



## **Benefit Program Summary**

### **BeneFlex Program**

Cleveland Clinic's Flexible Benefits Program - **BeneFlex** - allows you to select benefits according to your individual and family needs. Coverage selected under the BeneFlex Program begins from your date of hire. During the calendar year, you are eligible to change your BeneFlex selections within 31 days of a "life event" (such as marriage, divorce, birth, etc.). Cleveland Clinic also provides an annual open enrollment period so that you have the opportunity to customize your BeneFlex options as your needs change.

### Eligible Dependents

Several of the BeneFlex options offer coverage for your eligible dependents. Under the BeneFlex Program, your eligible dependents include:

- 1) Your lawful spouse (not divorced or legally separated).
- 2) Your dependent children who are: unmarried, your natural children, stepchildren, legally adopted children, or children under an official court-appointed guardianship who are under the age of 23.
- 3) Your unmarried children age 23 or older and deemed to be disabled by the Social Security Administration. Proof of disability must be provided.
- 4) Your dependent children ages 19-23 who are enrolled in school as part-time or full-time students or your dependent children ages 19-23 for whom you provide principal financial support.

Under the Health Plan options, you need to choose **one of the following coverage categories:**

- employee only
  - employee + one child
  - employee + spouse
  - family I (2 or 3 dependents\*)
  - family II (4 or more dependents\*)
- \* spouse and/or children

For additional detailed information or a copy of these benefit program summaries, please contact the GME Department.

## **Health Plans**

The BeneFlex Program provides several choices for your consideration. Health plan options are the same throughout Cleveland Clinic except for Kaiser HMO, which is only offered at some locations.

Included in each of the health plans is the availability for your to access the CCHS Physician Organization, which is comprised of a comprehensive network of medical professionals, including Primary Care Physicians (PCP), specialists, hospitals and other healthcare providers. There are no pre-existing condition exclusions in any of the health plans offered by Cleveland Clinic.

Antares Management Solutions serves as the Third-Party Administrator (TPA) for the Cleveland Clinic Employee Health Plan (EHP). Antares processes claims for all medical services received by Cleveland Clinic EHP members. If you have specific questions regarding your coverage, please call the Cleveland Clinic EHP Customer Service Unite at 216-297-8800 or toll-free at 1-866-811-4352.

### **Cleveland Clinic Employee Health Plan**

The Cleveland Clinic Employee Health Plan (EHP) is a two-tier plan that provides the highest level of coverage when a service is provided by a member of the CCHS Physician Organization. The Plan is designed to allow open access to specialist when encouraging employees and dependents to utilize the service of a PCP. Tier 2 providers consist of members of Cleveland Health Network (CHN).

You can use either provider 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.

To confirm a provider's participation, you can call either Antares Management Solutions Customer Service Unit at 1-800-451-7929 or the Cleveland Clinic EHP Customer Services Unit.

- Tier 1: CCHS Physician Organization
  - No annual deductible.
  - PCP office visits and routine annual physical covered at 100% after \$10 co-payment.
  - Specialty Physician office visits and routine annual vision examination covered by 100% after \$25 co-payment.
  - Emergency and/or urgent care services covered at 100% after \$50 co-payment.
  - Medical/Surgical inpatient hospital services covered at 100%.
  - Durable medical equipment and medical supplies covered at 80%.

- Tier 2: Cleveland Health Network
  - Annual deductible \$500 per individual/\$1,500 per family.
  - PCP and Specialty Physician office visits covered at 100% following annual deductible and per visit co-payment.
  - Emergency and/or urgent care services cover at 100% after \$50 co-payment.
  - Medical/Surgical inpatient hospital services covered at 70% following annual deductible.

#### Out of Area Network Provider

The Employee Health Plan has a provision for members and eligible dependents who may require emergency/urgent care when traveling on vacation or college students attending college outside of the area. Cleveland Clinic (Tier 1) and CHN (Tier 2) networks. Out of area coverage is used for urgent and or non-routine care and follow up care pertaining to an acute injury or illness. All out of area coverage is subject to Care Management Program rules.

The out of area network provider in the State of Ohio is the Medical Mutual Traditional Network. You can access their Web site at [www.SuperMedNetwork.com](http://www.SuperMedNetwork.com) and click on “Traditional”. Effective January, 2008 the new out of area network provider in all other states will change to USA Managed Care Organization (USAMCO). Their web site address is [www.usamco.com](http://www.usamco.com). You can also contact both of these network providers by calling the phone number listed on the back of your Cleveland Clinic EHP ID Card.

#### **SummaCare Health Plan EPO**

As an Exclusive Provider Organization (EPO), the SummaCare Health Plan allows access to providers that are part of the SummaCare Network, which include members of the Cleveland Clinic and CHN Provider Networks. At the time of enrollment, employees and their dependents are required to select a Primary Care Physician (PCP) to receive coverage.

- SummaCare Network Providers.
- No annual deductibles or out-of-pocket maximums.
- PCP and Specialist office visits covered at 100% after \$15 co-payment.
- Hospital services covered at 100%.
- Outpatient Services covered at 100% after \$15 co-payment.
- Routine physicals and vision examinations covered at 100% after \$15 co-payment.
- No coverage if EPO Plan rules are not followed.

### **Kaiser Permanente HMO**

If you are employed at the Cleveland Clinic, Cleveland Clinic Children’s Hospital for Rehabilitation, Cleveland Clinic Home Care Services or Fairview, Lakewood, Lutheran, Marymount Hospitals, you have the option to elect health coverage through Kaiser HMO Plan.

- Kaiser Permanente Network of Providers.
- Ten Kaiser Permanente medical offices throughout Northeast Ohio
- Affiliated community physicians practicing in their own offices throughout Northeast Ohio
- Primary Care Physician required.
- Professional services covered at 100% after \$15 co-payment.
- Hospital services covered at 100%.
- Prescriptions covered at 100% after a \$10 generic/\$25 brand name co-payment.
- No coverage if HMO Plan rules are not followed.

### **Cleveland Clinic Prescription Program**

Prescription coverage is included with each of the health plans, and is the same regardless of which plan you choose. The Program is administered through Caremark and provides for both short-term and maintenance prescription coverage, which utilizing a Formulary to afford you greater discounts. Prior authorization may be required for non-generic drugs. As an enhancement, members using designated Cleveland Clinic Pharmacies will receive additional savings for generic, preferred brands, and non-preferred categories. After reaching a \$100 single deductible or \$300 family deductible, the plan reimbursement is as follows:

Generic Drug	80/20%
Preferred Brand Drug (Formulary)	70/30%
Non-Preferred brand (Non-Formulary)	50/50%
High-Tech Drug	80/20%

### **Dental Plans**

Dental insurance is provided to you and your eligible dependents **after** one year of service at no cost to you. The Traditional dent plan takes effect on the first of the month following your anniversary date.

A dental plan may be elected and cost associated with the election would be deducted from each pay during the first 12 months of training at the Clinic.

The Cleveland Clinic offers three (3) dental plan options are available under BeneFlex. The **CIGNA Dental Care Plan** is a dental HMO with no charges for most preventive services, no deductibles, and no annual or lifetime maximums. The **Traditional Plan** provides coverage for all types of dental services, while the **Preventive Plan** is designed for individuals who only need preventative and the basic services.

With the CIGNA dental PPO you may choose any provider. If you use network providers, your co-payment will be less due to the discounted rates the CIGNA network providers have agreed to accept.

Enrollment in the (payroll deducted) dental plan must be made within 31 days of your start date; otherwise you must wait until the annual open enrollment period.

Please refer to the 2008 BeneFlex New Hire Election Form for Dental Plan Costs.

**CIGNA Dental Care Plan (Dental HMO)**

Covered Services	Your Charge
<b>Preventive Care:</b> oral exams, routine cleaning, x-rays	no charge
<b>Basic Services:</b> amalgam (silver) fillings, simple extractions anterior root canal	no charge \$ 160
<b>Major Services:</b> crown – porcelain fused to high noble metal complete denture – maxillary	\$ 405 \$ 485
<b>Orthodontia:</b> orthodontic evaluation class I, II, III malocclusion- comprehensive treatment; children (up to 19 <sup>th</sup> birthday) adults	\$ 50 \$1500 \$2000

**Traditional and Preventive Dental Plans**

Covered Services	Traditional Plan		Preventive Plan
	In-Network	Out of Network	
<b>Preventive Care:</b> oral exams, cleanings, x-rays, etc	100%	100% R&C	100% R&C
<b>Basic Services:</b> fillings, oral surgery, extractions, etc.	80% after deductible	70% R&C after deductible	80% R&C after deductible
<b>Major Services:</b> dentures, crowns, etc.	50% after deductible	50% R&C after deductible	Not Covered
<b>Orthodontia:</b> (subject to lifetime maximum Benefit of \$1,000 per eligible covered dependent under age of 23)	50% after deductible	50% R&C after deductible	Not Covered

<b>Annual Deductible:</b>	Per Person	\$50	\$50	\$50
	Family	\$150	\$150	\$150
<b>Annual Benefit Maximum</b>		\$1,250	\$1,000	\$500
		per person	per person	per person

### Vision Plan

Cleveland Clinic offers the EyeMed Vision Care Plan, which provides the flexibility to purchase eyewear from your provider of choice, but also maximizes benefits by using providers who are part of the EyeMed Vision Care network. Additionally, once you use the benefits, you can receive discounts for additional pairs of eyeglasses/contact lenses purchased. Enrollment into this (payroll deduction) Vision Plan must be made within 31 days of your start date; otherwise you will need to wait until the annual open enrollment period.

Please refer to the 2008 BeneFlex New Hire Election Form for Vision Plan Cost.

Vision		Frequency	In Network	Out of Network
Covered Services				
<b>Standard Lenses:</b>	Single	12 months	covered in full	\$25
	Bifocal	12 months	covered in full	\$40
	Trifocal	12 months	covered in full	\$50
<b>Lens Treatment</b>		unlimited	discounts available	not covered
<b>Frames up to \$120 Retail</b>		12 months	covered in full	\$30
<b>Contact Lenses Up to \$100 Retail</b>		12 months	covered in full	\$70

### Flexible Spending Accounts

BeneFlex offers two **Flexible Spending Accounts (FSA)**, one for medical expenses not covered by health related expenses, such as front-end deductibles and co-payments for medical, dental, vision plans and prescription drugs, and one for qualified dependent/child care expenses. Contributions to either of these accounts are determined by you and funded with money you wish to contribute through pre-tax salary reduction.

These special accounts provide you with valuable tax advantages by allowing you to reimburse yourself for qualified expenses incurred by you or your eligible dependents with tax-free money. Your expenses must be incurred during the Plan Year and

submitted for reimbursement within the established time frame after the end of the Plan Year to be eligible for reimbursement

When making decisions about your Flexible Spending Accounts, it is important to remember the following:

- The money must be used for qualified related expenses
- The minimum amount you can deposit into the Medical Flexible Spending Account is \$100 per calendar year (unless you are depositing leftover PTO trade-in dollars), and the maximum amount is \$2,500 per calendar year.
- The minimum amount you can deposit into the Dependent Care Flexible Spending Account is \$100 per calendar year (unless you are depositing leftover PTO trade-in dollars), with the maximum amount of \$5000 per calendar year if you are single or you are married and filing a joint tax return. If you are married and you and your spouse file separate tax returns, the maximum amount you can deposit is \$2,500 per calendar year.
- Money cannot be transferred from one account to the other
- Money that you do not spend during the course of the Plan Year cannot be returned to you or carried over into the next calendar year. Therefore, it is extremely important that you carefully consider the amount that you wish to deposit into either or both of these accounts.

#### Taxes Avoided, Not Deferred

When you use the money in your FSA to pay for allowable expenses, you never have to pay tax on the money (according to current tax law). You do not defer taxes that have to be paid sometime in the future; you avoid paying taxes on this money altogether. Your withholding taxes, including social security tax will be calculated and withheld each payday on your reduced pay. So you do not have to wait until you file your income tax return to enjoy the tax advantages.

Some expenses eligible for FSA reimbursement also may be eligible for income tax deductions. However, you are allowed to save taxes only once. It is illegal to use FSA dollars to save taxes on an expense and also take another tax deduction for that expense on your income tax return. You should consult with your tax advisor if you have questions about which approach best meets your needs.

#### Reimbursable Expenses for Health Care Expenses

You may use the money in your Medical FSA to reimburse yourself for health care expenses. The entire amount of your annual election is available for reimbursement as soon as the Plan Year begins. Most health related and dental expenses not otherwise covered by CCHS or other benefit plans can be reimbursed if incurred by you or your dependents. To be eligible, the expense must be incurred in the year in which you select this option. Included are expenses incurred for:

- deductible and co-payment amounts for medical or dental services
- eye exams, glasses, contacts, and contact lens solutions
- hearing aids, batteries and exams

- reconstructive surgery
- dental expenses, orthodontia, dentures and bridges
- prescription drugs
- over the counter (non-prescription) medications such as antacids, allergy medicine, pain relievers and cold medicines, and
- therapeutic devices (such as hospital beds and whirlpools).

Reimbursable expenses do not include expenses paid for by any other plan or premiums for other insurance coverage.

#### Reimbursable Expenses for Dependent Care Expenses

If you are eligible, you may use the money in your Dependent Care FSA to pay for your dependents' care. The payroll deductions must be made to your FSA in order to receive reimbursement. So that you can receive these optional benefits tax-free, the plan has been designed to meet government regulations. To be eligible for the benefits, you must be at work during the time your dependents are receiving care, and be:

- single with an eligible dependent
- married with an eligible dependent and a spouse who is
  - a wage earner; or
  - a full time student for at least five months during the year, or
  - disabled and unable to provide for his or her own care.

If you meet the eligibility requirements, you may use your FSA to pay for the care of your dependents who:

- are under age 13 and included as exemptions on your federal income tax return, or
- are physically or mentally disabled, including your spouse or dependent parents, and unable to care for themselves. In addition, the disabled dependent must spend at least eight hours a day in your home.

The expenses covered by the plan on the days you are working include the charges for:

- licenses nursery schools and day care centers
- babysitting
- before and after school care
- summer day camp programs
- housekeepers in your home
- a relative who cares for your dependents
- home care specialists
- disabled dependent care at centers

#### Tax Information

Even though you may use the Dependent Care FSA to reimburse yourself for dependent care expenses, you will need to report the social security number or employer identification number of the caregiver to the Internal Revenue Service when you file your Federal income tax return. It will also be necessary to report the social security number or employer identification number of the caregiver each time you submit receipts for



reimbursement. The amount reduced from you pay for dependent care during the year will appear on your W-2 form.

**CONCERN – Employee Assistance Program (EAP)**

Cleveland Clinic and system hospital employees and their dependents continue to have direct and confidential access to CONCERN, and Employee Assistance Program (EAP). CONCERN offers assessment, short-term counseling, referral services and follow up to employees and family members who want assistance in dealing with personal problems or work-related issues. Employees and families who use this benefit receive 100% coverage with no co-payment or co-insurance.

This benefits allows for 10 visits in a calendar year. Your visits must be with a CONCERN EAP Provider. To schedule an appointment or obtain additional information about CONCERN, please call 216-445-6970 or toll-free at 1-800-989-8820.

**Marymount Behavioral Health Services (MBHS)**

All outpatient and inpatient behavioral health and/or substance abuse services require **prior authorization** by MGHS in order to receive the maximum benefit coverage.

MBHS business hours are from 8:30am until 4:30pm, Monday through Friday. A clinician is available for emergency call after hours. For further information, call the MBHS Customer Service Unit at 216-663-3925 or toll-free at 1-877677-2247.

**Life Insurance Coverage**

All trainees are insured for \$25,000 as of your actual hire date. The Life Insurance Policy is part of the Group Life Insurance held by Cleveland Clinic. This benefit is of no cost to you. Additional/Supplemental insurance is not available.

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**The following pages are description summaries of the 2008 Cleveland Clinic Employee Health Plans.**

**After review, if you have any questions, please contact the Cleveland Clinic Employee Health Plan Customer Service Unit at 216-297-8800 or 1-866-811-4352.**

**Please take the time to review the detailed information provided, and complete the 2008 BeneFlex New Hire Election Form.**

**It takes approximately 45 days from your start date to receive your insurance card(s). These card(s) are mailed to your home address.**

**Reminder - A social security number/card is required for enrollment into any of the Cleveland Clinic medical health plans. Therefore, GME would need to copy your actual social security card.**

# Cleveland Clinic Employee Health Plan Medical Summary

	CPP PROVIDERS	CHN PROVIDERS
FACILITIES	<i>Tier 1</i>	<i>Tier 2</i>
Annual Deductible		
Individual	None	\$500
Family	None	\$1,500
Out-of-Pocket Maximum		
Individual	\$1,500	\$5,000
Family	\$3,000	\$15,000
COVERED SERVICES		
PCP Office Visit Family Practice, Gynecology, Internal Medicine, Obstetrics and Pediatrics	100% of Allowed Amount after \$10 co-pay (No co-pay for blood pressure reads, blood draws and nurse visits)	\$25 co-pay (after deductible)
Specialist Office Visits	100% of Allowed Amount after \$25 co-pay (no referral required)	\$50 co-pay (after deductible)
Maternity Care	100% of Allowed Amount after one time \$50 co-pay	One time \$100 co-pay (after deductible)
Routine (Annual) Physical Examination by PCP	100% of Allowed Amount after \$10 co-pay	Not Covered
Routine (Annual) Vision Examination	100% of Allowed Amount after \$25 co-pay (no referral required)	Not Covered
Inpatient Hospital Services	100% of Allowed Amount	70% of Allowed Amount
Outpatient Hospital Services	100% of Allowed Amount	70% of Allowed Amount
Laboratory/Diagnostics Tests	100% of Allowed Amount	70% of Allowed Amount
Emergency Department ( <i>Emergency and/or Urgent Care</i> )	100% after \$50 co-pay	100% after \$50 co-pay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	80% of Allowed Amount (does NOT accumulate to out-of-pocket max)
Extended Care/Skilled Nursing Care — 180 Days per Benefit Year	100% of Allowed Amount	70% of Allowed Amount
Long-Term Acute Care — 180 Days Lifetime Maximum	100% of Allowed Amount	Not Covered
Hospice	100% of Allowed Amount	100% of Allowed Amount
Home Health Care — 100 Visits per Benefit Year	100% of Allowed Amount	70% of Allowed Amount
Acupuncture — Maximum of 20 Visits per Benefit Year	First 10 visits: 100% of Allowed Amount after \$10 co-pay Second 10 visits: 50% of Allowed Amount	Not Covered
Chiropractic — Maximum of 20 Visits per Benefit Year	First 10 visits: 100% of Allowed Amount after \$10 co-pay Second 10 visits: 50% of Allowed Amount (Children 16 and under require prior authorization through Care Management)	Not Covered
Therapy Services Occupational/Speech/Physical	100% of Allowed Amount after \$10 co-pay per visit	100% of Allowed Amount after \$10 co-pay per visit (does NOT accumulate to out-of-pocket max)
Dental — Surgical extractions for soft/bony impactions, or Dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning*	100% of Allowed Amount	Not Covered
Infertility		
Diagnostic	100% of Allowed Amount	Not Covered
Treatment	Subject to Medical Policy	Not Covered
Hearing Aids	50% of Charge up to \$2,000/Ear — Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant		
Transplant Lifetime Maximum	100% of Allowed Amount Unlimited	70% of Allowed Amount Unlimited
Out-of-Pocket Maximum	See Above	Unlimited

For Tier 1, all co-payments and co-insurance listed on this grid accumulate to your out-of-pocket maximum with the exception of co-payments for infertility benefits. For Tier 2 ancillaries, co-payments and co-insurance do NOT accrue to the out-of-pocket maximum.

\*Marymount employees are subject to family planning exclusions including abortion, vasectomy, Norplant, Depo Provera, IUD, tubal ligation, and oral contraceptives, except if medically necessary.

# Employee Health Plan and SummaCare EPO Prescription Drug Benefit Administered Through Caremark

The Following Is a Summary Overview of the Prescription Drug Benefit:

Categories	Tier 1 Generic Rx	Tier 2 Preferred Brands (Formulary)	Tier 3 Non-Preferred Brands (Non-Formulary)	Tier 4 Specialized Drugs (Hi-Tech)	Drugs & Items at Discounted Rate	Non- Covered Drugs & Items
Annual Deductible	\$100 Individual \$300 Family				No	No
Employee % Co-pay Cleveland Clinic Pharmacies — up to 90 Day Supply	15%	25%	45%	20%	Employee Pays 100% of the Discounted Price	Not Available through Rx Plan
Employee % Co-pay Retail — 30 Day Supply Mail Order — 90 Day Supply	20%	30%	50%	20%	Employee Pays 100% of the Discounted Price	Not Available through Rx Plan
Is there a Minimum or Maximum to the Rx % Co-pay — Cleveland Clinic Pharmacies?	Yes \$3 Minimum/ \$50 Maximum per Month Supply	Yes \$3 Minimum/ \$50 Maximum per Month Supply	No	Yes No Minimum/ \$75 Maximum per Month Supply	No	No
Is there a Minimum or Maximum to the Rx % Co-pay — Retail?	Yes \$5 Minimum/ \$50 Maximum per Month Supply	Yes \$5 Minimum/ \$50 Maximum per Month Supply	No	NA	No	No
Is there a Minimum or Maximum to the Rx % Co-pay — Mail Order?	Yes \$15 Minimum/ \$150 Maximum 90 Day Supply	Yes \$15 Minimum/ \$150 Maximum 90 Day Supply	No	Yes No Minimum/ \$300 Maximum 90 Day Supply	No	No
Is there an Annual Out-of-pocket Max?	Individual = \$1,500 / Family = \$4,500 Combined Maximums for Retail and Mail Order				No	No
Components of Each Category	Generic Drugs	Brand Drugs See Formulary Guide  It identifies <i>both</i> Formulary and Non-Formulary medications. It also identifies Formulary alternatives for Non-Formulary medications.		Specialty Drugs* Antirejection Therapies Antivirals Blood Modifying Agents Cystic Fibrosis Therapies Gn RH Analog Growth Hormone Hemophilia Therapies Intravenous Immunoglobulin Interferons Multiple Sclerosis Therapies Oncology Therapies Rheumatoid Arthritis Therapies Other Medications: • Actimmune • Forteo • Raptiva • Regranex • Restasis • Rilutek • Sensipar • Soritane • Tracleer • Vfend • Zyvox	Life Style Drugs Benzoyl Peroxide Only Agents Caverject Cialis Clarinex Cosmetic Agents Denavir Cream Edex Fertility Agents Levitra Muse Non-controlled Cough and Cold Agents Penlac Propecia Relenza Tamiflu Topical Androgen Products Viagra Weight Control Products Zovirax Ointment	Over-the-Counter Alcohol Swabs DME (Durable Medical Equipment) Medical Devices Medical Supplies
Is Prior Authorization Required?	No	• Amevive • Boniva IV • Botox • Enbrel • Forteo • Growth Hormone • Humira • Kineret • Myobloc • Raptiva • Respigam/Synagis • Retin A >35 Yrs. Old • Rheumatoid Arthritis Therapies • Xolair			No	NA
Diabetic Supplies and Asthma Delivery Devices	Co-pay 20%			No	No	NA
Major Chains in the Retail Network	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.					

(1) Plan Includes: oral contraceptives — *EXCEPT Marymount plan participants — coverage provided only for medical necessity.*

(2) Diabetic Supplies — Insulin and all diabetic supplies covered. Includes: needles purchased separately, test strips, lancets, glucose meters, syringes and injection pens.

(3) Asthma Delivery Devices: includes spacers used with asthma inhalers.

\*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. Caremark Specialty Drug Program.

# SummaCare Health Plan EPO\*

SummaCare Health Plan	
Customer Service Telephone No.	1-800-753-8429
Facilities	SummaCare Hospitals
Annual Deductible — Single or Family	None
Out-of-Pocket Maximum — Single or Family	None
COVERED SERVICES	
PCP Requirement	Yes
PCP Office Visits	\$15 co-pay
Specialist Office Visits	\$15 co-pay
Routine Physical Examination	\$15 co-pay
Routine Vision Examination	\$15 co-pay
Maternity Care	100%
Infertility Diagnostic Treatment	\$15 co-pay Subject to Medical Policy
All Therapy Services	\$15 co-pay
Emergency Department (Emergency and/or Urgent Care)	\$50 co-pay
Durable Medical Supply	100%
Hospital Services	100%
Outpatient Services	\$15 co-pay
Extended Care/Skilled Nursing Care — 100 Day Maximum	100%
Home Health Care 30 Visits Maximum	100%
Dental Extractions Due to Accident TMJ Dental Implants Due to Accident Only or Certain Medical Conditions	\$15 co-pay Not Covered \$15 co-pay
Hearing Aid	Not Covered
Organ Transplant Transplant Lifetime Maximum Out-of-Pocket Maximum	100% None None

\*The benefits listed above are only a summary. Detailed benefit information and exclusions are available on request.

# Kaiser Permanente HMO\*

	Kaiser Permanente
<b>Customer Service Telephone No.</b>	<b>1-800-686-7100</b>
<b>Facilities</b>	<b>Kaiser Permanente</b>
Annual Deductible — Single or Family	None
Out-of-Pocket Maximum — Single or Family	None
<b>COVERED SERVICES</b>	
<b>Outpatient Care</b> Office Visits Including: Physician Exams, Allergy Testing, Well-Child Care, Hearing Tests Minor Surgery Specialist's Treatment Vision Exams Available Through Affiliated Providers  Prenatal Care Urgent Care: At Kaiser Permanente Facilities or Outside the Service Area  Urgent Care: Inside Service Area  Short-term Physical, Speech, and Occupational Therapy (Up to Two Months or 30 Visits per Therapy, Whichever Is Greater, per Medical Episode)	\$15 co-pay \$15 co-pay \$15 co-pay \$15 co-pay  No Charge \$35 co-pay, Waived if Admitted  Not Covered if Received at Non-plan Facility  \$15 co-pay
Diagnostic Services: Laboratory and Diagnostic Testing, X-rays	No Charge
<b>Hospital Inpatient Care</b> No Limit on Covered Days, Including: Physician and Surgeon Services; Room and Board, Anesthesia, Operating and Recovery Rooms; Laboratory and Diagnostic Testing, X-rays	No Charge
Alternate Care: Home Health Services Alternate Care: Hospice Home Care/Respite Care Alternate Care: Extended Care in a Skilled Nursing Facility (Up to 100 Days per Calendar Year)	No Charge No Charge No Charge
<b>Emergency Department Visits</b> Only When Required by Medical Condition and Transportation in any Other Vehicle Would Endanger Your Health  If Provided at Plan Facility (Charges Waived if Admitted) (Available 24 Hours a Day at Kaiser Permanente Emergency Facilities at the Cleveland Clinic and Parma Medical Center) (Emergency Medical Advice Is Available 24 Hours a Day)  If Provided at Other Facility (Charges Waived if Admitted)	\$50 co-pay  \$50 co-pay  \$50 co-pay
Ambulance Services (Only When Transportation in any Other Vehicle Would Endanger Your Health)	\$50 co-pay
<b>Mental Health Services</b> Inpatient — 30 Days of Hospital Care per Calendar Year Outpatient — 20 Visit Maximum: Individual (Each Visit Counts as One Visit Against Maximum) Group (Each Visit Counts as One-Half of a Visit Against Maximum)	No Charge \$15 co-pay \$7 co-pay
<b>Chemical Dependency Services</b> Inpatient: Detoxification in General Hospital Detoxification in a Specialized Facility (One Admit Per Year)  Outpatient: Detoxification Individual Therapy Group Therapy	No Charge No Charge  \$15 co-pay \$15 co-pay \$5 co-pay
<b>Infertility Services:</b> Inpatient Outpatient	30% of Total Charges 30% of Total Charges
<b>Additional Benefits and Services</b> Prescription Drugs: Covered Formulary Drugs and Accessories up to a 31 Day Supply at Kaiser Permanente and Affiliated Network Facilities 62 Day Supply of Maintenance Drugs by Mail Order from the Kaiser Permanente Mail Order Pharmacy  Durable Medical Equipment — Medicare Approved Equipment	\$10 co-pay Generic/ \$25 co-pay Brand  No Charge

\*The benefits listed above are only a summary. Detailed benefit information and exclusions are available on request.

# Cleveland Clinic EHP Behavioral Health Benefits

Benefit	Tier 1 CPP PROVIDER NETWORK	Tier 2 MBHS PROVIDER NETWORK
Deductible* Expenses for All Levels of Care Individual Family	\$0 \$0	\$500 \$1,500
Out-of-Pocket Out-of-Pocket Maximum	Unlimited	Unlimited
Outpatient Coverage 26 Outpatient (OP) Visits in a Calendar Year for Mental Health and/or Substance Abuse† Psychological and Neuro-Psychological Testing‡	100% of Allowed Amount after \$25 co-pay 100% of Allowed Amount after \$25 co-pay	\$50 co-pay (after deductible) with 100% of Allowed Amount \$50 co-pay (after deductible) with 100% of Allowed Amount
Inpatient Coverage Up to 30 Inpatient (IP) Days in a Calendar Year for Mental Health and/or Substance Abuse 23 Hour Observation Beds Are Covered Under IP Benefit and Are Counted as Equal to 1 IP Day Toward 30 IP Day Limit† Inpatient Lifetime Maximum for Mental Health Inpatient Lifetime Maximum for Substance Abuse	100%  None No Limit on Detox 3 Episodes of Treatment per Lifetime	70%  None No Limit on Detox 3 Episodes of Treatment per Lifetime
Intensive Outpatient (IOP) Counted as Two IOP Visits = One Inpatient Day Toward 30 Day IP Limit†	100%	70%
Partial Hospitalization Programs (PHP) Counted as Two PHP Visits = One Inpatient Day Toward 30 Day IP Limit†	100%	70%
Emergent/Urgent Care Coverage Emergency Department Admissions (For Emergency and/or Urgent Care) Emergency and/or Urgent Care Visits NOT Resulting in an Inpatient Admission	100% 100% \$50 co-pay	100% 100% \$50 co-pay
Note: Any <b>UNAUTHORIZED</b> programs, services, or visits, will not be covered by the Cleveland Clinic EHP under any circumstances and the subsequent charges will be the financial responsibility of the Cleveland Clinic EHP member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency care.		

\*The Behavioral Health Tier 2 deductible does **NOT** apply to other health plan provisions.

†Prior authorization and medical necessity required.

‡Prior authorization required.

**Note:** Prior authorization, predetermination, prior approval and precertification all mean the same thing and the terminology can be interchanged.