cleveland Clinic design a cost-effective healthcare plan each year, maintain costs, and to anticipate future needs, you are required to keep your selected benefit elections unless you or your dependents experience a “Life Event Change.”

Under Internal Revenue Service guidelines, the following occurrences meet the definition of a qualifying life event and permit you to change certain elections:

1. Changes in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
2. Changes in the number of dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death.
3. A dependent satisfies — or no longer satisfies — the plan requirements for unmarried dependents because of age, job status or other circumstances.
4. A qualified medical child support court order (QMCSO), or other similar order, that requires health coverage for a retiree’s child.
5. The retiree, spouse or dependent qualifies for Medicare or Medicaid. (If this happens, Health Plan coverage may be cancelled for that individual.)

If you experience a qualifying life event and wish to change your coverage, you must contact the Benefits Department within 31 days of the event and provide the necessary supporting documentation. Any adjustment to coverage must be consistent with the changes resulting from the qualifying life event.

Retirees/dependents covered under another health plan who lose that coverage as a result of one of the life events listed above are eligible to participate in RHP Total Care.

Continuation of Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may require that you and/or your dependents be provided with the opportunity to continue your group healthcare coverage on a contributory basis under the following circumstances. The extension of coverage applies to almost all employee health plans providing medical, dental, prescription drug, vision, or hearing benefits. You will be able to continue coverage through COBRA by paying all of the costs of the health plan you choose, including any portion formerly paid for by the Cleveland Clinic facility that employed you.

Qualifying Events: Who, When, and for How Long

If your RHP Total Care coverage terminates, you and your covered dependents may continue medical care coverage for up to 18 months:

1. If your employment terminates for any reason, including retirement, other than gross misconduct; or
2. If you lose your coverage due to a reduction in your hours of employment; or
3. If you or a dependent become disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months (29 months total).

Your covered dependents may continue such coverage under the RHP Total Care for up to 36 months:

1. If you die while covered by the plan; or
2. If you and your spouse are divorced, your marriage is annulled or you are legally separated from your spouse; or
3. If you become eligible for Medicare; or
4. If your dependent child is no longer eligible for coverage under RHP Total Care.
If you are entitled to Medicare benefits at the time coverage terminates due to your termination of employment or reduction in hours, the continuation period for covered dependents will be the longer of:
1. 18 months from the date coverage terminates due to your termination of employment or reduction of hours; or
2. 36 months from the date you became entitled to Medicare.

**When Continued Coverage Ends**
The continued coverage will end for any qualified person when:
1. The cost of continued coverage is not paid on or before the date it is due; or
2. That person becomes eligible for Medicare, if later than the date of the COBRA election; or
3. That person becomes covered under another group health plan unless that other plan contains an exclusion or limitation with respect to any pre-existing health condition; or
4. EHP Total Care terminates for all Employees; or
5. You or your dependent are no longer deemed disabled during the additional 11-month extended period; or
6. The last day of the applicable 18, 29 or 36 month time limit.

**How to Obtain Coverage**
When your coverage terminates, the Benefits Department will notify the COBRA Administrator (Ceridian). Ceridian then notifies you of your election rights. You will need to make your election **within 60 days** of the event in order to be eligible for continuation of coverage. For questions regarding COBRA, Ceridian can be reached toll-free at 1-800-877-7994 or you can contact the Benefits Department. There is generally a 1-2 week lag time between the time Ceridian processes the first paid premium and the time the Cleveland Clinic RHP Third-Party Administrator (TPA) is updated. **You will be able to receive covered care during this lag time. However, be prepared to provide proof of insurance or be prepared to resubmit the claim if denied the first time.**

If you elect to continue any benefits under COBRA, the first payment must be made within 45 days of your election to continue coverage. The first payment covers the period beginning with the date the qualifying event occurred through the date the continuation coverage was elected. Thereafter, monthly payments are due on the first of the month and must be paid within the 31 day grace period following the due date. COBRA regulations may change from time to time. The extension of coverage will be provided in accordance with current law.

Because COBRA rules are complicated, if you have any questions about eligibility, contact the Benefits Department.

---

**Termination of Coverage**

Cleveland Clinic will initiate Termination of Coverage if you stop premium payments for more than two months.
Prescription Drug Coverage Under Medicare

Effective January 1, 2006, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) added a prescription drug program to Medicare (Medicare Part D) for individuals who are enrolled in Medicare.

Typically, individuals become “entitled to” Medicare Part A when they reach age 65 and receive monthly Social Security benefits. An individual is eligible for the Medicare Part D Prescription Drug Benefit if covered by Medicare Part A and/or enrolled in Medicare Part B. Individuals under age 65 may also become entitled to Medicare benefits if they receive at least 24 months of Social Security benefits based on disability.

Each year, Cleveland Clinic Retiree Health Plan (RHP) members on Medicare have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31. All Medicare prescription drug plans provide a standard level of coverage established by Medicare. Some plans, however, offer additional coverage for a higher premium.

The Cleveland Clinic RHP has determined that your existing coverage with the RHP is as good as standard Medicare coverage. In many cases, coverage under the Cleveland Clinic RHP actually exceeds the standard Medicare coverage.

It is important, however, that you evaluate both the Cleveland Clinic RHP Prescription Plan 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 Total Care members who become Medicare Part D eligible receive a “Creditable Coverage” letter. 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 the Retirement Benefits office.

To help with this decision, Cleveland Clinic RHP members who answer “NO” to the two questions below should continue with their RHP coverage. Answering “YES” to either of these questions indicates that it may be in your financial best interest to enroll in the Medicare Part D Prescription Drug Benefit.

1. Are you currently enrolled in Medicaid, in addition to Medicare Part A and/or Medicare Part B?
2. Will your household’s annual income from all sources be less than the Medicare-allowed amount for individuals or couples? Income levels may vary in different years.

If you answered “NO” to both questions, your out-of-pocket costs with the Cleveland Clinic RHP will be lower, in most situations, than your out-of-pocket costs with the standard Medicare Part D plan.

If you answered “YES” to question 1, it may be in your financial best interest to participate in a prescription drug plan through Medicare Part D. If you answered “NO” to question 1 and “YES” to question 2, you have a choice of selecting either the Cleveland Clinic RHP or enrolling in the Medicare Part D Low-Income Subsidy.

Retirees with limited income and resources to pay for a Medicare prescription drug plan should contact the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call toll-free at 1-800-772-1213. TTY users should call 1-800-325-0778.

It is important to note that if you enroll in the Medicare Part D plan, you may no longer participate in RHP Total Care. You will lose both your Cleveland Clinic medical and drug benefits and will not be eligible to return to RHP Total Care in the future.
Medicare Part D eligible RHP members include:

- RHP members age 65 or over enrolled in Medicare;
- Dependents (such as spouses) of RHP members who are enrolled in Medicare;
- Disabled dependents (e.g., children) eligible for Medicare; and
- Long term disability (LTD) recipients eligible for Medicare Part D.

Other potential Medicare Part D eligible recipients include:

- Active working employees who become Medicare eligible;
- Dependents (such as spouses) of active working employees who are Medicare eligible; and
- Disabled dependents (e.g., children) eligible for Medicare.

Detailed information about the Medicare prescription drug plans that offer prescription drug coverage is available on Medicare's Web site at www.medicare.gov or by calling Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Contact the EHP Total Care Customer Service Unit with further questions at 216-448-0800 or toll-free at 1-866-811-4352.
Antares Management Solutions (Antares) functions as the Third-Party Administrator (TPA) for Cleveland Clinic Retiree Health Plan (RHP) Total Care. In this role, they are responsible for:

1. Member eligibility verification
2. Benefit coverage determinations
3. Processing claims and claims appeals
4. Issuing statements of Explanation of Benefits (EOB)
5. Coordinating benefits if a member is covered by more than one health plan
6. Subrogation processing

Information regarding contacting Antares is available in the Quick Reference Guide on page 61.

**Effectively Using Your Health Plan**

**Registration Process**

It is important that your provider has your and your dependents' correct address and telephone number, as well as any information about your spouse's employer and medical insurer. Correct registration information helps to ensure that your claim will be paid correctly and in a timely manner. **Therefore, please bring all applicable insurance cards with you when you receive medical services. The registrar will verify that the correct demographic and insurance information is accurate.**

**Coordination of Benefits (COB)**

Coordination of Benefits (COB) is the process used to pay healthcare expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare. Annual healthcare expenses for the Cleveland Clinic Employee Health Plan (EHP) exceed $187 million per year. Coordination of Benefits helps achieve cost savings for members.

If you/your dependents are covered by more than one healthcare insurance policy, the TPA follows rules established by Ohio law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). The combined payments of all healthcare insurance policies will not exceed the actual amount of your bills.
COB Process

All members are required to complete the COB process upon enrollment and in January of each year thereafter. The following three options are available for submitting your COB information to the TPA:

1. Complete the online COB form via the Antares Web site. You can access the Web site via the Cleveland Clinic Benefits Portal or log in as follows:
   

2. Complete the form where applicable, sign the bottom of the form, and return to the TPA at the address included on the form.

3. Call the TPA Customer Service at 1-800-451-7929 to update your COB information.

   Note: This option is only available if you have no other insurance in the plan year being updated or the prior plan year.

If the COB process is not completed, the TPA will send the form again when the first claim for a dependent is submitted. The form will be sent for each dependent’s initial claim until the COB process is complete. If no response is received within 45 days, the TPA will send an Explanation of Benefits (EOB) form notifying the RHP member that all claims will deny for the retiree’s dependents until the form is completed. Retirees have one year to complete the COB process. After one year, claim payment will become the responsibility of the member.

COB Form
Medicare Coordination

When you or your covered dependent become Medicare eligible (on your 65th birthday) and retire, it is important for you to enroll in Medicare Part B. Cleveland Clinic Retiree Health Plan (RHP) Total Care 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 physicians’ bills (out of your pocket) because RHP Total Care pays only 20% (what Medicare does not pay) as the secondary insurance.

In order for this claims payment process to work correctly, it is EXTREMELY IMPORTANT that you bring both your Medicare and RHP ID cards to all visits and inform the registrar that you are covered by two health plans. If you have more than these two plans, bring ALL the health plan cards you have to the visit so that coordination of benefits can be done correctly.

Medical plan benefits provided are also subject to the following non-duplication provision:

- The combined payments of all healthcare plans will not exceed the actual amount of your bills. In other words, you cannot expect to receive benefits in excess of 100% of the cost you incur and receive reimbursement on claims through both RHP Total Care and any other company sponsored plan where you have coverage.

Process for Determining Which Health Plan Is Primary

To determine which health plan is primary, the TPA has to consider both the coordination of benefit provision of the other health plan and which member of your family is involved in a claim. The primary health plan will be determined by the first of the following that applies:

1. **Non-Coordinating Plan:** If you have another group plan that does not coordinate benefits, it will always be primary.

2. **Children:**
   - **Birthday Rule** — When your children’s healthcare expenses are involved, the TPA follows the “birthday rule.” The birthday rule states that the health plan of the parent with the first birthday in the calendar year is always primary for the children. For example, if your birthday is in January and your spouse’s birthday is in March, your health plan will be primary for all of your children.
   - **Gender Rule and other Health Plan Rules** — Sometimes a spouse’s health plan has some other coordination of benefits rule, such as a gender rule, which states that the father’s health plan is always primary. In cases of the gender rule or other specific health plan coordination of benefits rules for children, the TPA will follow the rules of that health plan.

3. **Children (Parents Divorced or Separated):**
   - If the court decree makes one parent responsible for healthcare expenses, that parent’s plan is primary.
     
     **Note:** The Cleveland Clinic Retiree Health Plan Total Care reimburses claims according to its plan rules (i.e., network requirements must be adhered to even if a court decree dictates the Cleveland Clinic retiree’s health insurance is primary for children living outside of the Network of Providers).
   - If the court decree gives joint custody and does not mention healthcare, the TPA follows the birthday rule.
   - If neither of those rules applies, the order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

4. **Other Situations:** For all other situations not described previously, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

How the TPA Pays as Primary

As primary, the TPA will pay the full benefit provided by your health plan as if you had no other coverage, provided it is a covered benefit under RHP Total Care and all Network Provider and EHP Medical Management Department rules have been followed.
How the TPA Pays as Secondary

Based on Coordination of Benefits (COB), if RHP Total Care is secondary, it will pay only if the services are provided by a RHP Total Care network provider — Tier 1 or Tier 2 (refer to Section Three). As secondary, the TPA’s payments will be based on the balance left after the primary health plan has paid. A copy of the Explanation of Benefits (EOB) from the primary health plan must be submitted to the TPA. The TPA will pay no more than that balance. In no event will the TPA pay more than it would have paid had the TPA been primary. The TPA will pay no more than the “allowable expense” for the healthcare involved. If the TPA’s allowable expense is lower than the primary plan’s, the TPA will use the primary health plan’s allowable expense. The primary health plan’s allowable expense may be less than the actual bill.

• The TPA will NOT pay any co-payments required by the primary health plan. The TPA will pay only for services covered under your primary health plan only if you followed all of their procedural requirements including prior authorization, predetermination, and network provider rules.

• If a member seeks services from a Tier 2 provider, before the Cleveland Clinic Retiree Health Plan Total Care will reimburse as secondary, the deductible must be met.

When the member becomes Medicare eligible at age 65, Cleveland Clinic Retiree Health Plan Total Care will pay as secondary, as if the member has Medicare Part B, whether or not the member has enrolled in Medicare Part B. This means that Cleveland Clinic RHP Total Care will only reimburse 20% of the Allowed Amount. This does not apply to actively working age 65 or older employees.

Enforcement of Coordination of Benefits (COB) Provision

The TPA will coordinate benefits provided that the TPA is informed by you, or some other person or organization, of your coverage under any other health plan.

In order to apply and enforce this provision or any provision of similar purpose of any other healthcare plan, it is agreed that:

• Any person claiming benefits described under this Plan will furnish the TPA with any information the TPA needs; and

• The TPA may, without the consent of or notice to any person, release or obtain from any source any necessary information needed to complete the claims adjudication process.

Facility of Payment

If payment is made under any other health plan that the TPA should have made under this provision, then the TPA has the right to pay whoever paid under the health plan; the TPA will determine the necessary amount under this provision. Amounts so paid are benefits under this health plan and the TPA is discharged from liability to the extent of such amounts paid for covered services.

Right of Recovery

If the TPA pays more for covered services than this provision requires, the TPA has the right to recover the excess from anyone to or for whom the payment was made. The member agrees to do whatever is necessary to secure the TPA’s right to recover the excess payment.

Coordination Disputes

If you disagree with the way the TPA has paid a claim, your first attempt to resolve the problem should be by contacting the TPA. You must follow the TPA appeal process (see page 62). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint at 614-644-2673 or toll-free at 1-800-686-1526.
Claims Information

Using Tier 1 and Tier 2 (see Section Three) network providers within Cleveland Clinic Retiree Health Plan (RHP) Total Care allows you, in most instances, to receive care without sending any claims or paperwork to the Third-Party Administrator (TPA). After you receive care, you will receive an Explanation of Benefits (EOB) from the TPA. An EOB is a statement that explains how the bill was paid by the TPA. An example is provided below.

Explanation of Benefits (EOB)

Cleveland Clinic Employee Health Plan Total Care
Admin. by Antares Mgmt. Solutions
PO Box 89472
Cleveland, OH 44101-6472

Forwarding Service Requested

Cleveland Clinic

If you have questions please call a Customer Service Representative at 1-800-451-7929
For behavioral health questions, please call 216-986-1050 or 1-888-246-6648

Claim #: 012345678-F
Paid Date: 11/10/2009
Processor: EDI
Insured: JOHN DOE
ID #: EHP123456-00
Patient: JOHN DOE
Patient #: 12345678000
Group #: 0000123456

EXPLANATION OF BENEFITS--THIS IS NOT A BILL

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Provider</th>
<th>Date(s) Of Service</th>
<th>Benefit Description</th>
<th>Proc Code</th>
<th>Amount Billed</th>
<th>Excluded Amount</th>
<th>Co-Pay</th>
<th>Deductible</th>
<th>Allowed Amount</th>
<th>Paid At Balance Paid By Plan</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>CLEVELAND CLINIC F</td>
<td>10/26-10/26/2009</td>
<td>OFFICE VISIT</td>
<td>99212</td>
<td>80.00</td>
<td>38.90</td>
<td>10.00</td>
<td>0.00</td>
<td>31.10</td>
<td>100%</td>
</tr>
<tr>
<td>02</td>
<td>CLEVELAND CLINIC F</td>
<td>10/26-10/26/2009</td>
<td>DME</td>
<td>A4614</td>
<td>30.00</td>
<td>3.84</td>
<td>5.23</td>
<td>0.00</td>
<td>26.16</td>
<td>80%</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>110.00</td>
<td>42.74</td>
<td>15.23</td>
<td>0.00</td>
<td>57.26</td>
<td></td>
</tr>
</tbody>
</table>

Provider Payment Amount: 52.02
Amount Payable: 52.02
You Owe This Amount: 15.23

Claim Remarks
Line No. Explanation
1,2 (Line 01-$38.90)(Line 02-$3.84) Contractual adjustment.

The Coded Explanations for EOB Sample Above:

1. Antares Customer Service address.
2. Member’s name and address.
3. Date claim paid.
4. Name of Patient.
5. Group Number.
6. Name of Provider.
7. Date of Service.
8. Total amount billed by provider.
9. Difference between billed amount and contracted amount and any denied services.
10. Co-payment/co-insurance member is responsible for paying.
11. Deductible amount member is responsible for paying.
13. Total amount paid to provider.
14. The total of deductible, co-payment, co-insurance and non-covered services that the member may owe to the provider of service.
15. Claim remarks and explanation.
Two-Tier Network

Cleveland Clinic Retiree Health Plan (RHP) Total Care offers a two-tier Network of Providers. As a RHP Total Care member, you can use either tier at anytime throughout the benefit year and may see providers in both tiers if you choose. The tier you select, however, determines the amount of coverage you will receive. To receive maximum coverage, you must use Tier 1 providers.

Tier 1

Tier 1 providers consist of Cleveland Clinic and Regional hospitals, including participating physicians credentialed by the Cleveland Clinic Community Physician Partnership (CPP). These providers are, for the most part, located in Cuyahoga County. The Tier 1 Network of Providers includes Primary Care Providers (PCP), Specialist Providers (SP), Behavioral Health Providers, and Ancillary Services Providers. Ancillary services are services such as dialysis, ambulance, transportation, durable medical equipment (DME), home health, skilled nursing facilities, hospice and others.

If you seek services from a Tier 1 PCP, you are covered at 100% after a $10 co-payment per visit. Physician specialties considered primary care include Family Practice, Internal Medicine, Gynecology, Obstetrics, and Pediatrics. All other physician specialties are reimbursed at 100% after a $25 co-payment per visit. You do not require a referral to see a specialist.

Note: Some PCP’s are classified as “Specialists” because they specialize in a specific area and, for the most part, only see patients with medical conditions in their area. For example, an Oncology Gynecologist may only see cancer patients. In these instances, a co-payment of $25 is applied.

In addition to Specialty Care, co-payments will also be applied to other services such as annual vision examinations, therapy (Occupational (OT)/Physical (PT)/Speech (ST)), acupuncture, chiropractic services, maternity services, custom orthotics, sclerotherapy for symptomatic varicose veins, and emergency/urgent care. Durable medical equipment (DME) and medical supplies are reimbursed at 80%.

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

You have a maximum out-of-pocket (OOP) expense per year. For those who elect Single coverage, the maximum is $1,500 per year; Family coverage is $3,000 per year. In Tier 1, all co-payments accrue to your annual OOP maximum. In addition, your Behavioral Health Benefit and Prescription Drug Benefit have their own OOP maximums so co-payments for these services do NOT accrue to your RHP Total Care OOP maximum.
It is important to understand that not all physicians on the Cleveland Clinic and Regional hospital medical staff are in the Cleveland Clinic CPP. **It is the member’s responsibility to verify and obtain the most current Tier participation each time services are obtained.** The most current Tier 1 provider information can be found on the Internet at the CHN Web site: [www.chnetwork.com](http://www.chnetwork.com) and clicking on “EHP.” Information about special arrangements with additional Tier 1 providers for retirees who may have worked at Cleveland Clinic locations outside of Cuyahoga and Lorain Counties can be obtained by visiting the Cleveland Clinic Employee Health Plan Total Care Web site at [www.clevelandclinic.org/healthplan](http://www.clevelandclinic.org/healthplan). You will be required to log in using the group number found on your RHP Total Care Identification (ID) card.

Cleveland Clinic RHP Total Care does not print a hardcopy Provider Directory. If you do not have access to a Web site you can either call Antares Management Solutions toll-free at 1-800-451-7929 or the Cleveland Clinic Employee Health Plan Total Care Customer Service Unit at 216-448-0800 or toll-free at 1-866-811-4352 and request a listing of doctors in your geographic area by physician specialty. EHP Total Care Customer Service Unit can assist with problem resolution related to claims for healthcare services when services have been obtained from a Tier 1 provider.

### Tier 1 Hospitals in the Cleveland Clinic RHP

**Cleveland Clinic**  
9500 Euclid Avenue  
Cleveland, OH 44195  
216-444-2200  
[www.ccf.org](http://www.ccf.org)

**Ashtabula County Medical Center**  
2420 Lake Avenue  
Ashtabula, OH 44004  
440-997-2262  
[www.acmchealth.org](http://www.acmchealth.org)

**Cleveland Clinic Children’s Hospital for Rehabilitation**  
2801 Martin Luther King, Jr. Drive  
Cleveland, OH 44104  
216-721-5400  
[www.clevelandclinic.org/childrensrehab](http://www.clevelandclinic.org/childrensrehab)

**Euclid Hospital**  
18901 Lakeshore Boulevard  
Euclid, OH 44119  
216-531-9000  
[www.euclidhospital.org](http://www.euclidhospital.org)

**Fairview Hospital**  
18101 Lorain Avenue  
Cleveland, OH 44111  
216-476-7000  
[www.fairviewhospital.org](http://www.fairviewhospital.org)

**Hillcrest Hospital**  
6780 Mayfield Road  
Mayfield Heights, OH 44124  
440-312-4500  
[www.hillcresthospital.org](http://www.hillcresthospital.org)

**Huron Hospital**  
13951 Terrace Road  
East Cleveland, OH 44112  
216-761-3300  
[www.huronhospital.org](http://www.huronhospital.org)

*If you choose to see a physician at Cleveland Clinic Florida, you must see a physician who is employed by the hospital.*

**Lakewood Hospital**  
14519 Detroit Avenue  
Lakewood, OH 44107  
216-521-4200  
[www.lakewoodhospital.org](http://www.lakewoodhospital.org)

**Lutheran Hospital**  
1730 W. 25th Street  
Cleveland, OH 44113  
216-696-4300  
[www.lutheranhospital.org](http://www.lutheranhospital.org)

**Marymount Hospital**  
12300 McCracken Road  
Garfield Heights, OH 44125  
216-581-0500  
[www.marymount.org](http://www.marymount.org)

**Medina Hospital**  
1000 East Washington Street (Route 18)  
Medina, OH 44256  
330-725-1000  
[www.medinahospital.org](http://www.medinahospital.org)

**South Pointe Hospital**  
4110 Warrensville Center Road  
Warrensville Heights, OH 44122  
216-491-6000  
[www.southpointehospital.org](http://www.southpointehospital.org)

**Cleveland Clinic Florida**  
3100 Weston Road  
Weston, FL 33331  
954-689-5000  
[www.ccf.org/florida](http://www.ccf.org/florida)

**Cleveland Clinic Nevada**  
888 West Bonneville Avenue  
Las Vegas, NV 89106  
702-263-9797

### Other Cleveland Clinic Ambulatory Facilities

Cleveland Clinic Beachwood Ambulatory Surgery Center  
Cleveland Clinic Lorain Ambulatory Surgery Center  
Cleveland Clinic Outpatient Surgery Center
The following three provider networks comprise the Tier 2 network:

- **Cleveland Health Network (CHN)** — a regional network of hospitals, physicians, and other healthcare providers in northern Ohio and western Pennsylvania — Web site: [www.chnetwork.com](http://www.chnetwork.com).
- **Medical Mutual Traditional Network** — a network of providers **within** the state of Ohio. Web site: [www.supermednetwork.com](http://www.supermednetwork.com) and click on “Traditional.”
- **USA Managed Care Organization (USAMCO)** — a network of providers **outside** the state of Ohio. Web site: [www.usamco.com](http://www.usamco.com).

The providers in the Cleveland Health Network are credentialed by the Cleveland Clinic CPP. Providers in the MMO and USAMCO networks are credentialed by their respective companies.

**Tier 2 benefits include treatment for non-routine services such as treatment and/or follow-up for sprains, diabetes, hypertension, or any chronic condition, rehab therapies, colds, wounds, follow-up treatment for emergent/urgent care services (usually used for students outside of the Tier 1 network or if a member is on vacation and requires care).**

Tier 2 benefits include an annual deductible. For those who elect Single coverage, the annual deductible is $500; for Family coverage the annual deductible is $1,500. After your deductible is met, Primary Care Provider (PCP) and Specialist office visits will reimburse at 100% after an applicable $25 or $50 co-payment is made. Inpatient hospital services, outpatient hospital services, and laboratory/diagnostic services will reimburse at 70% after the deductible is met. **Certain benefit coverage including but not limited to routine health examinations, routine screening tests, and immunizations are not covered in Tier 2. See Medical Plan Benefits and Coverage Clarification section on page 24.**

Tier 2 has a maximum OOP expense per year. For those who elect Single coverage, the maximum is $5,000 per year; Family coverage is $15,000 per year. In addition, your Behavioral Health Benefit and Prescription Drug Benefit have their own OOP maximums so copayments for these services do not accrue to your RHP Total Care OOP maximum.

**Note:** Emergent/urgent care is covered at 100% after the applicable co-payment. Other specifics regarding Tier 2 coverage can be found in the RHP Total Care Health Plan Summary chart on page 18.

If you would like to choose a provider from one of the Tier 2 networks, you can obtain provider information on their Web sites listed above. You can also contact Antares Management Solutions Customer Service toll-free at 1-800-451-7929.

**The Cleveland Clinic Employee Health Plan Total Care Customer Service Unit has limited ability to assist with non-Tier 1 provider problem resolution.**

**Note:** Cleveland Clinic Retiree Health Plan Total Care has contracts with each of the Tier 2 networks listed above. There are no individual contracts with the providers in these networks. Because the network holds the individual provider contracts, members must contact the network that provided services directly to resolve discrepancies with claim payment issues. Cleveland Clinic Retiree Health Plan Total Care cannot resolve Tier 2 claim payment issues or quote the dollar amount of your financial obligation.

**There are services that are covered benefits only when provided within the Tier 1 Network of Providers and all RHP Total Care guidelines have been met. Note that there is no Tier 2 coverage for these services. (See Medical Plan Benefits and Coverage Clarification on page 24.)**
Cleveland Clinic Retiree Health Plan Total Care Benefits

Cleveland Clinic Employee Health Plan (EHP) Total Care is committed to providing comprehensive healthcare coverage for all members of RHP Total Care. The EHP Medical Management Department utilizes evidence-based information to authorize covered services of the employee population accessing services. This is accomplished by ensuring that quality-oriented, culturally sensitive healthcare services are provided at the appropriate level in the proper setting, in a timely manner. Reimbursement for all medical and behavioral health services is based on medical necessity.

Although you may choose to use a provider from either the Tier 1 or Tier 2 provider networks (as explained in Section Three), we encourage you to develop a relationship with a Primary Care Provider. Physician specialties considered primary care include most Family Practice, Internal Medicine, Gynecology, Obstetrics, and Pediatrics. This will provide you with the advantage of having a physician knowledgeable about your healthcare and can provide:

1. Preventive healthcare
2. Care if you become ill
3. Advice regarding the need to see a specialist

Because a single physician coordinates your care, you can feel assured that you are receiving the best possible healthcare available within the RHP Total Care Network of Providers.

This section of the Summary Plan Description (SPD) addresses:

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Total Care Health Plan Summary Chart</td>
</tr>
<tr>
<td>RHP Total Care Behavioral Health Benefits Chart</td>
</tr>
<tr>
<td>RHP Total Care Medical Plan and Behavioral Health Benefits</td>
</tr>
<tr>
<td>Medical Necessity Rules</td>
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<tr>
<td>Medical Plan Benefits and Coverage Clarification</td>
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<tr>
<td>Behavioral Health Benefits and Coverage Clarification</td>
</tr>
<tr>
<td>Prescription Drug Benefit</td>
</tr>
<tr>
<td>Health Plan Exclusions</td>
</tr>
</tbody>
</table>

Please read Section Four in its entirety so that you have a thorough understanding of your medical plan and behavioral health benefits. Note that all covered services must be medically necessary and are subject to coverage exclusions. Cleveland Clinic Retiree Health Plan Total Care has the right to review all claim reimbursements retrospectively and adjust payment according to RHP Total Care guidelines. This means the member may be financially accountable for services after they have been rendered. If you want the maximum benefit reimbursement, you should contact the EHP Medical Management Department prior to obtaining both medical and behavioral health services.

The Health Plan Summary and Behavioral Health Benefits charts on the following pages summarize Tier 1 and Tier 2 provider coverage, deductible, out-of-pocket maximum information, and covered services.
## RHP Total Care Health Plan Summary

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>Tier 1</th>
<th>Tier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Cleveland Clinic Provider Network</td>
<td>CHN, MMO* and USAMCO* Provider Networks</td>
</tr>
<tr>
<td>Single</td>
<td>None</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$1,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$15,000</td>
</tr>
<tr>
<td><strong>PCP Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practice, Gynecology, Internal Medicine, Obstetrics and Pediatrics</td>
<td>100% of Allowed Amount after $10 co-pay</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td>(No co-pay for blood pressure reads, blood draws and nurse visits)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Specialist Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount after $25 co-pay</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td>(no referral required)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Care</td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine (Annual) Physical Examination by PCP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td>Routine (Annual) Vision Examination</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Laboratory/Diagnostics Tests</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Emergency Department —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Medical Supplies and Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Extended Care/Skilled Nursing Care —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>180 Days per Benefit Year</td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Long-Term Acute Care —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>180 Days Lifetime Maximum</td>
<td>100% of Allowed Amount</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td>Respite Care —</td>
<td>10 Days per Benefit Year</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Home Health Care —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Visits per Benefit Year</td>
<td>100% of Allowed Amount</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td><strong>Acupuncture —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum of 20 Visits per Benefit Year</td>
<td>100% of Allowed Amount</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Chiropractic —</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum of 20 Visits per Benefit Year</td>
<td>100% of Allowed Amount</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Therapy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational/Speech/Physical —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum of 26 Visits per Therapy per Benefit Year</td>
<td>100% of Allowed Amount</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental — Surgical extractions for soft/bony impactions, or Dental implants for certain medical conditions or recent accidents/injuries</td>
<td>70% of Allowed Amount</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of Charge up to $2,000/Ear — Limited to one aid per Ear every 3 years</td>
<td>70% of Allowed Amount</td>
</tr>
<tr>
<td></td>
<td>100% of Allowed Amount</td>
<td>Unlimited</td>
</tr>
<tr>
<td></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Organ Transplant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant Lifetime Maximum</td>
<td>100% of Allowed Amount</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Not Covered</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

For Tier 1, all co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum.

For Tier 2 ancillaries (services such as dialysis, ambulance transportation, home health, skilled nursing facilities and hospice), co-payments and co-insurance do NOT accrue to the out-of-pocket maximum.

*MMO Traditional for the state of Ohio and USAMCO outside the state of Ohio.
## RHP Total Care Behavioral Health Benefits

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>Tier 1 Cleveland Clinic Provider Network</th>
<th>Tier 2 CHN, MMO* and USAMCO* Provider Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible†</td>
<td>$0</td>
<td>$500</td>
</tr>
<tr>
<td>Single</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Coverage*</td>
<td>100% of Allowed Amount after $25 co-pay</td>
<td>$50 co-pay (after deductible) with 100% of Allowed Amount</td>
</tr>
<tr>
<td>35 Outpatient (OP) Visits in a Calendar Year for Mental Health and/or Substance Abuse‡</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological and Neuro-Psychological Testing†</td>
<td>100% of Allowed Amount after $25 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(See Benefits and Coverage Clarification, page 31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage‡</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Up to 30 Inpatient (IP) Days in a Calendar Year for Mental Health and/or Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Lifetime Maximum for Mental Health</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient Lifetime Maximum for Substance Abuse</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Intensive Outpatient (IOP)†</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>24 Visit Limit per Calendar Year for Mental Health and/or Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization Programs (PHP)‡</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>24 Visit Limit per Calendar Year for Mental Health and/or Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Coverage</td>
<td>100% of Allowed Amount after $50 co-pay</td>
<td>100% of Allowed Amount after $100 co-pay</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>100% of Allowed Amount after $50 co-pay</td>
<td>100% of Allowed Amount after $50 co-pay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*MMO Traditional for the state of Ohio and USAMCO outside the state of Ohio (see page 16).
†The Behavioral Health Tier 2 deductible does NOT apply to other health plan provisions.
*No precertification required for Tier 1, precertification is required for Tier 2.
‡Precertification and medical necessity required
§Precertification required

**Note:** Precertification, prior authorization, predetermination and prior approval are often used interchangeably. The Medical Plan and Behavioral Health sections of this SPD use precertification. The Prescription Drug Benefit section uses prior authorization.

Any unauthorized programs, services, or visits will not be covered by RHP Total Care 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. See page 21 for Behavioral Health Precertification Rules.

The 35 visit Outpatient Coverage 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 telephone counseling services or school meetings by outpatient behavioral health practitioners.

### Behavioral Health Definition

Behavioral health refers to and includes all services for mental health and substance abuse. Levels of behavioral health services, as well as access to Care and Case Coordination Programs for Behavioral Health, are explained later in this section (see pages 31 and 34).

For additional information about Behavioral Health benefits, call the EHP Medical Management Department at 216-986-1050 or toll-free at 1-888-246-6648.
The following pages detail your medical plan and behavioral health benefits coverage. Antares Management Solutions is the Third-Party Administrator (TPA) that will reimburse medical and behavioral health claims. If you are not certain that a claim paid/reimbursed correctly, you should contact Antares for review. If you still disagree, contact the Cleveland Clinic Employee Health Plan Total Care Customer Service Unit at 216-448-0800 or toll-free at 1-866-811-4352.

Medical Necessity Rules

RHP Total Care is designed to provide coverage for members that is medically necessary. In order to assure that coverage is provided for medically necessary reasons, the EHP Medical Management Department has established rules and processes for members to follow in order for medically necessary care to be reimbursed appropriately and efficiently. These rules and processes are addressed below and in the “Precertification and Concurrent Review for Medical Necessity” section that follows on page 21.

A service is NOT considered medically necessary if it is:

1. Not ordered by a licensed or accredited physician, hospital, or healthcare provider or other healthcare facility.

2. Not recognized throughout the Medical profession as safe and effective, is not required for the diagnosis and treatment of a particular illness (physical or behavioral) or injury, and is not employed appropriately in a manner consistent with generally accepted United States medical standards.

3. Provided for vocational training.

4. An Educational Service, including those listed below, are not considered medically necessary unless required BECAUSE OF a new medical or behavioral condition or a change from baseline in a previous condition. Educational services that can be received within a school system are NOT considered medically necessary. Examples of services that are not covered unless they are deemed medically necessary include:
   • Training in the activities of daily living; and
   • Instruction in scholastic skills such as reading and writing; and
   • Preparation for an occupation, or treatment of learning disabilities for academic underachievement.

5. Experimental or Investigational — Generally, experimental or investigational refers to the medical use of a service or supply still under study and the service or supply is not yet recognized throughout the Physician’s profession in the United States as safe or effective for diagnosis and treatment of the illness or injury. This includes, but is not limited to: clinical trials, all treatment protocols based upon or similar to those used in clinical trials, and drugs approved by the Federal Food and Drug Administration that are being used for unrecognized indications. Experimental or investigational procedures are usually identified by those procedures that have no CPT code and are therefore coded into a “NOC — not otherwise classified” category. These will require precertification for medical necessity.

Cleveland Clinic Employee Health Plan Total Care reserves the right for final determination of medical necessity.
Precertification and Concurrent Review for Medical Necessity

The EHP Medical Management Department has a precertification feature that requires medical necessity approval before certain procedures will be covered. **Precertification, prior authorization, predetermination and prior approval are often used interchangeably.** The Medical Plan and Behavioral Health sections of this SPD use precertification. The Prescription Drug Benefit section uses prior authorization. Concurrent review is a medical necessity review for continued use of services, and occurs either during a member’s hospital stay or during the course of a prescribed treatment (e.g., home care, skilled nursing facility or durable medical equipment (DME)).

Precertification for medical necessity and concurrent reviews are performed on a prospective or concurrent timeline to assure appropriateness of admissions, continued length of stay and levels of care within inpatient facilities and episode of treatment in the outpatient setting. The reviews are conducted as a mechanism for assuring the consistency of application of criteria across the network and for the identification of quality-of-care issues. The reviews are also done to identify discharge planning issues and to initiate discharge planning in a timely fashion.

**Behavioral Health Precertification Rules**

There is no precertification process for Tier 1 Behavioral Health Outpatient Coverage. Members are entitled to 35 office visits in a calendar year for mental health and/or substance abuse. There is a $25 co-payment for each office visit. The 35-visit Outpatient Coverage also 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.

If a member needs more than 35 visits and medical necessity is established, the limit can be extended. The member must contact the EHP Medical Management Department prior to any additional visits. If the member does not, he or she will be financially responsible for all further services.

The number of visits will be extended only if the member agrees to participate in the EHP Total Care Case Coordination program (see page 34 for additional information). Outpatient Coverage will not be extended under any circumstance unless the member agrees to Case Coordination. A complete listing of Tier 1 providers can be found at [www.chnetwork.com](http://www.chnetwork.com).

Tier 2 outpatient visits require precertification. If precertification is not obtained before the service is provided, the member is fully responsible for the cost of the service. The first visit to a Tier 2 provider in a calendar year requires the member to obtain precertification. The provider is responsible for obtaining precertification for additional visits.

The EHP Medical Management Department business hours are from 8 a.m. until 4:30 p.m. Monday through Friday. If an urgent or emergency situation occurs, a Case Coordinator is on call after business hours and can be reached by calling the phone numbers below. These phone numbers are also on the back of your RHP ID card.

Cleveland Clinic EHP Medical Management Department
6000 West Creek Road, Suite 20 • Independence, OH 44131
Phone: 216-986-1050 • Toll-Free: 1-888-246-6648
Fax: 216-901-2050
Member Responsibility for Precertification

As soon as a member learns from a physician that the services listed below and on page 23 are being recommended, they MUST call the EHP Medical Management Department. The member is required to participate in the precertification process to ensure the member’s understanding of potential treatment options, to ensure the member has participated in maintenance therapy before advancing to a more aggressive therapy, and to ensure the correct treatment in the correct setting. If the member does not participate in the precertification process before obtaining the service there will be NO REIMBURSEMENT for the service.

Precertification for medical necessity is the responsibility of the provider of service EXCEPT for the four services noted below:

- Bariatric Surgery
- Infusion for Migraine
- ADHD Summer Treatment Program
- Tier 2 Behavioral Health Outpatient Provider Visits

It is to the member’s benefit to remind their physician/provider that this is a requirement so that claims payment issues can be avoided.

Member Responsibility for Concurrent Review

In the process of a concurrent review, a determination may be made that the hospital stay or service is no longer medically necessary. In that case, the provider and member will be notified via a letter that further services are being denied. The appeal process will be outlined, but the member should be aware that he or she may be held liable for all charges for continued services if the denial is upheld.

It is up to the member to discuss options for discontinuation of treatment and/or other options for care with their physician or provider.

Medical, Behavioral Health and Pharmaceutical Services That Require Precertification

The following list includes those medical and behavioral health services that must receive precertification for medical necessity, by the provider of service, prior to being rendered except for emergency/urgent situations:

**Inpatient Services (both Medical and Behavioral Health)**

- Acute Rehabilitation Admission
- Elective Hospital Admission*
- Out-of-Network and Out-of-Area Care (All)**
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission
  *Elective inpatient hospitalizations require precertification for medical necessity and may be subject to concurrent review.
  **The EHP Medical Management Department’s goal is to transition all care into a Tier 1 provider. Refusal to transition may result in the patient/member being financially responsible.
Outpatient Services

• Breast Reduction
• Capsule Endoscopies
• Experimental or Investigational Procedures
• Head and Lumbar MRI
• Home Care
• Home Use of Tocolytic Agents/Home Use of Uterine Monitoring
• Human Organ or Bone Marrow Transplant
• Infusion for Migraine
• Neurofeedback and Biofeedback
• Potentially Cosmetic Procedures
• Tilt Table Testing
• Vestibular Testing Battery
• Durable Medical Equipment (DME)*:
  – Cochlear implants
  – Continuous passive motion machines
  – Electric wheelchairs

*Reimbursement for DME will only be made at the established contracted rate for standard equipment. Any rate differential for “deluxe” equipment will be the member’s responsibility.

Behavioral Health Services

• Inpatient (IP)
• Intensive outpatient (IOP)
• Intensive Home-Based Treatment
• Partial Hospitalization Programs (PHP)
• Autism
• Summer Treatment Program
• Residential Treatment
• All Tier 2 Services

Pharmaceuticals

• Amevive
• Botox
• Cimzia
• Differin >26 Years Old
• Enbrel
• Flector Patches
• Forteo
• Growth Hormone
• Humira
• Increlex
• IVIG

• Kineret
• Kuvan
• Lotronex
• Raptiva
• Reclast
• Relistor
• Synagis
• Tazorac >26 Years Old
• Topical Tretinoin Products >26 Years Old
• Tracleer
• Voltaren Gel

Notification to the EHP Medical Management Department

• Hospice — EHP Medical Management Department notification is required for precertification.

You must notify the EHP Medical Management Department about elective and emergency admissions.
Care Outside of Tier 1 Cleveland Clinic RHP Total Care Network of Providers

In some cases, your Cleveland Clinic physician may wish to refer you for care outside of Cleveland Clinic at the Tier 1 level of reimbursement. This is appropriate for coverage under RHP Total Care only when medical or behavioral health care cannot be provided by Cleveland Clinic. These services will be covered as a Tier 1 benefit if:

• The Cleveland Clinic EHP Chief Medical Officer authorizes the service before it is received.
• The service is determined to be medically necessary.
• The service is not available within the Cleveland Clinic Tier 1 network.

Contact the EHP Medical Management Department prior to the service being scheduled for further information.

Medical Plan Benefits and Coverage Clarification

<table>
<thead>
<tr>
<th>Reimbursement for Services within the Tier 1 Cleveland Clinic RHP Total Care Network of Providers ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following services are covered benefits ONLY when provided within the Tier 1 Network of Providers AND Benefit Guidelines are met. There is NO coverage outside of the Tier 1 Network of Providers.</td>
</tr>
<tr>
<td>1. Services provided for the evaluation and conformity of hearing aids.</td>
</tr>
<tr>
<td>2. Services for routine eye and hearing examinations.</td>
</tr>
<tr>
<td>3. Contact lens fitting (covered only when ophthalmologic condition cannot be corrected by glasses).</td>
</tr>
<tr>
<td>4. Routine health maintenance tests, routine screening tests, and standard immunizations.</td>
</tr>
<tr>
<td>5. Services for long-term acute care.</td>
</tr>
<tr>
<td>6. Family planning services.</td>
</tr>
<tr>
<td>7. Education or training services.</td>
</tr>
<tr>
<td>8. Dental implants for accidents or certain medical conditions.</td>
</tr>
<tr>
<td>10. Surgical extractions for soft/bony dental impactions.</td>
</tr>
<tr>
<td>11. Genetic testing.</td>
</tr>
<tr>
<td>12. Nutritional counseling.</td>
</tr>
<tr>
<td>13. Protein Sparing Modified Fast (PSMF) diet.</td>
</tr>
<tr>
<td>14. Chiropractic services.</td>
</tr>
<tr>
<td>15. Acupuncture services.</td>
</tr>
<tr>
<td>16. Outpatient cardiac rehabilitation programs.</td>
</tr>
<tr>
<td>17. Sclerotherapy or vein stripping for varicose veins.</td>
</tr>
<tr>
<td>18. Custom-made orthotics.</td>
</tr>
<tr>
<td>19. RAST (allergy blood) testing.</td>
</tr>
<tr>
<td>22. Treatment for reduction mammoplasty.</td>
</tr>
<tr>
<td>23. Services for treatment of sleep apnea.</td>
</tr>
<tr>
<td>24. Services provided for autism by the Cleveland Clinic Center for Autism.</td>
</tr>
<tr>
<td>25. Infusion for migraine.</td>
</tr>
<tr>
<td>26. Vestibular testing battery.</td>
</tr>
</tbody>
</table>
**Acupuncture**

A maximum of 20 visits are covered per calendar year within the Tier 1 Network of Providers only. The first 10 visits require a $10 co-payment per visit. The second 10 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for 50%.

**Bariatric Surgery**

To be eligible for this benefit, a member must be a participant in RHP Total Care for a minimum of two consecutive years. Second surgeries (covered under RHP Total Care or another plan or if done at Cleveland Clinic or another facility) will not be covered.

- Precertification is required through the EHP Medical Management Department. The member must call the EHP Medical Management Department when the workup begins to initiate the precertification process.
- To be eligible for surgery, the member must meet the RHP Total Care’s established clinical criteria. A member may qualify for surgery through the Bariatric Center, **BUT NOT** meet RHP Total Care clinical criteria. In this instance the surgery will not be authorized for reimbursement.
- Member must have a BMI greater than 40 for at least the preceding full year.
- Members with a BMI of 35 to 40 will be reviewed by the EHP Medical Management Department and approval will require significant co-morbid(s) such as hypertension, diabetes, hyperlipidemia, or sleep apnea which are not amenable to maximum conservative treatment.
- If a member with a BMI of 35 to 40 does not meet the above criteria and gains weight to reach a BMI of 40, he or she will not be considered for surgery for one year.
- If approved, service is covered only when provided by Cleveland Clinic.
- If approved, all pre-workup physician visits require a $25 co-payment. Workup visits include diagnostic and laboratory tests, assessments by endocrinology, psychiatry/psychology, nutrition, general surgery, and possibly other specialists such as cardiology. It is estimated the total co-payment cost for physician workup visits will be $250 to $300.
- An upfront $2,750 co-payment is required for the surgical procedure.

**Breast Reconstruction**

Breast reconstruction is covered at 100% for a member who elects breast reconstruction in connection with a mastectomy due to cancer, including surgery and reconstruction of the other breast to produce a symmetrical appearance. Services are limited to one surgery for the non-affected breast. Services must be provided in the Tier 1 network. Coverage includes treatment for postoperative complications of mastectomy and reconstruction surgeries.

**Cataract Surgery**

Cataract surgery is a covered benefit under RHP Total Care for standard intraocular lenses. If the member chooses to receive the Crystalenor ReSTOR lenses, RHP Total Care will only pay up to the contracted rate for standard intraocular lenses. Crystalenor ReSTOR lenses are not considered standard and the member will be required to pay the difference from the standard lenses.

**Chiropractic Services**

A maximum of 20 visits are covered per calendar year within the Tier 1 Network of Providers only. There is a $10 co-payment attached to the first 10 visits. The second 10 visits are reimbursed at 50% of the Allowed Amount. The member is financially responsible for 50%. X-rays done at the chiropractor’s office are a non-covered benefit. Patients under age 16 require precertification through the EHP Medical Management Department. Chiropractors are licensed to perform physical therapy. If the Chiropractor performs physical therapy, the visit is counted as a Chiropractic visit. When there are both a chiropractic and physical therapy service, a co-payment will apply for each service. MRIs, regardless of the member's age, ordered by a Chiropractor require precertification by the EHP Medical Management Department. If precertification is not obtained, the member may be responsible for payment.
Contact Lenses and Lens Fittings
Contact lenses and lens fittings will be covered only when an ophthalmologic condition that cannot be corrected by glasses, such as keratoconus, is present. Services must be provided by a Tier 1 Provider. The member is responsible for submitting a letter from the servicing physician to the EHP Medical Management Department in order for the claim to be adjudicated appropriately.

Cosmetic Surgery Combined with Medically Necessary Surgery
If a member chooses to have cosmetic surgery at the same time they are having medically necessary surgery, the coverage will be as follows:

- The professional fee for the cosmetic surgery will not be covered.
- The patient/member is responsible for 50% of the billed charges for all technical/facility fees and the anesthesia professional fee.

If the combined surgeries result in a hospital admission, the coverage will be as follows:

- If the usual course of the medically necessary procedure requires hospitalization, hospital days will be covered at 100%.
- If the usual course of the medically necessary procedure does not require hospitalization, the entire hospital charge is the patient/member’s responsibility.

Cosmetic surgery is always an excluded benefit. The treatment of complications resulting from cosmetic surgery is also excluded. Life threatening complications that require inpatient care may be covered but must be reviewed by the EHP Medical Management Department.

In addition, the EHP Medical Management Department reserves the right to retrospectively review these claims and adjust them according to these guidelines. This means the member may be financially accountable for services after they have been rendered.

Dental
This section pertains to dental benefits covered by RHP Total Care, not the Dental Plan. Questions about Dental Plan coverage should be directed to the Benefits Department.

1. Dental Implants: Dental implants are covered under RHP Total Care when all of the following conditions are met:
   - Implants are determined to be medically necessary and the medical need is primarily caused by a specific medical condition or a recent (within one year) accident or injury. If medical necessity is determined due to an accident or injury within one year, the patient must have been a RHP Total Care member at the time of the accident or injury to be eligible for coverage.
   - Precertification is required through the EHP Medical Management Department.
   - Services are performed within the Tier 1 Network of Providers.

   If these conditions are met, the surgery (implant) and the prosthodontic (crown, bridge, etc.) will be covered under RHP Total Care. The implant will be covered at 100%. The coverage for the prosthodontic will be 50%, up to a maximum of $1,250 annually. The prosthodontic coverage under RHP Total Care is the identical level of coverage as offered under the Cleveland Clinic Traditional Dental Plan.

2. Surgical Extraction for Soft or Bony Dental Impactions:
   - Surgical extraction for impacted teeth surgically removed is covered at 100% as long as services are provided within the Tier 1 Network of Providers.
   - Treatment for non-impactions, which entails pulling of the teeth, is covered by the member’s Dental Plan. For example, if all four of an employee’s wisdom teeth need removed, and only two are impacted, RHP Total Care covers the two teeth that are surgically removed. The other two are covered under the Dental Plan. We recommend that you consult with your dentist and/or doctor before receiving treatment.
   - Emergent surgical extractions follow Emergency/Urgent Care guidelines.
3. Anesthesia for dental procedures is **NOT** a covered benefit under RHP Total Care unless the dental procedure is one of the procedures listed on the previous page. The only exceptions are cases where anesthesia is necessary to do dental work that is required because of an **Underlying Medical Condition**. These cases will be subject to precertification through the EHP Medical Management Department. If approved, the anesthesia will be reimbursed under the health plan but the dental work will not. Anesthesia for pediatric cases where extensive restoration is required, but the tooth decay was not caused by an underlying medical problem, are **NOT** covered under RHP Total Care.

4. Dental procedures such as root canals, crowns, caps, re-implantation, etc. are **NOT** covered under RHP Total Care even if they are recommended because of a minor accident or injury. The EHP Medical Management Department will review cases of severe trauma, in which major reconstruction is required, prior to services being rendered.

**DXA Scans (Bone Density)**

One screening is covered every two years for women over 65 and men over age 70. Screening for members under these ages or in need of more frequent scans are covered only if medically necessary.

**Durable Medical Equipment (DME)**

Reimbursement for DME will only be made at the established contracted rate for standard equipment. Any rate differential for “deluxe” equipment will be the member’s responsibility. Over-the-counter DME products are not a covered benefit (e.g., breast pumps).

- If the contracted rate is less than the amount of the co-payment, the member is still responsible for the corresponding co-payment/co-insurance.

**Emergency Care**

Emergency and Urgent Care are covered at 100% regardless of the provider as long as the visit meets Emergency or Urgent Care criteria as defined in Section Six, Definition of Terms (pages 69 and 71). A co-payment is required for any emergency department visit that does **NOT** result in an admission ($50 for Tier 1; $100 for Tier 2). Observation stays in the hospital are **NOT** considered admissions. If an emergency room hospitalization occurs at an out-of-network facility, every effort will be made to transfer the member to a Cleveland Clinic hospital (Florida or Ohio). Appropriate transfer of the member is based on medical necessity as determined by the EHP Medical Management Department. The EHP Medical Management Department has the right to refuse payment of an Emergency and/or Urgent Care visit if access to the service was truly non-emergent/urgent.

**Emergency Transportation**

Emergency transport to an emergency room is always covered. However, if a member becomes sick or injured while away from the Cleveland area and must be admitted to a hospital anywhere in the United States or Canada, RHP Total Care will pay 100% for transportation — including professional ambulance, air ambulance, or regularly scheduled airline (limit: one trip during any one accident or illness) — if transported from such other hospital to the nearest Cleveland Clinic Hospital (Florida or Ohio) for treatment. This type of transportation to a Cleveland Clinic Hospital must meet the precertification process of the EHP Medical Management Department.

**Enteral Feedings**

Non-legend enteral feedings available without a prescription are not a covered benefit. Examples include but are not limited to Ensure, Osmolite, Portogen, and Sustacal.

**Genetic Testing**

If medical necessity is determined, genetic testing is a covered benefit for a member or a member’s covered dependent. It is not covered when the service does not benefit the insured or the insured’s covered dependent.

**Hair Loss**

Reimbursement will be made up to $200 lifetime maximum for a cranial prosthesis (wig) and only as a result of hair loss due to chemotherapy or radiation treatments and/or alopecia areata. The wig must be purchased from Tier 1 provider, Elegant Essentials.
Hearing Aids
Hearing aids are covered at 50% of billed amount up to $2,000 per ear; one aid per ear every three years within the Tier 1 Network of Providers. Evaluation, consulting, and dispensing fees are covered at 100% within the Tier 1 Network of Providers. Repair of hearing aids are not covered. There is no coverage of the hearing aids, evaluation, consultation, or dispensing fees outside of the Tier 1 Network of Providers.

Hospice
To be eligible to receive the hospice benefit, patients must have a life expectancy that is less than six months and have a caregiver(s) in the home 24 hours a day, 7 days a week. The four levels of service that are included in the benefit are: routine home care, continuous home care, inpatient respite care, and general inpatient care. Inpatient respite care provides rest and relief for the patient’s primary caregivers. General inpatient care provides pain and symptom management not possible in the home setting. Services that are not covered under the hospice benefit include: custodial and/or experimental therapies. Notification to the EHP Medical Management Department is required for coordination of care. Hospice Respite Care is limited to 10 days per calendar year.

Immunizations
Standard immunizations are covered only when given within the Tier 1 Network of Providers. Tetanus toxoid, Rabies vaccine, and Meningococcal polysaccharide vaccines will be covered outside of Cleveland Clinic only if they are given as part of Emergency/Urgent Care Services. Hepatitis A is covered for children 12 to 23 months. Hepatitis A requires precertification for any other age group, but is not covered for travel or when required for school. Refer to Preventive chart on page 38.

Gardasil and Cervarix are the vaccines for HPV and are covered only if all three immunizations are received within six months. Claim payment will not be made until after the third immunization is completed. Coverage is for males and females age 9 to 26. All three receipts must be sent together to:

EHP Medical Management Department/Attn: Immunizations
6000 West Creek Road, Suite 20
Independence, OH 44131

Infusion for Migraine
Infusion for migraine requires precertification and will be approved only when maximum conservative abortive therapy has been tried and failed over a period of four days. Members requesting more than two infusion therapy visits in a six month period must be compliant with preventive medications. Clinical information will be required from the physician ordering the treatment. The member is responsible for obtaining precertification before obtaining services for maximum reimbursement.

IUD and Depo-Provera Guidelines
IUD insertions are a form of birth control; and in most cases, Depo-Provera is used as a birth control method.

IUD insertions are a form of birth control and therefore will have a $50 co-payment charge at the provider’s office.

If Depo-Provera is used as a birth control method, the member will be charged the Prescription Drug Benefit co-payment of $15 per injection when supplied by a doctor’s office. Standard co-payment rates are charged if Depo-Provera is purchased at a pharmacy.

Maternity Care
A one-time $50 co-payment for each pregnancy is required for maternity services. However, if you change obstetricians during a pregnancy, an additional $50 co-payment will be required. The co-payment covers routine physician visits throughout the pregnancy, as well as the six week follow-up visits. Routine is defined as 12 physician visits and approximately two ultrasounds for a normal pregnancy. More than the defined number of visits or visits to a specialist will require additional co-payments.
RHP Total Care does not restrict benefits for any hospital length of stay in connection with childbirth for mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, RHP Total Care will not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, RHP Total Care will NOT require that a provider obtain authorization from the EHP Medical Management Department or the Third-Party Administrator for prescribing a length of stay not in excess of 48 or 96 hours. Doula services are NOT considered medically necessary and therefore are NOT a covered benefit. If you would like coverage for your newborn, you have 31 days from birth to add the baby to Cleveland Clinic Retiree Health Plan Total Care. Contact the Benefits Department at 216-448-0600.

**Nutritional Counseling**
Outpatient Dietician/Nutritional counseling — 10 visits per calendar year are covered. There is no precertification requirement for the first 10 visits. If additional visits are required, medical necessity must be verified by the EHP Medical Management Department.

**Orthotics**
- **Custom-made**: covered at 80% of Allowed Amount after $50 co-payment in the Tier 1 Network of Providers only.
- **General**: not a covered benefit.
- **If the contracted rate is less than the amount of the co-payment, the member is still responsible for the corresponding co-payment/co-insurance.

Orthopedic shoes and diabetic shoes are not considered orthotics.

**Pain Management**
Treatments, such as injections, are covered up to three injections per specific anatomical site per benefit year. More than three injections per specific site require precertification through the EHP Medical Management Department. Members in programs that have a psychiatric component should contact the EHP Medical Management Department for precertification of that component of their pain management program if the program is in Tier 2.
- Tier 2 Behavioral Health counseling sessions require precertification through the EHP Medical Management Department.

**PAP/HPV Testing**
- For women over 30, both tests are done together initially. If both are negative, the HPV test and Pap smear should be repeated once every three years. A pelvic exam is still recommended as part of the yearly physical; however, a Pap smear is not necessary.
- Women under 30 who are sexually active should have an annual Pap smear with their examination. An HPV test is needed only if there is an abnormal Pap smear.
- Women of any age whose cervix has been removed during a hysterectomy have no coverage for Pap/HPV. Screening Pap smears will be covered once every three years and diagnostic Pap smears will be covered as needed. **Members will be held financially responsible if they receive the tests more frequently without a medical condition.**

**Personal Grooming**
Reimbursement will be made up to $200 lifetime maximum for a cranial prosthesis (wig) and only as a result of hair loss due to chemotherapy or radiation treatments and/or alopecia areata. The wig must be purchased from Tier 1 provider, Elegant Essentials.

**Protein Sparing Modified Fast (PSMF) Diet**
The PSMF diet is covered only when services are provided within the Tier 1 Network of Providers and benefit guidelines are met.
**RAST (Allergy Blood) Testing**
RAST testing (allergen specific IgE blood testing) will be covered if obtained by a Tier 1 network provider only.

**Routine (Annual) Vision Examination**
One routine (annual) vision examination is covered in a 12-month period in the Tier 1 network. Examinations are not covered under the Cleveland Clinic Vision Plan. The Vision Plan covers hardware only. Services for contact lenses and lens fittings are not a covered benefit unless the contact lenses are required because of an ophthalmologic condition that cannot be corrected by glasses.

**Spider Veins and Varicose Veins**
- Spider veins — Sclerotherapy is **NOT** a covered benefit.
- Varicose veins:
  - Sclerotherapy for symptomatic varicose veins is covered at 100% after a $50 co-payment per session; and
  - Vein stripping for symptomatic varicose veins is a covered benefit in the Tier 1 Network of Providers only.

**Temporomandibular Joint Syndrome (TMJ)**
The treatment of TMJ is **NOT** a covered service under most major medical plans or under RHP Total Care. The EHP Medical Management Department will consider approving this service for unique individual circumstances. Any services for TMJ must be done within the Tier 1 Network of Providers. Members who choose to be evaluated for TMJ will incur the cost of the evaluation whether treatment is approved by the EHP Medical Management Department or not. Evaluation to determine medical necessity includes but is not limited to consultation and x-ray. Precertification for treatment of TMJ will be provided only if it is determined there is an underlying medical condition. The EHP Medical Management Department must review and approve requests prior to treatment being initiated.

**Therapy**
- **Occupational***
  26 visits per calendar year are covered after a $10 co-payment per visit. There is no precertification requirement.
- **Physical***
  26 visits per calendar year are covered after a $10 co-payment per visit. There is no precertification requirement.
- **Speech***
  26 visits per calendar year are covered after a $10 co-payment per visit. There is no precertification requirement.

*Services are not a covered benefit when they are for non-medical conditions. Non-medical conditions include, but are not limited to, impulse control disorders, conduct disorders, and developmental delays. Refer to the Medical Necessity Rules on page 20 for more information.

**Vestibular Testing Battery**
Vestibular testing battery, used by some physicians to determine the causes of dizziness and vertigo, requires precertification. The provider will be responsible for forwarding the following clinical information:
- Prior consultation by ENT or neurology.
- History of persistent (at least one month) and severe repeat episodes of vertigo for which diagnosis is not benign positional vertigo.
Behavioral Health Benefits and Coverage Clarification

“Behavioral Health” refers to and includes all services for mental health and substance abuse.

Behavioral Health Definitions

Levels of Care

1. **Outpatient Visits (OP):** Ambulatory care, usually non-urgent, for problems or conditions that can be treated on a periodic basis.

2. **Inpatient (IP):** A medical facility that is licensed to provide 24 hour, 7 days per week medical care and provides a high degree of safety. The facility employs a multi-disciplinary staff that must include psychiatrists and nurses. Services are comprehensive and usually include medication management, individual, group and/or family psychotherapy, social services, milieu and activity therapy. Inpatient care is not the same as residential care. See page 33 for information regarding Residential Treatment.

3. **Partial Hospitalization Programs (PHP):** Highly structured ambulatory, multi-disciplinary treatment program with a high staff to patient ratio. A psychiatrist must be available for consultation as needed on an ongoing basis. A PHP includes treatment modalities found in a comprehensive inpatient program. The program may be appropriate whenever a patient does not require 24 hour acute care hospitalization, but does need more comprehensive services than can be provided at an outpatient level of care. The program is open a minimum of 20 hours per week.

4. **Intensive Outpatient Program (IOP):** Similar to Partial Hospitalization Program (PHP) in that they are structured programs with a multi-disciplinary team approach and a variety of treatment modalities. The program is usually less restrictive than a PHP. Patients are more stable, considered low risk for self harm, can function in the community and manage some daily activities, but require more comprehensive services than can be provided at an outpatient level of care. The patient participates in the program a minimum of nine hours per week.

Access to Care

- **Immediate** is defined as having access to emergency care immediately for a life-threatening emergency.
- **Emergent** is defined as having access to emergency care within six hours for a non-life-threatening emergency.
- **Urgent** is defined as having access to care within 48 hours.
- **Routine** is defined as having access to a routine office visit within 10 business days.

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**Reimbursement for Services within the Tier 1**

**Cleveland Clinic RHP Total Care Network of Providers ONLY**

The following services are covered benefits **ONLY** when provided within the Tier 1 Network of Providers **AND** Benefit Guidelines are met. There is **NO** coverage outside of the Tier 1 Network of Providers.

1. Autism/Outreach Program.
2. Cleveland Clinic Summer Treatment Program.
3. Psychological and Neuro-psychological testing.
4. Neurofeedback and Biofeedback.
ADHD Summer Treatment Program

Full benefit coverage applies only if the child and parent each complete their designated portions of the program. Precertification and medical necessity review is required. RHP Total Care coverage for the Summer Treatment Program is $2,000. The member is responsible for the difference between what the RHP Total Care covers and the billed charges for the program. An additional $500 will be covered ONLY if the parents participate in the parent education portion of the program. All outpatient social skills training for children and adolescents with ADHD is covered as group therapy under the behavioral health outpatient benefit.

Autism

RHP Total Care will cover school and outreach program services for Autism when provided by the Cleveland Clinic Center for Autism. Outreach program services will not be covered while the child is also enrolled in the Autism School Program. Additionally, members are required to notify Cleveland Clinic Retiree Health Plan Total Care of any outside funding obtained for their child. If the child is enrolled in the Autism School Program and also receives Outreach Autism Program services at the same time, the outside funding will be applied to the school tuition costs and the parents will be responsible for covering the costs associated with the Outreach Program services.

Benefit coverage is as follows and requires precertification through the EHP Medical Management Department.

Autism School Program

Benefit coverage for a school year is determined by the student’s age at the beginning of the school year (or at the start of services if other than September):

- < 4 years – 100%
- 4 through 5 years – 50%
- > 6 years – 25%

Although the benefit year is from January to December, the RHP Total Care will reimburse the Autism School from the dates of September through August and benefit coverage is determined by the student’s age as of September (or at the start of services if other than September). For example, a student starting the program in September at age three receives 100% coverage for the entire school year — the benefit coverage is not reduced for that school year when the student turns four.

Should outside funding such as state grants or scholarships be secured by the child’s parents, these funds are applied to the total tuition cost, with the remaining tuition balance paid according to the benefit coverage in effect at the time of enrollment.

Example: The total tuition cost for 2008-2009 school year was $67,020. If a $20,000 grant was secured, and the benefit coverage was 50%, the parent and RHP Total Care would both be responsible for $23,510 [$67,020 – $20,000 = $47,020 x 50% = $23,510].

Outreach Autism Program

Benefit coverage is determined by the student’s age at the beginning of the month the services are provided.

- < 4 years – 100%
- > 4 years – 75%

A student who turns four after the first day of any month receives 100% benefit coverage for that month. For example, a student turning four on March 5 receives 100% benefit coverage through March. Services provided after March 31 are covered at 75%.

Call the EHP Total Care Customer Service Unit at 216-448-0800 or toll-free at 1-866-811-4352 for details.

Center for Autism Social SPIES Program

Full benefit coverage applies only if the child and parent each complete their designated portions of the program. Precertification and medical necessity review required. All outpatient group therapy and parent education is covered under the behavioral health outpatient benefit. RHP Total Care covers $2,000 of the cost of the summer camp portion of the program. The member is responsible for the difference between what RHP Total Care covers and the billed charges for the summer camp portion of the program. Call the EHP Medical Management Department for details.
Full Spectrum Light Boxes
For Seasonal Affective Disorder. Precertification and medical necessity review required. Coverage is 80%. The member is responsible for all shipping and handling charges. Call the EHP Medical Management Department regarding supplier information. RHP Total Care does not provide coverage for full spectrum light boxes for the purpose of treating a primary sleep disorder.

Intensive Home-Based Treatment
Approval for Intensive Home-Based Treatment (IHBT) is given on a case by case basis following a review with the Chief Medical Officer. IHBT services are made available to individuals and their family and are provided in the home by a specially trained behavioral health professional. Services are usually provided two to five times per week up to an average of four to 10 hours over several weeks. Precertification is required. Members are required to participate in Case Coordination to obtain this benefit.

Pain Management
Treatments, such as injections, are covered up to three injections per specific anatomical site per benefit year. More than three injections per specific site require precertification through the EHP Medical Management Department. Members in programs that have a psychiatric component should contact the EHP Medical Management Department for precertification of that component of their pain management program if the program is in Tier 2.

- Tier 2 Behavioral Health counseling sessions require precertification through the EHP Medical Management Department.

Psychological and Neuro-psychological Testing

Psychological Testing
Up to six hours of testing are automatically reimbursed without precertification. Testing is covered in Tier 1 only.

*Note:* If more hours/visits than the Allowed Amounts listed above are utilized, the hours/visits will not be covered by RHP Total Care under any circumstances and the subsequent charges will be the financial responsibility of the member.

Neuro-psychological Testing
Up to eight hours of testing are automatically reimbursed without precertification. Testing is covered in Tier 1 only.

*Note:* If more hours/visits than the Allowed Amounts listed above are utilized, the hours/visits will not be covered by RHP Total Care under any circumstances and the subsequent charges will be the financial responsibility of the member.

Residential Treatment
Residential Treatment (RT): Room and board services are provided on a 24 hour per day basis in conjunction with a highly structured mental health and/or substance abuse treatment program. Residential Treatment programs are generally in non-hospital settings. The patient is able to participate in individual, group and/or family psychotherapy, as well as other activities and/or therapies that address the patient's psychosocial needs within a controlled environment. The focus of the treatment should be to resolve any problems with the patient's support system, as well as the development and maintenance of skills and behavioral changes that will allow the patient to successfully reintegrate into the community. Halfway houses are not considered to be Residential Treatment programs by RHP Total Care.

Approval for Residential Treatment will be determined by the Chief Medical Officer on an individual case basis, following a review for medical necessity. This level of care is only available to those members who have been referred to the EHP Medical Management Department. If approved there is a 120 day limit. Tier 1 reimbursement is 80/20% and Tier 2 is 70/30% after deductible.
Total Care Medical and Behavioral Health Case Coordination

Cleveland Clinic Retiree Health Plan (RHP) Total Care is committed to helping you and your family stay healthy. However, if faced with medical illness, we are also committed to helping you with important decisions to ensure that you get the healthcare you need.

The EHP Medical Management Department offers a Case Coordination Program that provides members with telephone access to a Case Coordinator (Registered Nurse or Licensed Social Worker/ Counselor) for assistance with complex medical care needs, complex behavioral health needs, network access issues, and referrals to community services. Members can self-refer or be referred by their physician or family for evaluation.

Case Coordination Programs for medical conditions include End-Stage Renal Disease, high-risk maternity, complex care needs, palliative care needs, and transplant coordination, among others. Behavioral Health Case Coordination Programs include anxiety disorders, childhood disorders, dual diagnoses, eating disorders, mood disorders, psychotic disorders, and substance abuse.

Case Coordinators also make courtesy calls to members who have repeat emergency room visits, repeat inpatient stays within 90 days or have an inpatient stay with a length-of-stay of five or more days to assess for any post discharge care needs.

If you have a medical or behavioral health question related to a Case Coordination Program, the EHP Medical Management Department can be reached at 216-986-1050 or toll-free at 1-888-246-6648 during regular business hours of 8 a.m. to 4:30 p.m. Monday through Friday, excluding holidays. A confidential voicemail box is available to accept non-urgent messages after hours.

The Total Care Coordinated Care Programs address the self-management needs of members with chronic illnesses such as diabetes, high blood pressure and asthma. Conversations with a Care Manager will assist you in learning ways to continue feeling your best.

Registered Nurses will work closely with members and their doctors to provide valuable information about long-term illnesses, including ways to monitor progress and prevent complications. Coordinated Care Programs focus on education and self-management strategies, with a goal of improving overall health and promoting the best quality of life. These programs do not replace a physician’s care. They are designed to compliment a doctor’s care, reinforcing recommendations so members stay healthier between office visits. The programs are offered at no extra cost to members and participation is completely voluntary.

Features of the programs are based on specific health issues and may include:

- Monthly phone assessment interviews from a Case Coordinator.
- Educational mailings.
- Referral to community resources.
- Referral to informative Web sites.

The incentives for Coordinated Care Programs provide RHP Total Care members with the tools necessary to manage chronic conditions. To start, when a member enrolls in a program, they qualify for co-payment reimbursement for any needed screening equipment. This incentive applies only to programs in which screening equipment is necessary and includes items such as a peak-flow meter for the Asthma program, glucometer and testing supplies for the Diabetes program, a blood pressure cuff (up to $55) for the Hypertension and Heart Failure programs, and a scale (up to $40) for the Heart Failure program.

Once the member conquers all of the hurdles to self-management success (educational and clinical goals), any condition-specific office visit co-payment receipt incurred by the member after the enrollment date that is less than 12 months old will qualify for reimbursement. And, after six months of maintaining goals, the member can qualify for condition-specific pharmacy co-payment reimbursements.

If you have a medical care question or would like to inquire about any of the following Total Care Coordinated Care Programs, the EHP Medical Management Department can be reached at 216-986-1050 or toll-free at 1-888-246-6648 during regular business hours of 8 a.m. to 4:30 p.m. Monday through Friday, excluding holidays. A confidential voicemail box is available to accept non-urgent messages after hours.
**Asthma (for adults and children)**
Learn how to identify and avoid personal asthma triggers and how to self-manage your condition using an asthma action plan.

The hurdles that this program addresses are:
- Knowing asthma triggers and how to anticipate them.
- Having a peak flow meter and knowing how to use it.
- Obtaining a prescription for a daily long-term control medicine and a quick-relief medicine.
- Having a written Asthma Action Plan.

**Chronic Kidney Disease (CKD) Program**
Learn how to self-manage this often symptom-free condition through nutrition, diet, medication, and regular monitoring through periodic physician visits and blood tests. CKD-related office visit co-payment reimbursement is available when you reach all of the hurdles of this program.

**Diabetes (for adults and children)**
Learn how to control this condition through nutrition, diet, medication and regular monitoring through periodic physician visits and blood tests for hemoglobin A1c, cholesterol and kidney function.

The hurdles you will address in this program are:
- Understanding what type of diabetes you have.
- Obtaining a prescription for oral hypoglycemic agent or insulin.
- Performing blood sugar testing as ordered by the doctor. Testing urine as ordered.
- Understanding your dietary instructions.
- Exercising regularly.
- Recognizing the difference in symptoms of hypo- and hyper-glycemia.
- Understanding the additional special lab work needed (HbA1c quarterly; micro albumin and lipid profile annually).
- Being aware of the additional annual special exams (Retina, foot check).
- Moving toward the goal for HbA1c goal of 7 or below.
- Obtaining a LDL goal of 100 or lower.
- Maintaining blood pressure of 130/80 or lower.

We also have a Prediabetes Program available, which is for members who have been told they are borderline diabetic or have prediabetes. You may self-refer or inquire by contacting the EHP Medical Management Department.

**Heart Failure (CHF)**
Learn how to improve and maintain your activity level by tracking your weight, watching your sodium intake, and recognizing symptoms early enough to prevent congestion in your lungs.

The hurdles addressed in this program include:
- Weighing yourself everyday.
- Determining whether you have/need a prescription for medications for your CHF.
- Knowing how to limit your sodium to 2000mg or less per day.
- Monitoring your fluid intake.
- Managing any breathing problems.
- Establishing a regular exercise routine and keeping an exercise log.
- Identifying special lab work you may need and how often you should have it (Kidney function tests for adverse effects of medications).
- Knowing your Ejection Fraction (EF) and when it was measured.
- Moving toward the goal of <140/90 (<130/80 if diabetic) blood pressure.
- Getting a flu shot and pneumonia vaccine.
Hyperlipidemia
Learn what to do to bring your elevated LDL (bad) cholesterol level under control. Receive educational materials on what your lipid panel numbers mean and become aware of how simple changes in your diet, activity level and medication routines can improve your heart health. The hurdle you will address in this program is: Obtaining a LDL goal of 130 or lower.

Hypertension
Learn the importance of routine home blood pressure monitoring in combination with medication, diet and exercise compliance to prevent long-term health complications.

The hurdles addressed in this program are:
• Having a blood pressure cuff and knowing how to use it.
• Having a prescription for medications for your high blood pressure.
• Knowing how to limit your sodium to 2000mg or less per day.
• Having a regular exercise routine.
• Knowing what special lab work you need and how often you should have it.
• Establishing a goal blood pressure <140/90 (<130/80 if diabetic) or moving toward that goal.

Migraine
Learn how to keep a headache diary to help identify and avoid your specific triggers and recognize the early signs of a migraine. Learn the difference between prophylactic and abortive medications and which kinds you should talk to your doctor about.

The hurdles that this program addresses are:
• Knowing what type of migraine headaches you get.
• Knowing what triggers your migraine headaches.
• Keeping a migraine diary.
• Determining whether you have/need a prescription for an abortive headache medicine and a prophylactic headache medicine.

Rare Disease Management
All medical conditions present challenges. But some diseases, often classified as “rare,” can be especially devastating physically and emotionally — and not just for the members who are diagnosed, but also for their families.

Cleveland Clinic Retiree Health Plan Total Care is partnered with Accordant, a CVS Caremark Company, to provide plan members with a Rare Disease Management Program that specializes in 16 uncommon conditions. This program is voluntary and is provided at no additional cost to members.

Members who enroll in the program will receive the latest information about their conditions, help in managing co-morbidities and services provided by RN case managers who will communicate and coordinate with pharmacy staff, PCPs and specialists to help members maintain continuity, consistency and quality care. Rare Disease Management Program staff will work with the EHP Medical Management Department to ensure our members receive seamless, quality care within our network.

The complex, rare conditions covered under this program are:
• Amyotrophic lateral sclerosis (ALS)
• Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
• Crohn’s disease
• Cystic Fibrosis
• Dermatomyositis
• Gaucher disease
• Hemophilia
• Lupus
• Multiple Sclerosis
• Myasthenia Gravis
• Parkinson’s disease
• Polymyositis
• Rheumatoid Arthritis
• Scleroderma
• Seizure disorders
• Sickle Cell Anemia
**Weight Management — Non Surgical**

The non-surgical weight management program is designed to support your weight loss goals. Members are required to contact the EHP Medical Management Department to participate. The hurdles this program addresses are:

- Setting a short-term weight loss goal.
- Following the program regimen.
- Participating in routine exercise.

**Weight Management — Surgical (for adults over age 18)**

The Surgical Weight Management Program is designed to support the follow-up for bariatric surgery (see page 25). Members are required to contact the EHP Medical Management Department upon starting the workup for bariatric surgery. If the member receives an APPROVAL letter from the Bariatric Center, he or she must call the EHP Medical Management Department to complete the precertification process and a Care Manager will be assigned. To be eligible for this benefit, the employee must be a member in RHP Total Care for two consecutive years. Also, reimbursement is contingent on the member remaining an active member of the RHP Total Care.

An upfront co-payment of $2,750 is required, which is reimbursed, based on meeting the required hurdles. Hurdles are based on keeping all follow-up appointments as scheduled by the Cleveland Clinic Weight Management Program. These appointments include lab work, meetings with the surgeon, dietician, and support group, as well as the assigned psychologist. Reimbursement is as follows:

- 10% at six months
- 10% at one year
- 15% at two years
- 20% at three years
- 20% at four years
- 25% at five years

*Note:* RHP Total Care allows members to participate in only one weight management program at a time. For example, you cannot participate in both the surgical and non-surgical programs simultaneously.

**Preventive Healthcare**

Preventive healthcare services are those that would be performed for otherwise healthy, asymptomatic people, with the intent of reducing future adverse outcomes. Preventive services include prophylactic interventions (e.g., immunizations) and screening tests that seek to improve outcomes through early diagnosis.

The following guidelines represent an approach to preventive care. The guidelines have been generated from available healthcare literature. They are organized into adult and pediatric sections and include those interventions that are recommended. It is important to note that unless specified, the stated guidelines are meant to apply to average risk, asymptomatic, healthy individuals. Preventive care interventions appropriate for those at other levels of risk will vary by individual circumstance and physicians are encouraged to tailor the approach to these patients as necessary.

---

**Major Professional Organizations Used to Develop Cleveland Clinic Preventive Healthcare Guidelines:**

- AAP American Academy of Pediatrics
- ACS American Cancer Society
- ACP American College of Physicians
- ACOG American College of Obstetrics and Gynecology
- AAFP American Academy of Family Physicians
- USPSTF U.S. Preventive Services Task Force
# Preventive Screening and Immunization Guidelines
## for Asymptomatic Healthy Adults

<table>
<thead>
<tr>
<th>Disease</th>
<th>Interventions</th>
<th>Target Population</th>
<th>Interval</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Weight</td>
<td>All</td>
<td>At primary care visits</td>
<td>Diet and Exercise</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Problem drinking screening</td>
<td>All</td>
<td>At primary care visits</td>
<td>CAGE or AUDIT questionnaires recommended</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Blood pressure</td>
<td>All</td>
<td>Every 2 years</td>
<td>Recommended for primary intervention</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>Non-fasting cholesterol</td>
<td>Men age 30 and up Women age 30 and up</td>
<td>Every 5 years</td>
<td>Low fat diet and regular exercise recommended</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Mammography Clinical breast exam</td>
<td>Women age 50 and up</td>
<td>Every 1-2 years</td>
<td>Start at age 40 for high-risk population</td>
</tr>
<tr>
<td>Chlamydia Infection</td>
<td>Chlamydia screen</td>
<td>Sexually active young females</td>
<td>Periodic</td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus*</td>
<td>HPV vaccine</td>
<td>Females/Males age 9-26</td>
<td>3 doses</td>
<td>Prevents cervical cancer/genital warts</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Annual Pap smear under age 30</td>
<td>All women except those who have had a total hysterectomy</td>
<td>Every 1-3 years; annual for high risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pap plus HPV over age 30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B vaccine</td>
<td>All young adults, without previous immunization</td>
<td>Three dose series (age 0, 1 and 6 months)</td>
<td>Screen for infection in pregnant woman at first prenatal visit</td>
</tr>
<tr>
<td>Varicella</td>
<td>Varicella vaccine</td>
<td>Persons with no history of Varicella or previous vaccination</td>
<td>Two doses, 4-8 weeks apart</td>
<td>Consider offering serologic testing prior to vaccination</td>
</tr>
<tr>
<td>Rubella</td>
<td>Rubella titer</td>
<td>Women of childbearing age</td>
<td>Once</td>
<td>Consider offering vaccination without screening to non-pregnant women of childbearing age</td>
</tr>
<tr>
<td>Measles</td>
<td>MMR vaccine</td>
<td>Persons born after 1956 lacking evidence of immunity to measles</td>
<td>Once</td>
<td>Second dose recommended for young adults who did not receive one previously</td>
</tr>
<tr>
<td>Influenza</td>
<td>Influenza vaccine</td>
<td>All</td>
<td>Annually</td>
<td>One time revaccination after five years for those with chronic conditions</td>
</tr>
<tr>
<td>Pneumococcal Pneumonia</td>
<td>Pneumococcal vaccine</td>
<td>Those over age 65 or those with chronic conditions</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>Tetanus/Diphtheria/Pertussis</td>
<td>Vaccine</td>
<td>All</td>
<td>Every 10 years</td>
<td></td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>Fecal occult blood test (FOBT) and Sigmoidoscopy or Colonoscopy</td>
<td>All over age 50</td>
<td>FOBT — Annual Sigmoidoscopy every 5 yrs. Colonoscopy every 10 yrs.</td>
<td>Start age 40 if first degree relatives with colon cancer under age 60</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>PSA and digital rectal exam; may consider doing earlier if a high risk patient category</td>
<td>Men age 50-70 years Black men age 40 and up</td>
<td>Annually Every 3 years if PSA is less than 1.0</td>
<td>Counseling before testing for risks and benefits of testing</td>
</tr>
<tr>
<td>AIDS/HIV</td>
<td>HIV test</td>
<td>High Risk – Male with same sex partner; IV drug use or history of same; male or female prostitute, or multiple sex partners, HIV-positive partner</td>
<td>Annually (or periodically)</td>
<td>Screen for infection in pregnant woman at first prenatal visit</td>
</tr>
<tr>
<td>Shingles</td>
<td>Zostavax vaccine</td>
<td>Age 60 and up</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>Helmet (bike riding), unattached rugs, hand rails, smoking education, seat belts, water safety, firearm safety</td>
<td>Age 60 and up</td>
<td>Periodic</td>
<td></td>
</tr>
</tbody>
</table>

*See page 28 Immunizations.*
**Injury and Accident Prevention in Children**

Recommendations for keeping your child/children safe from injury should be discussed with your pediatric primary care provider regularly at office visits. Some of the most important topics you will want to have current information on include:

- Crib safety
- Use of booster seats*
- Use of bicycle helmets/protective gear (sports)
- Firearms safety
- Burn prevention
- Teaching your children to access emergency services (911)
- Preventing smoking, alcohol use, and drug use (preadolescents and adolescents)

*The recommendation regarding booster seats includes their use in children until they are at least 80 pounds. This is because booster seats help to properly position shoulder and lap belts on the child.

---

**Immunization Recommendations for Healthy Children**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>HepB #1</td>
</tr>
<tr>
<td></td>
<td>HepB #2</td>
</tr>
<tr>
<td></td>
<td>HepB #3</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Rota</td>
</tr>
<tr>
<td>(DPT) Diphtheria, Tetanus, Pertussis</td>
<td>DTaP</td>
</tr>
<tr>
<td>(Hib) H. Influenza Type b</td>
<td>Hb</td>
</tr>
<tr>
<td>Inactivated Polio</td>
<td>IPV</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>PCV</td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>(MMR) Measles, Mumps, Rubella</td>
<td>MMR</td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Var</td>
</tr>
<tr>
<td>(Chicken Pox) Varicella</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
</tr>
</tbody>
</table>

Shaded gray areas indicate ranges when immunizations should be given. Consult your Pediatrician regarding when to give immunizations that were missed.
Prescription Drug Benefit

The Retiree Health Plan (RHP) Prescription Drug Benefit is administered through informedRx®, formerly National Medical Health Card Systems, Inc. (NMHC).

Important Notice: In 2009, NMHC changed their name to informedRx. This change DOES NOT affect any of your prescription drug benefits. This Summary Plan Description reflects the informedRx name, but both companies are one in the same. You can continue using your NMHC prescription benefit card at your retail pharmacy and informedMail (formerly NMHC Mail) for your prescriptions. Prescription reimbursement checks will now be from informedRx.

informedRx has a dedicated, toll-free Customer Service Number for RHP members to call, 1-866-443-1095. Operators are available 24 hours a day, 7 days a week. informedRx Customer Service is also available at www.myinformedrx.com.

If your RHP informedRx Prescription card is lost or stolen, contact informedRx at the phone number or e-mail address listed above for a replacement card.

Members can also go to the informedRx Web site at www.myinformedrx.com for the following:

- Prescription Refills for informedRx Mail Program
- Request Forms
- Order Status
- Frequently Asked Questions
- Pharmacy Locations
- 13 Month Drug History
- Benefit Coverage
- Additional Health Information

When you call informedRx or visit their Web site, please have the following information available:

- Member’s ID Number
- Member’s Date of Birth
- Payment Method

Appropriate and cost-effective use of pharmaceutical therapies can be the key to a successful strategy for improving individual patient outcomes and containing overall healthcare costs. Through your Prescription Drug Benefit, you have three options for filling your prescription medications. The three options described on the following pages include the Cleveland Clinic Pharmacies and Home Delivery Service (includes Cleveland Clinic Pharmacies in Cleveland and Cleveland Clinic Weston Pharmacy), the informedRx Retail Network Pharmacies, and the informedRx Mail Program.

**Cleveland Clinic Pharmacies and Home Delivery Service**

RHP Total Care members receive a lower percentage co-insurance for their prescriptions by using Cleveland Clinic Pharmacies in Cleveland, Cleveland Clinic Weston Pharmacy, or the Home Delivery Service. In addition, a deductible will not be charged for generic prescriptions filled at these pharmacies or via home delivery. Call the pharmacy hotline at 216-445-MEDS (6337) for answers to your questions and to obtain pharmacist consultation services. You can receive up to a 90 day supply of medication at any of the Cleveland Clinic Pharmacies in Cleveland, the Cleveland Clinic Home Delivery Service or Weston Pharmacy.

**Note:** By law, the Cleveland Clinic Home Delivery Service must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90 day plan limit. (30 days plus two refills does not equal one prescription written for 90 days.)
You may pick up your prescriptions at any of the locations listed below or you can have your prescription(s) mailed to your home by using the Cleveland Clinic Home Delivery Service. There is a turnaround time of ten calendar days from the day you send your order for all home delivery orders. See page 42 for details.

Cleveland Clinic Pharmacies — Locations and Hours of Operation

- **Cleveland Clinic Pharmacies On Main Campus:**
  - Euclid Avenue Parking Garage
    - 216-445-MEDS (6337), Fax: 216-445-6015
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Monday–Friday, 8 a.m.–8 p.m., Saturday, 9 a.m.–3 p.m.
  - Crile Building (A Building)
    - 216-445-MEDS (6337), Fax: 216-445-7403
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Monday–Friday, 8 a.m.–6 p.m.
  - Children's Hospital & Surgery Center Pharmacy (P Building)
    - 216-445-MEDS (6337), Fax: 216-444-9514
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Monday–Friday, 9 a.m.–5 p.m.
  - Taussig Cancer Center (R Building)
    - 216-445-MEDS (6337), Fax: 216-445-2172
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Monday–Friday, 9 a.m.–5 p.m.

- **Cleveland Clinic Pharmacies Off Campus:**
  - Beachwood Pharmacy
    - 26900 Cedar Road, Beachwood, OH 44122
    - 216-445-MEDS (6337), Fax: 216-839-3271
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Direct Dial: 216-839-3270
    - Monday–Friday, 8 a.m.–6 p.m.
  - Fairview Health Center Pharmacy
    - 18099 Lorain Road, Cleveland, OH 44111
    - 216-445-MEDS (6337), Fax: 216-476-9905
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Direct Dial: 216-476-7119
    - Monday–Friday, 8 a.m.–6 p.m.
  - Marymount Family Pharmacy
    - 12000 McCracken Road, Suite 151
    - Garfield Heights, OH 44125
    - 216-445-MEDS (6337), Fax: 216-587-8844
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Direct Dial: 216-587-8822
    - Monday–Friday, 8 a.m.–6 p.m.
    - Saturday, 9 a.m.–1 p.m.
  - Strongsville Family Health Center
    - 16761 Southpark Center, Strongsville, OH 44136
    - 216-445-MEDS (6337), Fax: 440-878-3148
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Direct Dial: 440-878-3100
    - Monday & Thursday, 9 a.m.–8 p.m.
    - Tuesday, Wednesday & Friday, 9 a.m.–5:30 p.m.
  - Willoughby Family Health Center
    - 2570 SOM Center Road, Willoughby, OH 44094
    - 216-445-MEDS (6337), Fax: 440-516-8629
    - Toll-free: 1-800-CCF-CARE (223-2273), ext. 52100
    - Direct Dial: 440-516-8620
    - Monday–Friday, 8 a.m.–6 p.m.

- **Cleveland Clinic Florida Pharmacy**
  - Cleveland Clinic Weston Pharmacy
    - 2950 Cleveland Clinic Blvd., Weston, FL 33331
    - 954-659-MEDS (6337), Fax: 954-659-6338
    - Toll-free: 1-866-2WESTON (293-7866)
    - Monday–Friday, 9 a.m.–6 p.m.
Cleveland Clinic Home Delivery Service Ordering Instructions

The Home Delivery Service is designed to ship medication directly to your home with no shipping charge. By using the Home Delivery Service, members receive a lower percentage co-insurance for their medications compared to the informedRx Retail Pharmacy Network and can enjoy the convenience of having 90 day supplies of their maintenance medications delivered directly to their home. Here’s how you can get started:

1. Fill out a Home Delivery Prescription Processing Form to indicate payment and shipping information for you and your dependents. This information will be kept on file to avoid filling out a form every time you place a prescription order. This is the only form you will need to fill out for prescriptions that are:
   - Called in by your physician to 1-866-650-MEDS (6337), option 2
   - Faxed in by your physician to 216-328-6076
   - e-Scripted by your physician via EPIC (CCF Home Delivery Pharmacy)
   - Called in by using our automated refill system at 1-866-650-MEDS (6337), option 1
   - Requested through our online form at www.clevelandclinic.org/myrefills
   - Members can also visit www.clevelandclinic.org/myrefills to create a profile for each member of your family. This is an alternative to using the paper forms. Your health information and payment information are safe and secure.

To obtain a Home Delivery Prescription Processing Form:
   - Visit www.clevelandclinic.org/healthplan, then click on “Customer Service” and “Frequently Requested Forms”
   - Visit via the Internet: www.clevelandclinic.org/pharmacy
   - Visit via the Intranet: http://pharmacy.ccf.org
   - Call 216-328-6075 to have one mailed or faxed to you directly

2. If you have a hard copy of a prescription or are transferring a prescription from a pharmacy other than a Cleveland Clinic Pharmacy, please use the Home Delivery Prescription Processing Form and mail the form and the prescription(s) to:
   - Home Delivery Service
   - P.O. Box 25220
   - Garfield Heights, OH 44125-0220

The Cleveland Clinic Home Delivery Service is available Monday–Friday from 7:00 a.m. to 6:00 p.m. Please allow ten calendar days from the day you send your order for all home delivery orders.

Please call 216-328-6075 for questions or additional information on the Cleveland Clinic Home Delivery Service.
Advantages of Utilizing the Cleveland Clinic Pharmacies and Home Delivery Service

**Lower cost:** You will pay less for prescription co-insurance — by an average of 20% to 25% less compared to using the informedRx Retail Pharmacy Network. In addition, your deductible will be waived for generic prescriptions filled at these pharmacies.

**Convenience:** You may request a 90 day supply of medications.

*Note: The prescription must be written for a 90 day supply.*

**Peace of mind:** You will have access to a toll-free hotline number for questions and pharmacist consultation services during regular business hours.

### Filling Prescriptions

- Your doctor can call in the prescription.
- You can call to request refills.
- You or your doctor can mail in the prescription.

### Pick up or Home Delivery of Prescriptions

- You may pick up prescriptions directly from the pharmacy where you dropped them off.
- You may have it mailed to your home within ten calendar days from the day you send your order for all home delivery orders at no shipping cost.
Options for Members Who Don’t Live or Work Near a Cleveland Clinic Pharmacy

Members have the option of either mailing their original prescriptions or having their doctor call in a prescription to the Cleveland Clinic Home Delivery Pharmacy in Cleveland. Your prescription will then be mailed to you at no additional charge. You can then either call the desired pharmacy or request refills via the Web site at www.clevelandclinic.org/myrefills. Contact your pharmacist for instructions on how to gain access to your pharmacy profile via this Web site.

informedRx Retail Network Pharmacies

For the convenience of picking up prescriptions at your neighborhood pharmacy, RHP members can take advantage of this option. See the Prescription Drug Benefit chart on page 45 for major chains in the retail network. When using the informedRx Retail Network, member co-insurance is higher than under the Cleveland Clinic Pharmacies and Home Delivery Service. informedRx offers over 55,000 participating retail pharmacies in their national pharmacy network, which are listed on informedRx’s Web site at www.myinformedrx.com.

informedRx Mail Program

New Prescriptions

informedRx’s Mail Program provides a way for you to order up to a 90 day supply of maintenance or long-term medication for direct delivery to your home. Follow this easy step-by-step ordering procedure:

1. For new maintenance medications, ask your doctor to write two prescriptions:
   • One, for up to a 90 day* supply plus refills, to be ordered through the informedRx Mail Program; and
   • The other, to be filled immediately at an informedRx participating retail pharmacy for use until you receive your prescription from the informedRx Mail Program.

   Note: *By law, informedRx must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90 day plan limit. (30 days plus two refills does not equal one prescription written for 90 days.)

2. Complete a informedRx Mail Program order form and send it to informedRx, along with your original prescription(s) and the appropriate payment for each prescription. Be sure to include your original prescription, not a photocopy. Forms are available on informedRx’s Web site at www.myinformedrx.com.
   • You can expect to receive your prescription approximately 14 calendar days after informedRx receives your order.
   • You will receive a new informedRx Mail Program order form and pre-addressed envelope with each shipment.

informedRx Mail Program Refills

Once you have processed a prescription through informedRx, you can obtain refills using the Internet, phone or mail. Please order your prescription three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from informedRx. You will receive specific instructions related to refills from informedRx.
RHP Total Care Prescription Drug Benefit
Administered Through informedRx
The Following Is a Summary Overview of the Prescription Drug Benefit:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Tier 1 Preferred Brands (Formulary)</th>
<th>Tier 2 Preferred Brands (Formulary)</th>
<th>Tier 3 Non-Preferred Brands (Non-Formulary)</th>
<th>Tier 4 Specialty Drugs (Hi-Tech)</th>
<th>Drugs &amp; Items at Discounted Rate</th>
<th>Non-Covered Drugs &amp; Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$100 Individual</td>
<td>(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Member % Co-pay Cleveland Clinic Pharmacies — up to 90 Day Supply</td>
<td>15%</td>
<td>25%</td>
<td>45%</td>
<td>20%</td>
<td>Member Pays 100% of the Discounted Price</td>
<td>Not Available through Rx Plan</td>
</tr>
<tr>
<td>Member % Co-pay informedRx Retail Network — 30 Day Supply informedRx Mail Program — 90 Day Supply</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
<td>Member Pays 100% of the Discounted Price</td>
<td>Not Available through Rx Plan</td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-pay — Cleveland Clinic Pharmacies?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-pay — Retail and Mail Program?</td>
<td>Yes $5 Minimum/ $50 Maximum per 30 Day Supply</td>
<td>Yes $5 Minimum/ $75 Maximum per 30 Day Supply</td>
<td>No</td>
<td>Yes $3 Minimum/ $75 Maximum per 30 Day Supply</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Is there an Annual Out-of-pocket Max?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Components of Each Category:
- **Generic Drugs**
- **Brand Drugs**
- **Specialty Drugs**
- **Life Style Drugs**
- **Over-the-Counter**

<table>
<thead>
<tr>
<th>Prior Authorization Required</th>
<th>Co-pay 20%</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>NA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Supplies† and Asthma Delivery Devices†</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Chains in the Retail Network</td>
<td>ACME, Cleveland Clinic Pharmacies, 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*There are 3 options for obtaining medications in the category listed above. The options are: 1. Cleveland Clinic Pharmacies in Cleveland and Cleveland Clinic Weston Pharmacy, 2. Cleveland Clinic Home Infusion Pharmacy (injectables only), and 3. informedRx Specialty Drug Program.
†Diabetic Supplies — Insulin and all diabetic supplies covered. Includes: needles purchased separately, test strips, lancets, glucose meters, syringes and injection pens.
Asthma Delivery Devices — Includes spacers used with asthma inhalers.
Prescription Drug Benefit Guidelines

Prescription Drug Benefit — Deductible

The Prescription Drug Benefit has an annual deductible of $100 per individual.

Not all pharmacy charges apply toward the deductible. The total charges for medications not covered by the plan (e.g., Viagra, Levitra, weight control products, cosmetic agents) do not apply to the deductible.

In addition, the Dispense as Written Penalty (DAW) that applies to some brand name medications does not apply to the deductible. If a generic version of the prescribed brand medication exists, the Prescription Drug Benefit will reimburse only up to the price of the generic version. If you choose to use the brand name, you are required to pay the price difference between the generic and the brand medication. That difference does not apply to the deductible (see Generic Medication Policy).

Note: Prescriptions filled at Cleveland Clinic Pharmacies and Cleveland Clinic Home Delivery Service for generic medications are not subject to the deductible. Members will still pay the deductible when they purchase all brand name and generic medications at other pharmacies.

Generic Medication Policy

Cleveland Clinic supports and encourages the use of FDA-approved generic drugs that are both chemically and therapeutically equivalent to manufacturer’s brand name products. Generically equivalent products are safe and effective treatments that offer savings as alternatives to brand name products. If a member or physician requests the brand name drug be dispensed when a generic is available, the participant will be required to pay their generic co-insurance AND the cost difference between the brand name drug price and the generic drug price. Please note: the Generic Medication Policy does not apply to retirees enrolled in Medicare Part D.

Prior Authorization

Prior Authorization is necessary for coverage of certain medications. These medications are listed on page 45. The medications on the list may change during the year due to new drugs being approved by the FDA or as new indications are established for previously approved drugs. A Coverage Determination Request Form (see page 47) must be completed before a case will be reviewed. All requests must meet clinical criteria approved by the Pharmacy and Therapeutics (P&T) Committee before approval is granted. In some cases, approvals will be given limited authorization date. If a limited authorization date is given, both the member and the physician will receive documentation on when this authorization will expire. Although this process is managed by informedRx, the Cleveland Clinic EHP Pharmacy Coordination Department will assist in the determination process. If your initial request is denied, the appeal process is described on page 55.

Formulary Failure Review Process

If it is determined that a RHP member is not responding to drugs available on the Formulary, your physician may request a review for preferred coverage of a Non-Formulary drug. To start the review process, your physician should call informedRx at 1-866-443-1095 and request a Coverage Determination Request Form or you may provide your physician with the form yourself (see sample on the following page). All requests must be in writing and signed by the prescribing physician. If a Non-Formulary drug is approved, the member will be responsible for a 30% co-insurance* with no monthly maximum out-of-pocket. In most cases, approvals will be given an unlimited authorization date so that you will not be required to resubmit a request every year. Although this process is managed by informedRx, the Cleveland Clinic EHP Pharmacy Coordination Department will assist in the determination process. If your initial request is denied, the appeal process is described on page 55.

*Lower co-insurance will be assessed from the date of authorization. No refunds will be made for previously purchased prescriptions.
Medicare Part D Coverage Determination Request Form

INFORMEDRX MEDICARE – PLEASE FAX COMPLETED FORM TO (866) 511-2202.

CUSTOMER CARE NUMBER (800)777-0074  TTY/TDD (866) 443-1094

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

¾ Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

¾ Biotech or other specialty drugs for which drug-specific forms are required. [See links to plan websites at http://www.medicare.nmhc.com OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]

Patient Information

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Prescriber Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Prescriber Name:</td>
</tr>
<tr>
<td>Member ID#:</td>
<td>NPI# (if available):</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Office Phone #:</td>
<td>Office Fax #:</td>
</tr>
<tr>
<td>Sex (circle):</td>
<td>M F</td>
</tr>
<tr>
<td>DOB:</td>
<td>Contact Person:</td>
</tr>
</tbody>
</table>

Diagnosis and Medical Information

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Strength and Route of Administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Prescription</td>
<td>Expected Length of Therapy:</td>
</tr>
<tr>
<td>Date Therapy Initiated:</td>
<td>Diagnosis:</td>
</tr>
<tr>
<td>Height/Weight:</td>
<td>Drug Allergies:</td>
</tr>
<tr>
<td>Prescriber’s Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Rationale for Exception Request or Prior Authorization

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)

⇒ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

⇒ Specify below: Anticipated significant adverse clinical outcome

☐ Medical need for different dosage form and/or higher dosage

⇒ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ Request for formulary tier exception

⇒ Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

☐ Other:________________________________________________________________

⇒ Explain below

REQUIRED EXPLANATION:_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS] FAX TO (866) 511-2202

⇒ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER’S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Benefits and Coverage Clarification

Compounded Prescriptions
A customized medication prepared by a pharmacist according to a doctor’s specifications is considered a compounded prescription. These prescriptions are considered non-preferred and have a charge of 45% at a Cleveland Clinic Pharmacy or 50% at all other locations.

IUD and Depo-Provera Guidelines
IUD insertions are a form of birth control; and in most cases, Depo-Provera is used as a birth control method.

IUD insertions are a form of birth control and therefore will have a $50 co-insurance charge at the providers office.

If Depo-Provera is used as a birth control method, the member will be charged the Prescription Drug Benefit co-payment of $15 per injection when supplied by a doctor’s office. Standard co-payment rates are charged if Depo-Provera is purchased at a pharmacy.

Oral Medications for Onychomycosis (Nail Fungus)
All oral prescriptions for the treatment of nail fungus are covered at the Non-Preferred rate (see the Prescription Drug Benefit chart on page 45), which is 45% at Cleveland Clinic Pharmacies and Home Delivery Service or 50% at all other locations. This Non-Preferred rate is in effect for brand name and generic medications appropriate for treating this condition. Formulary overrides to reimburse 25% at Cleveland Clinic Pharmacies or 30% at all other locations are given to members who have this condition and diabetes or some form of peripheral vascular disease (poor blood flow). Overrides are also given to any member who has the fingernail form of this condition; however, only one course of treatment will be covered at the Formulary rate in a lifetime.

Over-The-Counter (OTC) Medications
Medications that are available without a prescription are not covered under the Prescription Drug Benefit. When a drug is available in the identical strength, dosage form and is approved for the same indications, the prescription drug is usually not covered by the plan. Providers should recommend the equivalent over-the-counter (OTC) product to the patient.

Sharps Container Program
Members who obtain their self-administered injection medications from the Cleveland Clinic Pharmacies are eligible to receive one Sharps Container (1.5 quart size) every six months at no cost.

Please note that the Cleveland Clinic Pharmacies in Cleveland and the Cleveland Clinic Weston Pharmacy cannot take back full containers. Each container should be disposed of properly. Should you have additional questions, please contact your Cleveland Clinic pharmacist.
Pharmacy Coordination Programs

Quantity Level Limits

Quantity level limits are applied to medications for various reasons. For example, to prevent medication misuse or abuse, to promote adherence to an appropriate course of therapy for reasons of efficacy and safety, and to prevent the stockpiling of medication. Below is a list of medications that have quantity level limits. Cleveland Clinic Retiree Health Plan Total Care will continue to monitor drug utilization to possibly expand quantity level limits for other medications.

- Actonel 35mg — 4 tablets per 30 days
- Actonel 75mg — 2 tablets per 30 days
- Actonel w/Calcium — 1 tablet per day
- Actoplus met — 1 tablet per day
- Actos — 1 tablet per day
- Ambien 5mg — 1 tablet per day
- Amerge tablets — 9 tablets per 30 days
- Amrix — 1 tablet per day
- Anzemet — 1 tablet per day
- Avandamet — 1 tablet per day
- Avandaryl — 1 tablet per day
- Avandia — 1 tablet per day
- Axert tablets — 12 tablets per 30 days
- Boniva 150mg — 1 tablet per 30 days
- Celebrex — 2 capsules per day
- Cimzia — 4 injections (2 kits) per month
- Cymbalta 30mg — 1 capsule per day
- Detrol LA 2mg — 1 capsule per day
- Effexor XR 37.5mg — 1 capsule per day
- Effexor XR 75mg — 1 capsule per day
- Fexmid — 3 week supply per prescription
- Flector Patches — 2 patches per day for 14 days per prescription
- Fosamax 5mg — 1 tablet per day
- Fosamax 10mg — 1 tablet per day
- Fosamax 35mg — 4 tablets per 30 days
- Fosamax 40mg — 1 tablet per day
- Fosamax 70mg — 4 tablets per 30 days
- Fosamax solution — 4 bottles (300 milliliters) per 30 days
- Fosamax + D — 4 tablets per 30 days
- Frova tablets — 9 tablets per 30 days
- Imitrex tablets — 9 tablets per 30 days
- Imitrex nasal spray — 9 sprays per 30 days
- Imitrex injection — 4 kits per 30 days
- Kytril — 12 tablets per 30 days
- Lexapro — 1 tablet per day
- Maxalt tablets — 12 tablets per 30 days
- Reclast — 1 injection per year
- Relpax tablets — 12 tablets per 30 days
- Skelid — 2 tablets per day
- Somatuline Depot — 1 per month
- Tasigna — 4 capsules per day
- Tasigna — 30 day supply; limit based on instructions for use
- Teslac — 30 day supply; limit based on instructions for use
- Toradol 10mg — 20 tablets per 30 days
- Treximet — 9 tablets per month
- Treximet 85-500 — 12 tablets per 30 days
- Valtrex 1000mg — 30 tablets per 365 days
- Valtrex 500mg — 10 tablets per 30 days
- Various acetaminophen containing products — 4 grams a day
- Voltaren Gel — 1 tube (100 grams) every 4 days
- Vyvanse — 1 capsule per day
- Wellbutrin XL 150mg — 1 tablet per day
- Zofran — 18 tablets per 30 days
- Zomig nasal spray — 12 sprays per 30 days
- Zomig tablets — 12 tablets per 30 days

Statin Co-Payment Reduction Program (formerly Statin Half-Tablet Program)

Members save money by splitting larger dose tablets that may be similar in cost to smaller dose tablets; which means only 45 tablets are purchased for a 90 day supply.

The medications that are eligible for this program are:

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mevacor*</td>
<td>lovastatin</td>
<td>Lipitor</td>
<td>atorvastatin</td>
</tr>
<tr>
<td>Pravachol*</td>
<td>pravastatin</td>
<td>Crestor</td>
<td>rosvastatin</td>
</tr>
<tr>
<td>Zocor*</td>
<td>simvastatin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you participate in the Statin Co-Payment Reduction Program, your co-payment for the generic medications listed above is $6. When ordering the brand medications listed above, after paying the deductible, your co-payment will be $30. Members who receive Zocor* (simvastatin) do not need to split tablets in half to receive the co-pay reduction.

To take advantage of the Statin Co-payment Reduction Program, the prescription must be filled for a 90 day supply at a Cleveland Clinic Pharmacy.

Note: *If you receive the brand name instead of the preferred generic form of Mevacor, Pravachol, or Zocor, the standard generic medication policy will apply, see page 46.

### Step Edit Program

Step edits are a process for prescribing the most effective and least expensive medication for a particular condition. First, they help verify that the member has the covered condition so that preferred rates are applied when filling prescriptions. Second, prescriptions for less expensive — but equally effective — generic medications for covered conditions will be approved; the computer system will stop orders for more expensive drugs.

The chart below and on the following page lists medications that are subject to a Step Edit under the Retiree Health Plan Total Care Prescription Drug Benefit. The medications listed in column two will be covered only after a trial of the first line medications listed in column three. Please note that members who are currently receiving one of the antidepressants or high blood pressure medications listed in column two will continue to have coverage for their current medication.

During the benefit year, new medications may be added to this list. Members will be notified before these changes take effect.

<table>
<thead>
<tr>
<th>Drug or Therapeutic Category</th>
<th>Medications Affected</th>
<th>First Line Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Medications</strong></td>
<td>Actos (pioglitazone)</td>
<td>Glucophage (metformin)</td>
</tr>
<tr>
<td>ActoplasMet (pioglitazone/metformin)</td>
<td>Duetact (pioglitazone/glimepiride)</td>
<td></td>
</tr>
<tr>
<td>Avandia (rosiglitazone)</td>
<td>Avandamet (rosiglitazone/metformin)</td>
<td></td>
</tr>
<tr>
<td>Avandaryl (rosiglitazone/glimepiride)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Osteoporosis Agents</strong></td>
<td>Actonel (risedronate)</td>
<td>Fosamax (alendronate)</td>
</tr>
<tr>
<td>Boniva (ibandronate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-Inflammatory — Cox-2 Inhibitors</strong></td>
<td>Celebrex (celecoxib)</td>
<td>Anaprox (naproxen)</td>
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<tr>
<td>Ansaid (flurbiprofen)</td>
<td>Cataflam (diclofenac)</td>
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</tr>
<tr>
<td>Clinoril (sulindac)</td>
<td>Daypro (oxaprozin)</td>
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<tr>
<td>Clinoril (sulindac)</td>
<td>Feldene (piroxicam)</td>
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<tr>
<td>Diclofenac (sulindac)</td>
<td>Indocin (indomethacin)</td>
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<tr>
<td>Diclofenac (sulindac)</td>
<td>Lodine (etodolac)</td>
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<tr>
<td>Meloxicam (piroxicam)</td>
<td>Motrin (ibuprofen)</td>
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<tr>
<td>Naproxen (naproxen)</td>
<td>Orudis (ketoprofen)</td>
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<tr>
<td>Orudis (ketoprofen)</td>
<td>Relafen (napasumetone)</td>
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</tr>
<tr>
<td>Tolmetin (tolmetin)</td>
<td>Voltaren (diclofenac)</td>
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</tr>
<tr>
<td>Drug or Therapeutic Category</td>
<td>Medications Affected</td>
<td>First Line Therapy</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td><strong>Antidepressants</strong>*</td>
<td>Aplenzin (bupropion hydrobromide)</td>
<td>Celexa (citalopram)</td>
</tr>
<tr>
<td></td>
<td>Cymbalta (duloxetine)</td>
<td>Effexor (venlafaxine)</td>
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<tr>
<td></td>
<td>Effexor XR (venlafaxine)</td>
<td>Luvox (fluvoxamine)</td>
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<tr>
<td></td>
<td>Lexapro (escitalopram)</td>
<td>Paxil (paroxetine)</td>
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<tr>
<td></td>
<td>Luvocx CR (fluvoxamine maleate extended-release capsules)</td>
<td>Prozac (fluoxetine)</td>
</tr>
<tr>
<td></td>
<td>Paxil CR (paroxetine)</td>
<td>Zoloft (sertraline)</td>
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<tr>
<td></td>
<td>Pristiq (desvenlafaxine)</td>
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<tr>
<td></td>
<td>Prozac Weekly (fluoxetine)</td>
<td></td>
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<tr>
<td><strong>Fibrates</strong></td>
<td>Antara, Lipofen, Tricor, Triglide</td>
<td>Prolia (fenofibrate)</td>
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<tr>
<td></td>
<td>(different brand names for fenofibrate)</td>
<td>Lopid (gemfibrozil)</td>
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<tr>
<td><strong>Proton Pump Inhibitors</strong></td>
<td>Brand Name Aciphex (rabeprazole)</td>
<td>Generic Prilosec (omeprazole)</td>
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<tr>
<td></td>
<td>Brand Name Nexium (esomeprazole)</td>
<td>Generic Protonix (pantoprazole)</td>
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<tr>
<td></td>
<td>Brand Name Prilosec (omeprazole)</td>
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<tr>
<td></td>
<td>Brand Name Prevacid (lansoprazole)</td>
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</tr>
<tr>
<td></td>
<td>Brand Name Protonix (pantoprazole)</td>
<td></td>
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<tr>
<td><strong>High Blood Pressure Medications</strong>*</td>
<td>Atacand (candesartan)</td>
<td>Accupril (quinapril)</td>
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<tr>
<td></td>
<td>Avalide (candesartan/HCTZ)</td>
<td>Accuretic (quinapril/HCTZ)</td>
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<tr>
<td></td>
<td>Avapro (irbesartan)</td>
<td>Altace (ramipril)</td>
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<tr>
<td></td>
<td>Avapro HCT (irbesartan/HCTZ)</td>
<td>Capoten (captopril)</td>
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<tr>
<td></td>
<td>Benicar (olmesartan)</td>
<td>Capozide (captopril/HCTZ)</td>
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<tr>
<td></td>
<td>Benicar HCT (olmesartan/HCTZ)</td>
<td>Lotensin (benazepril)</td>
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<td>Cozaar (losartan)</td>
<td>Lotensin HCT (benazepril/HCTZ)</td>
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<td>Hylzaar (losartan/HCTZ)</td>
<td>Mavik (trandolapril)</td>
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<td>Diovan (valsartan)</td>
<td>Monopril (fesinopril)</td>
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<td>Diovan HCT (valsartan/HCTZ)</td>
<td>Monopril-HCT (fesinopril/HCTZ)</td>
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<td>Micardis (telmisartan)</td>
<td>Prinivil (lisinopril)</td>
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<tr>
<td></td>
<td>Micardis HCT (telmisartan/HCTZ)</td>
<td>Prinzide (lisinopril/HCTZ)</td>
</tr>
<tr>
<td></td>
<td>Tevoten (eprosartan)</td>
<td>Univas (moexipril)</td>
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<td>Tevoten HCT (eprosartan/HCTZ)</td>
<td>Vaseretic (enalapril/HCTZ)</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>Amitiza (lubiprostone)</td>
<td>Zestoretic (lisinopril/HCTZ)</td>
</tr>
<tr>
<td></td>
<td>Amrix (cyclobenzaprine)</td>
<td>Zestril (lisinopril)</td>
</tr>
<tr>
<td></td>
<td>Bystolic (nebivolol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fexmid (cyclobenzaprine)</td>
<td></td>
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<tr>
<td></td>
<td>Januvia (sitagliptin)</td>
<td></td>
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<tr>
<td></td>
<td>Leukotriene Receptor Antagonists (Singulair, Accolate, Zyflo, Zyflo CR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Luvocx CR (fluvoxamine extended-release)</td>
<td></td>
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<tr>
<td></td>
<td>Myrac (tetracycline)</td>
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<tr>
<td></td>
<td>Onglyza (saxaglptiin)</td>
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<tr>
<td></td>
<td>Oracea (doxycycline)</td>
<td></td>
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<tr>
<td></td>
<td>Proton Pump Inhibitors (Nexium, Aciphex, (Nexium, Aciphex, Kaptid, Preacid, Preacid Solu tabs, Prilosec)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Texecmet (sumatriptan-naproxen)</td>
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<tr>
<td></td>
<td>Vyvanse (lisdexamfetamine dimesylate)</td>
<td></td>
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</tbody>
</table>

*Member using one of the medications in these classes will have their existing coverage “grandfathered” and will not have to undergo a trial with a first line medication.
Specialty Drug Benefit

In addition to the Cleveland Clinic RHP Total Care comprehensive Pharmacy Coordination Programs, informedRx offers specialized pharmaceutical services for individuals with chronic or genetic disorders, and disease management programs for individuals with complex conditions. By combining proven managed care strategies with a strong clinical orientation and sophisticated information systems, the Specialty Drug Benefit enables plan members to enhance their clinical outcomes and gain control over their out-of-pocket (OOP) expenses.

Members will be responsible for their co-payment for all drugs that are determined to be self-administrable by the patient. Self-administrable medications are defined as medications that are typically administered subcutaneously (SC) and have patient instruction for use in the package insert (PI). Some intramuscular injections are also considered self-administrable due to frequency of injection and PI instructions for the patient on how to self-administer the drug. A co-payment applies at all locations where the drug can be obtained. If a self-administrable drug is administered in a doctor’s office, the member will be responsible for the office co-payment as well as the drug co-payment. If administered in the physician’s office, the co-payment is not applied to the pharmacy deductible or out-of-pocket maximum. Medications that are not self-administered are covered under the medical benefit.

RHP Total Care considers the following categories of drugs as specialty drugs:

- **Analgesics**
  - Arava
  - Enbrel
  - Humira
  - Kineret
  - Simponi
- **Anti-Infectives**
  - Agenerase
  - Aptivus
  - Atripla
  - Baraclude
  - Combivir
  - Copegus
  - Crixivan
  - Cytovene
  - Emitriva
  - Epivir
  - Epivir HBV
  - Epzicom
  - Fuzeon
  - Hepsera
  - Infergen
  - Intelegence
  - Intron-A
  - Invirase
  - Isentress
  - Kaletra
  - Lexiva
  - Norvir
  - Noxafil
  - Pegasys
  - Peg Intron
  - Prezista
  - Rebetol
  - Rebetron
- **Anti-Infectives (continued)**
  - Rescriptor
  - Retovir
  - Reyataz
  - Selzentry
  - Sustiva
  - Trizivir
  - Truvada
  - Tyzeka
  - Valcyte
  - Vfend
  - Videx
  - Videx EC
  - Viracept
  - Viramune
  - Viread
  - Zerit
  - Ziagen
  - Zyvox
- **Cardiovascular**
  - Exjade
  - Letairis
  - Revatio
  - Tracleer
  - Ventavis
- **Central Nervous System**
  - Avonex
  - Betaseron
  - Copaxone
  - Rebif
  - Rilutek
- **Dermatological**
  - Oxsooralen
  - Panretin
- **Dermatological (continued)**
  - Soriatane
  - Sulfamylon
- **Endocrine/Diabetes**
  - Arcalyst
  - Buphenyl
  - Forteo
  - Genotropin
  - Humatrope
  - Increlex
  - Lupron
  - Nutropin
  - Nutropin AQ
  - Nutropin Depot
  - Omnitrope
  - Orfadin
  - Protropin
  - Rebranex
  - Saizen
  - Sensipar
  - Serostim
  - Stimate
  - Sucraird
  - Synarel
  - Tev-Tropin
  - Trelstar
  - Zavesca
  - Zoladex
  - Zorbtive
- **Immunosuppressants/ Antineoplastics**
  - Actimmune
  - Afinitor
  - Alkeran
<table>
<thead>
<tr>
<th><strong>Immunosuppressants/ Antineoplastics (continued)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Aranesp</td>
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<tr>
<td>- Arimidex</td>
</tr>
<tr>
<td>- Aromasin</td>
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<tr>
<td>- CeeNU</td>
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<td>- Cellecept</td>
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<td>- Emcyt</td>
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<td>- Epogen</td>
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<td>- Ergamisol</td>
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<td>- Femara</td>
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<td>- Gleevec</td>
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<td>- Hexalen</td>
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<td>- Hycamtin</td>
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<td>- Iressa</td>
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<td>- Leukeran</td>
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<td>- Leukine</td>
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<td>- Lysodren</td>
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<th><strong>Immunosuppressants/ Antineoplastics (continued)</strong></th>
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<td>- Matulane</td>
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<td>- Myfortic</td>
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<td>- Néoral</td>
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<td>- Roferon-A</td>
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<td>- Sandostatin</td>
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<td>- Spryclol</td>
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<th><strong>Immunosuppressants/ Antineoplastics (continued)</strong></th>
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<td>- Tarceva</td>
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<td>- Thioguanine</td>
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<td>- VePesid</td>
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<td>- Vesanooid</td>
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<th><strong>Other Specific Medications</strong></th>
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<td>- Cimzia</td>
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<td>- Kuwan</td>
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<td>- Restasis</td>
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<td>- Syprine</td>
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Medications that fall under the categories listed on the previous page and above *cannot* be obtained through the informedRx Retail Network. There are three options for obtaining these medications:

1. Cleveland Clinic Pharmacies in Cleveland and Weston
2. Cleveland Clinic Home Infusion Pharmacy in Cleveland (injectables only)
3. informedRx Specialty Drug Program — toll-free at 1-800-850-9122
What Can You Do If You Have a Grievance with informedRx Medicare PDP Gold?

You, or your appointed representative, may file a grievance with informedRx orally, or in writing within 60 Days of the Event or Incident That Brought About the Grievance.

Written requests can be mailed to: informedRx Medicare PDP Gold, 26 Harbor Park Drive, Port Washington, NY 11050 or Fax: 1-866-511-2202

Oral requests can be made by calling informedRx toll-free Customer Care Center at: 1-866-443-1095 / TTY/TDD 1-866-443-1094

When Can You Expect a Response by informedRx?

informedRx will notify the enrollee as expeditiously as the enrollee’s health requires but no later than 30 days after the date that informedRx receives the Grievance. Please note that informedRx has the right to extend this deadline up to 14 calendar days if the additional information and/or documentation needed is in the best interest of the enrollee. Enrollees will be notified in writing if an extension is needed.

Under certain circumstances, informedRx is required to respond within 24 hours when a grievance involves a refusal by informedRx to grant an enrollee’s request for an expedited coverage determination or expedited redetermination, or when the enrollee has not yet purchased or received the drug in dispute.

If the enrollee addresses two or more issues in one complaint, each issue will be processed separately. All grievances and related resolution notes will be tracked by the informedRx call tracking application regardless of the method used to file the grievance.

Each grievance issue will be forwarded to the appropriate department for review and resolution (where applicable) if he grievance in question cannot be resolved immediately by informedRx’s Customer Care Center.

All grievance resolutions and follow-up will be made as follows:
- In writing if the request was made in writing.
- By telephone if the request is made orally.
- In writing if the grievance is related to quality of care, regardless of how the request was filed with informedRx.
# Appeals Process

## Cleveland Clinic Retiree Health Plan and informedRx Appeals Process

If your request for Coverage Determination (Tier, Quantity Limit, or Non-Formulary Exceptions) is denied, there are five levels to help obtain your medication. Cleveland Clinic will assist with all determinations.

### First Level

If you received an adverse decision on your coverage determination request, you, your authorized representative, or your doctor can submit a written or oral request for a **Redetermination** to:

informedRx, 26 Harbor Park Drive, Port Washington, NY 11050
or call toll-free at 1-800-626-0072 or Fax: 1-866-511-2201.

You have **60 days** to file a request for a **Redetermination**, and it must be decided within **seven days**. If seven days is too long to wait you or your doctor can request an **Expedited Redetermination**, which must be decided within **72 hours**.

**Note:** This only applies if your health would be seriously jeopardized during a standard request review period.

### Second Level

If you received an adverse decision on your redetermination request, you, your authorized representative, or your doctor can submit a written request for a **Reconsideration**, which is handled by an Independent Review Entity (IRE), to:

Maximus Federal Health Services, Part D QIC, 1040 First Avenue, Suite 200, King of Prussia, PA 19406.

You have **60 days** to file a request for a **Reconsideration** and it must be decided within **seven days**. If seven days is too long to wait, you or your doctor can request an **Expedited Reconsideration**, which must be decided within **72 hours**.

### Third Level

If you received an adverse decision on your reconsideration request, you can request a hearing before an **Administrative Law Judge (ALJ)**, as long as the amount in controversy is at least $110. You must ask for this hearing within **60 days**, and the decision must be made within **90 days**. Requests can be made by writing the entity specified on the reconsideration letter sent to you.

### Fourth Level

If you received an adverse decision by the **Administrative Law Judge (ALJ)**, you can ask the **Medicare Appeals Council (MAC)** to review the ALJ’s decision. You must ask for this review within **60 days**, and the decision must be made within **90 days**. Requests can be made in writing to CMS MAC (address provided by the ALJ denial letter).

### Fifth Level

If you received an adverse decision by the Medicare Appeals Council (MAC), you can take your case to **Federal District Court**, as long as the amount in controversy is at least $1,090. Requests can be made to the entity specified on the MAC’s decision letter sent to you.
Exclusions

Cleveland Clinic
Retiree Health Plan Total Care Coverage Exclusions

Coverage is Not Provided for the Following Services and Supplies:

General Exclusions

1. Treatment that is not a covered service, even if authorized or deemed medically necessary by your physician.
2. Care which is not medically necessary and/or has not received precertification. If precertification is required and NOT obtained, RHP Total Care is not obligated to reimburse for services even if it is a covered benefit.
3. Any treatment not recommended or approved by a physician or medical provider.
4. Medical services that do not benefit the insured (e.g., organ donation or genetic testing).
5. Services provided by a member of your immediate family.
6. Services that are not reasonable or necessary for the diagnosis or treatment of sickness or injury, including a non-medically necessary circumcision for a non-newborn or non-newly adopted child, or any services associated with the use of general anesthesia when local anesthesia would be acceptable.
7. Expenses payable in your behalf under Medicare, whether you are enrolled or not.
9. Services received under the following circumstances:
   • Physical examinations or services required by an insurance company to obtain insurance;
   • Physical examinations or services required by a governmental agency such as the Federal Aviation Administration, Department of Transportation, and Immigration and Naturalization Services;
   • Physical examinations or services required by an employer in order to begin or continue working, unless medically necessary;
   • Premarital examinations and associated required testing; or
   • Physical examinations or screening test for professional school or private school.
10. Services provided at no charge or that normally would not generate a charge in the absence of this or another insurance plan.
11. Services provided by a hospital or institution maintained by the U.S. government.
12. Treatment for any sickness or injury caused by war, acts of war or similar events — whether the war is declared or undeclared.
13. Treatment for sickness or injury contracted while in any branch of the armed forces.
14. Treatment for sickness or injury incurred while committing a felony, or other criminal activity.
15. Expenses reimbursed for which you are entitled to reimbursement through any public program.
16. Services or expenses that are prohibited by laws in the area in which you live.
18. Services for educational, vocational, or training purposes unless for an underlying medical condition.
19. Services of any kind for developmental, diversional, or recreational purposes.
20. Charges associated with telephone consultations, missed appointments, completion of claim forms, or copies of medical records.
21. Expenses associated with custodial, domiciliary, convalescent or intermediate care.
22. Hospitalization for “rest cures” or convalescence in a nursing home.
23. Charges incurred for care in which the member left the medical facility against medical advice (AMA).
24. Bathroom convenience items including but not limited to tub rails, handrails and elevated toilet seats.
25. Charges for experimental or investigational procedures, drugs, devices, or medical treatments.
26. Marymount Hospital retirees are subject to family planning exclusions, including all abortions, 
vaginal dilation and curettage, Norplant, Depo-Provera, IUD, tubal ligation, and oral contraceptives except if medically necessary.
27. Services related to gender reassignment.
28. Services that would normally be reimbursed by Corporate Health.
29. Personal clothing or comfort items such as orthopedic shoes, diabetic shoes, wigs, or hygiene items.
30. Non-covered services or services specifically excluded in the text of this Summary Plan Description.
31. Care that occurred prior to your effective date or after your coverage has been terminated.

**Medical Coverage Exclusions**

32. Expenses solely for cosmetic procedures or complications from cosmetic procedures.
33. Expenses for the treatment of obesity unless treatment has received precertification through the EHP Medical Management Department.
34. Services or expenses incurred for a second bariatric surgery.
35. Expenses for the treatment of Temporomandibular Joint Syndrome (TMJ) unless treatment has received precertification through the EHP Medical Management Department.
36. Charges associated with teeth or periodontia unless specifically defined elsewhere in this Summary Plan Description.
37. Reversal of voluntary infertility.
38. Doula services.
40. Services provided for fitting of contact lenses unless the contact lenses are required because of an ophthalmologic condition that **CANNOT** be corrected by glasses.
41. Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
42. Hearing aid *accessories*.
43. Charges associated with the rental or purchase of durable medical equipment (DME) when rental expense exceeds purchase price, or for replacement of equipment that is less than five years old or that can be repaired.
44. Sales tax on medical supplies/DME items.
45. Over-the-counter DME products, (*i.e.*, breast pumps).
46. Rehabilitation (lift) chairs.
47. Home defibrillators.
48. Take home supplies.
49. General orthotics that can be purchased over-the-counter including devices such as splints, shoe inserts, arch supports, and braces.
50. Retrieval and implantation of non-human or artificial organs.
51. Harvesting of human organs or bone marrow when the **recipient is not** an RHP Total Care member.
52. Hypnosis.
53. Massage therapy even if provided by a physical therapist.
54. Alternative and homeopathic therapies.
55. Alternative Care Programs.
56. X-rays taken in a chiropractor's office.
57. Treatment for paring of corns and calluses or trimming of toenails, unless the patient has complications associated with circulation or diabetes.
58. Full body CT scans.
60. Hepatitis A Immunization unless member has received precertification by the EHP Medical Management Department.
61. Nasal flu vaccine, FluMist for members greater than 18 years of age. (FluMist is covered for members ages 2 to 18.)
62. Travel Clinic and related services (e.g., immunizations, medications).
63. Sclerotherapy for spider veins.
64. Unattended electrical stimulation.
65. Cervical home traction units.

**Behavioral Health Coverage Exclusions**

66. Treatment, testing, or forensic evaluations that are Court ordered or recommended as a condition of probation or parole or for any other reason including child custody. This applies to residential, inpatient, PHP, IOP, or outpatient levels of care unless they are medically necessary and have received precertification from the EHP Medical Management Department.
67. Services for mental illnesses that cannot be treated; however, services to determine if the mental illness is treatable are covered.
68. Services for mental deficiency or mental retardation, except for services rendered for necessity of evaluation of diagnosis of mental deficiency or retardation.
69. Athletic performance enhancement training, evaluation, or counseling.
70. Services required by an employer in order to begin or continue working, unless they are medically necessary and have received precertification from the EHP Medical Management Department.
71. Services for weight control or reduction that are not related to a primary Axis I disorder such as Anorexia or Bulimia.
72. Behavioral modification programs unless authorized through Behavioral Health.
73. Report writing and/or court testimony for any purpose.
74. School meetings for any purpose.
75. Time spent traveling or travel expenses incurred by a service provider.
76. Any travel expenses for a member other than for emergency transport by a private ambulance service or non-emergent transport that has received precertification from the EHP Medical Management Department.
77. Residential level of care solely for the purpose of treating nicotine and/or smoking addictions (excluding marijuana).
78. Halfway houses.
79. Telephone counseling services or school meetings by outpatient behavioral health practitioners.
Prescription Drug Benefit Exclusions

80. The replacement of lost or damaged prescriptions. Stolen medications will be covered at the plan rate when accompanied by a police report.

81. Drugs prescribed for the treatment of sexual dysfunction.

82. Drugs to enhance libido function.

83. Vitamins and nutritional supplements that can be purchased without a prescription.

84. Drugs used for experimental or investigational purposes.

85. Drugs that can be purchased without a prescription.

86. Drugs used for cosmetic purposes.

Refer to the Prescription Drug Benefit chart on page 45 and see the Drugs & Items at Discounted Rate and Non-covered Drugs & Items for additional exclusions.
Mission

To manage the retiree health plan benefits in a manner that is consistently customer-focused, quality-oriented, and fiscally responsible.

Communication and Service

The Cleveland Clinic Employee Health Plan (EHP) Total Care continually updates members about new initiatives or changes regarding their health plan coverage. It is our goal to do this through the HealthWise Bulletin, through the local hospital newsletter, and through the centralized Cleveland Clinic Employee Health Plan (EHP) Total Care Customer Service Unit available during business hours.

EHP Total Care Customer Service Unit

The EHP Total Care Customer Service Unit is open Monday through Friday from 7:30 a.m. to 3:30 p.m. A trained representative is available to answer health plan benefit questions. The Customer Service Unit will be able to assist you with medical, behavioral health/substance abuse, and prescription drug questions and issues. If you have questions regarding any other benefit coverage you must contact the Benefits Department.

The Cleveland Clinic Employee Health Plan Total Care Customer Service Unit is responsible for providing key information regarding RHP Total Care benefits. You can contact us by:

Phone: 216-448-0800 or toll-free 1-866-811-4352
Fax: 216-448-0326
E-mail: cehpao@ccf.org
Mailing address:
   Cleveland Clinic Employee Health Plan Total Care
   Customer Service Unit / AC332b
   3050 Science Park Drive
   Beachwood, OH 44122
### Cleveland Clinic Employee Health Plan (EHP) Total Care Customer Service Unit

- Eligibility Verification
- Benefit Determination
- Referral/Claims Issues
- Network Provider Questions
- General Health Plan Questions
- EHP Wellness

| Phone numbers: 216-448-0800 | E-mail address: cehpao@ccf.org |
| Fax number: 216-448-0326 |

### Cleveland Clinic Benefits Department

- Life Events
- Short-Term Disability
- Salary Continuation
- Savings & Investment Plan
- PayFlex
- Retirement/Pension
- Dental/Vision
- COBRA

| Phone number: 216-448-0600 |
| Fax number: 216-448-0637 |

### Antares Management Solutions (Antares) Customer Service (Cleveland Clinic RHP Total Care TPA)

| Phone number: toll-free 1-800-451-7929 |
| Mailing address: P.O. Box 89472 Cleveland, OH 44101-6472 |

### EHP Total Care Medical Management and Pharmacy Department (Medical, Behavioral Health, and Pharmacy Services)

- Precertification for Medical Necessity and Notification
- Coordinated Care Programs
- Case Coordination
- Formulary Drug Review
- Pharmacy Coordination Programs

| Phone numbers: 216-986-1050 | Web address: www.chnetwork.com |
| or toll-free 1-888-246-6648 |
| Fax number: 216-901-2050 |

### Prescription Drug Benefit

- Cleveland Clinic Pharmacy Information Hotline
  - Phone numbers: 216-445-MEDS (6337) or toll-free 1-800-CCF-CARE, (223-2273), ext. 52100
  - Web address: www.clevelandclinic.org/pharmacy

- Home Delivery Service
  - Phone number: 216-328-6075
  - Fax number: 216-328-6076

- Cleveland Clinic Home Infusion Pharmacy (injectables only)
  - Phone numbers: 216-444-HOME (4663) or toll-free 1-800-263-0403

- informedRx phone numbers:
  - Medicare Primary Retirees: 1-866-443-1095
  - All Other Retirees: 1-800-880-1188
  - Web address: www.myinformedrx.com

For MEDICARE information: toll-free at 1-800-Medicare (1-800-633-4227)
Appeal Process

The Cleveland Clinic Employee Health Plan (EHP) Total Care has established an appeal process for medical, behavioral health/substance abuse, pharmacy, dental or vision coverage including:

1. A determination regarding benefits under the program(s).
2. Appropriateness of reimbursement.
3. Medical necessity and appropriateness of the services furnished or proposed to be furnished.
4. Appropriateness of the setting in which the services were or are proposed to be furnished.

Routine Appeal Process

Prior to initiating the appeal process with Cleveland Clinic Employee Health Plan Total Care, the member must contact the Third-Party Administrator (TPA) Customer Service Department and complete the TPA appeal process. If the situation is not resolved to the retiree’s satisfaction through the TPA appeal process, the retiree should contact the Cleveland Clinic Employee Health Plan Total Care Customer Service Unit at 216-448-0800 or toll-free at 1-866-811-4352. Before calling, the retiree must have all the information and paperwork sent to and received from the TPA as well as the name and phone number of the contact person at the TPA. The Cleveland Clinic Employee Health Plan Total Care Customer Service Unit will instruct the member on the next steps to take to resolve the issue and can provide you with the appropriate Appeal Form.

A routine appeal must be resolved within 45 days of the initial request if the required documents to conduct the appeal are submitted. Appeals must be submitted within 180 days of the date of initial coverage decision.

Expedited Appeal Process

If the appealing party believes that the initial determination could seriously jeopardize the life or health of the retiree or the retiree’s dependent or the ability to regain maximum function, Cleveland Clinic Employee Health Plan Total Care will consider this a request for an expedited appeal. Cleveland Clinic Employee Health Plan Total Care personnel, in consultation with the Cleveland Clinic Employee Health Plan Total Care Chief Medical Officer, reserve the right to disallow the retiree use of the expedited appeal process if, in the sole exclusive opinion of the Chief Medical Officer, a non-expedited appeal would in no way seriously jeopardize the life or health of the retiree or retiree’s dependent. Such appeals will follow the Appeal Process guidelines. Expedited appeals must be resolved within 72 hours of the initial request. Cleveland Clinic Employee Health Plan Total Care will immediately research the adverse determination by:

1. Reviewing all supporting written documentation in Cleveland Clinic RHP Total Care’s possession.
2. Making reasonable efforts to obtain additional documentation if indicated.
3. Discussing the matter with the TPA, the EHP Medical Management Department, the retiree, physician, or ancillary provider.
4. Discussing the matter with the individual who made the initial determination.

Role of Cleveland Clinic Employee Health Plan Total Care Advisory Committee

If it is determined that the appeal cannot be resolved through the TPA, Cleveland Clinic Employee Health Plan (EHP) Total Care, or Compensation/ Benefit review process, the case will be forwarded to the Health Plan Advisory Committee (HPAC) for Third Level Appeal Review. Physician members of the Cleveland Clinic Employee Health Plan Total Care Advisory Committee must hold a current, active, unrestricted license to practice and be Board Certified. Committee members include EHP Total Care Chief Medical Officer, Senior Director, Legal Counsel, Senior Director Compensation and Benefits, Cleveland Clinic Medical Director, Director of Health and Welfare Benefits, Director of Retirement/Voluntary Benefit Plans, Director, EHP Medical Management, EHP Total Care Pharmacy Director, and Behavioral Health representatives. Appeal decisions made by Cleveland Clinic Employee Health Plan Total Care or the HPAC are final and binding. If you are dissatisfied with an appeal decision, refer to Section Six, page 66, “A Statement of Your Rights Under ERISA.”
Reimbursement and Subrogation Rights of the Plan

This Section of this Summary Plan Description addresses the Cleveland Clinic Retiree Health Plan’s (referred to as the “Plan”) “subrogation” and “reimbursement” rights. The terms “Covered Person,” “Third Party,” “Claim,” and “Claim Proceeds” are defined at the end of this Section.

First, this Plan does not provide any benefits to a Covered Person to the extent that there is any other type of non-healthcare insurance coverage that would provide reimbursement for a Covered Person’s medical expenses (including auto insurance that provides underinsured and non-insured motorist coverage, and insurance maintained by Cleveland Clinic or its affiliates on retirees and insurance maintained by other employers).

Second, if a Covered Person has a Claim against a Third Party, this Plan will provide benefits to, or on behalf of, a Covered Person only under the following terms and conditions:

1. To the extent that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Person’s Claims against any Third Party. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure the subrogation rights of the Plan. The Covered Person shall do nothing to prejudice the subrogation rights of the Plan. By submitting a claim for benefits under the Plan, the Covered Person hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing subrogation forms and in giving such information surrounding any accident or other set of facts and circumstances as the Plan or its representatives deem necessary to fully investigate and enforce the Plan’s subrogation rights.

2. The Plan is also granted a right of reimbursement from any Claim Proceeds. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph 1, but only to the extent of the benefits provided under this Plan.

3. The Plan, by providing benefits hereunder, is hereby granted a lien on any Claim Proceeds intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the Claim Proceeds and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person and his/her representatives agree to hold the Claim Proceeds in trust for the benefit of the Plan to the extent of 100% of all benefits paid by the Plan on behalf of the Covered Person.

4. By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any Claim Proceeds. This assignment is binding on any attorney who represents the Covered Person whether or not an agent of the participant and on any insurance company or other financially responsible party against whom a Covered Person may have a claim.
5. The subrogation and reimbursement rights and liens apply to any Claim Proceeds received or payable to the Covered Person, including but not limited to the following:
   a. Payments made directly by a third party tortfeasor, or any insurance company on behalf of a third party tortfeasor, or any other payments on behalf of a third party tortfeasor.
   b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
   c. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as the result of negligence or alleged negligence of a third party.
   d. Any workers compensation award or settlement.
   e. Any recovery made pursuant to no-fault insurance.
   f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

6. No adult Covered Person hereunder may assign any rights that such person may have to recover medical expenses from any Third Party to any minor child or children of said adult Covered Person without the prior express written consent of the Plan. The Plan’s right to recover (whether by subrogation or reimbursement) shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.

7. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

8. The Plan’s rights of subrogation and reimbursement shall be a prior lien against any Claim Proceeds, and shall not be defeated nor reduced by the application of any so-called “Make-Whole Doctrine,” “Rimes Doctrine,” or any other such doctrine purporting to defeat the Plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Plan’s rights of subrogation and reimbursement provide the Plan with the right to receive the first dollars of any Claim Proceeds, irrespective of whether the Covered Person has been fully compensated or partially compensated for all or any of injuries, damages or other claims of the Covered Person.

9. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder, specifically, no court costs or attorneys fees may be deducted from the Plan’s recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called “Fund Doctrine,” or “Common Fund Doctrine,” or “Attorney’s Fund Doctrine.”

10. The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.

11. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

12. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Covered Person has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

13. Any reference to state law in any other provision of this Plan shall not be applicable to this provision if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

For purposes of this Section:

“Covered Person” includes, individually and collectively, a participant, beneficiary or any other covered person under this Plan. A reference to a Covered Person includes the Covered Person’s estate and any representative of the Covered Person.
“Third Party” refers to any person or entity who, with respect to a claim for benefits of a Covered Person, is not the Covered Person (e.g., a third party tortfeasor). References to a Third Party include, without limitation, any auto or other insurer that provides coverage of any kind (including non-insured or underinsured motorists coverage) to the Covered Person or to any Third Party, including insurers that provide coverage to retirees of the Cleveland Clinic or another employer. The term Third Party also may refer to another person who is a Covered Person under this Plan.

“Claim” means any type of legal, equitable, insurance, or other claim that a Covered Person (or any representative of the Covered Person) has against a Third Party, if that claim could, or would, provide any amount of money or other consideration to the Covered Person because of, or in any way attributable to, the Covered Person’s claim for benefits under this Plan, or because of any set of facts and circumstances that are in any way related to the Covered Person’s claim for benefits under the Plan. The reference to a Covered Person’s Claims includes, without limitation, claims of pain and suffering and loss of consortium, as well as claims for consequential, punitive, exemplary or other damages.

“Claim Proceeds” includes any money or other consideration recovered from, or payable by, any Third Party that is attributable to a Claim of a Covered Person. Claim Proceeds includes, without limitation, amounts received by settlement, judgment or otherwise, and any insurance proceeds of any kind, or in satisfaction of any judgment or settlement, insurance claim of any kind, or otherwise. Claim Proceeds includes, without limitation, proceeds received by a Covered Person for claims of pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is Federal law that pertains to group health plans. HIPAA has the following three basic provisions:

• It prohibits an employer health plan from imposing pre-existing condition exclusions on retirees and dependents, except in limited, specified circumstances and for limited periods of time.
• It prohibits an employer health plan from prohibiting enrollment or charging a higher retiree contribution amount or premium because of “health status-related factors.”
• It requires an employer health plan to allow enrollment for retirees and dependents who lose coverage under other plans or insurance policies.

Any other questions or issues related to the HIPAA law should be directed to your local Benefits Department.

Employee Retirement Income Security Act of 1974 (ERISA)

About the Cleveland Clinic Retiree Health Plan (RHP) Total Care

The official name of this health plan is the Cleveland Clinic Retiree Health Plan Total Care. It is part of the retiree benefit program of the Cleveland Clinic and Regional hospitals and provides medical benefits to retirees and their family members. The Cleveland Clinic RHP Total Care is on file with the U.S. Department of Labor under employer identification number 34-0714585. The Cleveland Clinic RHP Total Care number is 510.

Plan records are kept on a calendar year basis with the Plan year from January 1 through December 31. Copies of the latest full annual report or other materials pertaining to the Plan are available at:

Cleveland Clinic Employee Health Plan Total Care
Customer Service Unit / AC332b
3050 Science Park Drive
Beachwood, OH 44122

A reasonable charge may be made to cover the cost of reproduction of these materials.
This booklet describes the Cleveland Clinic Retiree Health Plan Total Care as in effect January 1, 2010.

The Cleveland Clinic Retiree Health Plan Total Care’s agent for service of legal process is:

Cleveland Clinic
Office of the Secretary and General Counsel / AC321
3050 Science Park Drive
Beachwood, OH 44122

Future of the Cleveland Clinic Retiree Health Plan (RHP) Total Care

Cleveland Clinic intends to continue the Cleveland Clinic Retiree Health Plan Total Care. However, Cleveland Clinic reserves the right to modify, suspend, or terminate the Cleveland Clinic RHP Total Care, or any part of it, any time. The decision to change or end the Cleveland Clinic RHP Total Care may be due to changes in federal or state laws governing retiree benefits, the requirement of the Internal Revenue Code or ERISA, or any other reason. A Health Plan change may provide for the transfer of Cleveland Clinic RHP Total Care assets and liabilities to another plan, split a plan into two or more parts, decrease benefits, or add/increase contributions for coverage. If such steps are planned, you will be given notice. You will also be informed of the effect of any material change in the Cleveland Clinic RHP Total Care or on your rights to benefits.

A Statement of Your Rights Under ERISA

As a participant in the Cleveland Clinic Retiree Health Plan (RHP) Total Care, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You, your spouse and your dependents may have the right to continue group health coverage if you lose coverage on account of a qualifying event. You or your spouse or dependents may have to pay for the coverage. Review this Summary Plan Description and the Plan documents regarding your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-existing Conditions Under Your Group Health Plan if You Have Creditable Coverage from Another Plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the retiree benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim was frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
Definition of Terms

Activities of Daily Living — The skill and performance of physical, psychological, and emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.

Against Medical Advice (AMA) — The act of an individual leaving the care of a medical facility without proper discharge by a physician.

Allowed Charges — Negotiated charges for allowed healthcare services as described in this SPD.

Behavioral Health Definitions — Levels of Care

1. **Outpatient Visits (OP)**: Ambulatory care, usually non-urgent, for problems or conditions that can be treated on a periodic basis.

2. **Intensive Outpatient Program (IOP)**: Similar to Partial Hospitalization Program (PHP) in that they are structured programs with a multi-disciplinary team approach and a variety of treatment modalities. The program is usually less restrictive than a PHP. Patients are more stable, considered low risk for self harm, can function in the community and manage some daily activities, but require more comprehensive services than can be provided at an outpatient level of care. The patient participates in the program a minimum of nine hours per week.

3. **Partial Hospitalization Program (PHP)**: Highly structured ambulatory, multi-disciplinary treatment program with a high staff to patient ratio. A psychiatrist must be available for consultation as needed on an ongoing basis. A PHP includes treatment modalities found in a comprehensive inpatient program. The program may be appropriate whenever a patient does not require 24 hour acute care hospitalization, but does need more comprehensive services than can be provided at an outpatient level of care. The program is open a minimum of 20 hours per week.

4. **Inpatient (IP)**: A medical facility that is licensed to provide 24 hour, 7 days per week medical care and provides a high degree of safety. The facility employs a multi-disciplinary staff that must include psychiatrists and nurses. Services are comprehensive and usually include medication management, individual, group and/or family psychotherapy, social services, milieu and activity therapy. Inpatient care is not the same as residential care. See page 33 for information regarding Residential Treatment.

Benefits Period — The period of time specified in the Schedule of Benefits during which covered services are rendered and benefit maximums are accumulated; the first and last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Cleveland Clinic and Regional hospitals — Fully integrated Healthcare Delivery System that covers all components of healthcare services including Medical Professional, Ambulatory (outpatient/office), Hospital, and Ancillary Services.

Cleveland Clinic consists of the following group of hospitals:

- Cleveland Clinic, Ashtabula County Medical Center, Cleveland Clinic Hospital for Children’s Rehabilitation, Euclid Hospital, Fairview Hospital, Hillcrest Hospital, Huron Hospital, Lakewood Hospital, Lutheran Hospital, Marymount Hospital, Medina Hospital, South Pointe Hospital, Cleveland Clinic Florida Hospital in Weston, and Cleveland Clinic Nevada.

Co-insurance — The payment the employee owes for services rendered when Cleveland Clinic Retiree Health Plan Total Care coverage is less than 100%; co-insurance payments usually accrue toward an annual out-of-pocket maximum and/or annual deductible.

Concurrent Review — This review is conducted either during an RHP Total Care member’s hospital stay or during the course of a prescribed treatment. The concurrent review may result in additional covered care that exceeds the original authorized EHP Medical Management Department approval.

Contracted Rate — The hospital rate and physician fee schedule that is paid by the Third-Party Administrator (TPA) for the RHP Total Care contract.

Co-payment — A dollar amount that you are required to pay at the time covered services are rendered; generally, a co-payment does **NOT** accrue toward an annual out-of-pocket maximum and/or annual deductible.
Covered Charges — Charges for medical services or procedures that are covered by Cleveland Clinic Retiree Health Plan Total Care.

Custodial Care — Care which does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:
• Administration of medication which can be self-administered or administered by a lay person; or
• Help in walking, bathing, dressing, feeding, or the preparation of special diets.

Deductible — An amount, usually stated in dollars, for which you are responsible each benefit period before the TPA will start to reimburse benefits.

Domiciliary — A temporary residence, such as for disabled veterans.

Effective Date — Health benefit coverage is effective on the first day of your active employment at Cleveland Clinic provided that you enrolled in Cleveland Clinic RHP Total Care.

Emergency — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
• Serious jeopardy to the health of the individual, or, in the case of a pregnant woman, the health of the woman or her unborn child; or
• Serious impairment to bodily functions; or
• Serious dysfunction of any bodily organ or part.

Examples of emergency medical conditions include, but are not limited to:
• Chest pain
• Stroke/CVA
• Loss of consciousness
• Hemorrhage
• Multiple trauma

An emergency condition may or may not result in an inpatient hospital admission.

Experimental or Investigational — Drugs, Devices, Medical treatment, or Medical procedures that are not considered to be a standard of practice in this healthcare market for a particular diagnosis.

Explanation of Benefits (EOB) — A statement received by the patient from the TPA after services have been rendered that explains how the bill was paid.

Fee schedule — The rate the physician is paid by the TPA for the Cleveland Clinic RHP Total Care contract.

Hospital — An institution which meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio.

Identification (ID) Card — Card provided to individuals having group health benefit coverage listing the individual's name, group number, and important contact phone numbers to call to verify coverage for health, prescription, and behavioral health/substance abuse benefits. This card should be carried with you at all times.

Inpatient — A person who receives care as a registered bed patient in a hospital or other facility provider where a room and board charge is made.

Medical Care — Professional services received from a physician or another healthcare provider to treat a condition.

Medical Management — A comprehensive Physician-directed program utilizing Registered Nurses to provide education and follow-up to employees to assure the delivery of medically necessary, high quality, and cost-effective healthcare in the most appropriate setting. The EHP Medical Management Department provides Case Coordination and Coordinated Care Programs.
Medical Necessity — A service, supply, and/or prescription drug that is required to diagnose or treat conditions which Cleveland Clinic Retiree Health Plan Total Care (administered through the TPA) determines is:

- Appropriate with regard to the standards of good medical practice;
- Not primarily for your convenience or the convenience of a provider or another person; and
- The most appropriate supply or level of service that can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to prescription drugs, this means the prescription drug is cost effective compared to alternative prescription drugs that produce comparable effective clinical results. (See page 20 for complete information.)

Network Provider — A participating provider who has agreed to accept the Allowed Amount as payment in full for covered services rendered after applicable co-payment/co-insurance. The member is not liable for any amount charged over the Allowed Amount.

- RHP Total Care offers a two-tier provider network. Tier 1 providers are contracted and credentialed through the Cleveland Clinic Community Physician Partnership (CPP). Tier 2 providers are contracted and credentialed through their respective companies.

Non-Contracting — The status of a hospital or other facility provider which does not meet the definition of a contracting Cleveland Clinic Retiree Health Plan Total Care Provider.

Non-Covered Charges — Billed charges for services and supplies which are not covered services under EHP Total Care.

Notification — Process required by RHP Total Care of informing the EHP Medical Management Department that an emergency admission has occurred. Notification by the physician is required within two business days of the admission.

Out-of-Network — A provider that does not participate in the Tier 1 Network of Providers (Cleveland Clinic CPP Providers) or Tier 2 Network of Providers (CHN, MMO Traditional and USAMCO).

Out-of-Pocket Maximum — The accrued value of co-insurance payments that has to be satisfied before the reimbursement for covered services will be provided in full.

Outpatient — The status of a covered person who receives services or supplies through a hospital, other facility provider, physician, or other healthcare provider while not confined as an inpatient.

Participating — The status of a physician or other healthcare provider that has an agreement with Cleveland Clinic Retiree Health Plan Total Care to accept Allowed Amount as payment in full.

Physician — A person who is licensed and legally authorized to practice medicine.

Precertification — The process of verifying member eligibility and benefit coverage under RHP Total Care. Precertification also includes the process of determining whether or not a patient has met the medical necessity criteria outlined by RHP Total Care for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Precertification, predetermination, prior authorization and prior approval are often used interchangeably.

Predetermination — The process of verifying member eligibility and benefit coverage under RHP Total Care. Predetermination also includes the process of determining whether or not a patient has met the medical necessity criteria outlined by RHP Total Care for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Predetermination, precertification, prior authorization and prior approval are often used interchangeably.

Prescription Drug (Federal Legend Drug) — Any medication which by Federal or State law may not be dispensed without a prescription order.

Primary Care Providers (PCP) — Physician practices expert in providing diagnosis and treatment of illness and provision of preventive care; they also serve as coordinators of the overall care of their patients.
Prior Approval — The process of verifying member eligibility and benefit coverage under RHP Total Care. Prior Approval also includes the process of determining whether or not a patient has met the medical necessity criteria outlined by RHP Total Care for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Prior approval, precertification, predetermination and prior authorization are often used interchangeably.

Prior Authorization — The process of verifying member eligibility and benefit coverage under RHP Total Care. Prior Authorization also includes the process of determining whether or not a patient has met the medical necessity criteria outlined by RHP Total Care for medical, prescription drug, and behavioral health/substance abuse services. Approval for a service prior to the service being rendered. Prior authorization, precertification, predetermination and prior approval are often used interchangeably.

Provider — A person or organization responsible for furnishing healthcare services.

Registration — Process of verifying patient information including name, current address, phone number, insurance plan, and group number. The registration process must be completed anytime you receive a healthcare service.

Specialty Care Providers — Physician practices with expertise in a specific medical specialty or sub-specialty.

Student — Eligible/participating dependent attending a school, college, or university.

Surgery —
- The performance of generally accepted operative and other invasive procedures;
- The treatment of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonable and approved by EHP Total Care.

Urgent Care — Care received for medical conditions that are unforeseen and require attention within 24 hours. Examples of urgent care include, but are not limited to:
1. Minor cuts/lacerations
2. Minor burns
3. Minor trauma
4. Seemingly minor illnesses that include a high fever
5. Sprains

Usual and Customary Amount (U&C) — The maximum amount allowed for a covered service provided by a physician or other healthcare provider based on the following criteria:
1. The U&C Amount will never exceed the actual amount billed by the physician or other healthcare provider for a given service and for some services may be the amount billed.
2. The U&C Amount may be limited to the customary charge based on the distribution of charges billed by all physicians and other healthcare providers for a given service within a given specialty and geographic area.
3. The U&C Amount must also be reasonable as defined by the Cleveland Clinic Employee Health Plan Total Care TPA with respect to customary charges or costs for services of comparable complexity and difficulty.
Notes

Please use this page to keep a record of contact dates and names of correspondence for your personal records.