

EHP Total Care Medical Management

The following pages detail your 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.

EHP Total Care Medical Management includes five elements:

1. **Utilization Management** to establish prior authorization and determine clinical appropriateness of requested services. This section also includes detailed benefits coverage clarification information.
2. **Case Coordination** for assistance with complex medical and behavioral health needs.
3. **Coordinated Care** addresses self-management care needs of members with chronic illnesses.
4. **Health Promotion** includes short telephonic programs to preserve healthy status.
5. **Rare Disease Management** provides assistance with uncommon conditions and is administered by Accordant, a CVS Company.

Utilization Management

EHP Total Care is designed to provide coverage for members that is clinically appropriate. In order to ensure that provided services are clinically appropriate, the EHP Medical Management Department has rules and processes for members to follow so that clinically appropriate care is reimbursed appropriately and efficiently. These rules and processes are addressed below and in the “Prior Authorization and Concurrent Review for Clinical Appropriateness” section that follows on page 21.

A service is **NOT** considered clinically appropriate 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 clinically appropriate 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 clinically appropriate. Examples of services that are not covered unless they are deemed clinically appropriate 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 prior authorization for clinical appropriateness.

Cleveland Clinic Employee Health Plan Total Care reserves the right for final determination of clinical appropriateness.

Prior Authorization and Concurrent Review for Clinical Appropriateness

The EHP Medical Management Department has a prior authorization feature that requires clinical appropriateness approval before certain procedures will be covered. **Prior authorization, precertification, predetermination and prior approval are often used interchangeably.** This *Summary Plan Description (SPD)* uses prior authorization. Concurrent review is a clinical appropriateness 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., inpatient stays, home care or skilled nursing facility).

Prior authorization for clinical appropriateness 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.

Any unauthorized programs, services, or visits will not be covered by EHP 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.

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 EHP 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 Prior Authorization

As soon as a member learns from a physician that the services listed below and on page 22 and/or 23 are being recommended, he or she **MUST** call the EHP Medical Management Department. The member is required to participate in the prior authorization 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 prior authorization process before obtaining the service there will be **NO REIMBURSEMENT** for the service.

Prior authorization for clinical appropriateness is also the responsibility of the provider of service **EXCEPT** for the three services noted below:

- Bariatric Surgery
- Infusion for Migraine
- All 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 clinically appropriate. 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 and Behavioral Health Services That Require Prior Authorization

The following list includes those medical services that **must** receive prior authorization for clinical appropriateness, 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*
- All Inpatient Behavioral Health
- Out-of-Network and Out-of-Area Care (All)
 - See Emergency Care/Transfers on page 30
- Skilled Nursing Facility (SNF)/Transitional Care Unit (TCU)/Sub-Acute Admission

Outpatient Services

• Behavioral Health

- All Tier 2 Services
- Full spectrum light boxes
- Intensive Home-Based Treatment
- Intensive Outpatient (IOP)
- Partial Hospitalization Programs (PHP)
- Residential Treatment
- Summer Treatment Program

• Medical

- Breast Reduction
- Botox
- Capsule Endoscopies
- Head and Lumbar MRI
- Home Care
- Home Use of Tocolytic Agents/
Home Use of Uterine Monitoring
- Infusion for Migraine
- Neurofeedback and Biofeedback
- Peripheral Nerve Stimulation
- Potentially Cosmetic Procedures
- Tilt Table Testing
- Treatment for Temporomandibular
Joint Syndrome (TMJ)
- Vestibular Testing Battery

• Medical (continued)

- Durable Medical Equipment (DME)**:
 - Cochlear implants
 - Continuous glucose monitor
 - Continuous passive motion machines
 - Crutch substitute, lower leg platform, with or without wheels
 - Electric wheelchairs
 - Extension/Flexion (dynamic and bi-directional) devices
 - Fully automatic beds
 - High-end (hinged) braces
 - High-end prosthetics
 - High frequency chest wall oscillation system
 - Home oxygen therapy
 - Home CPAP or BiPap
 - Insulin Pumps
 - Low air loss beds
 - Non-standard size wheelchairs — lightweight/heavyweight
 - Osteogenesis stimulators
 - Pneumatic compression devices
 - Scooters
 - Speech assistance devices

*May be subject to concurrent review

**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.

Special Services

These services require prior authorization whether inpatient or outpatient:

- Autism specific services require prior authorization through the Autism School (prior authorization is through EHP).
 - Autism School
 - Outreach
 - Summer Treatment Program
- Bariatric restrictive procedures or malabsorptive procedures for weight reduction
- Experimental or Investigational treatments or procedures
- Hospice
- Human Organ or Bone Marrow Transplant

Pharmaceuticals

See page 44 for a list of medications that require prior authorization.

Care Outside of Tier 1 Cleveland Clinic EHP 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 EHP 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 clinically appropriate.
- 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.

Benefits Coverage Clarification

Services That Must Be Provided by EHP Total Care Tier 1 Providers

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. Bariatric surgery.
3. Botox for migraine.
4. Breast reconstruction in connection with a mastectomy due to cancer.
5. Chiropractic services.
6. Cleveland Clinic Summer Treatment Program.
7. Contact lens fitting (covered only when ophthalmologic condition cannot be corrected by glasses).
8. Custom-made orthotics.
9. Dental implants for accidents or certain medical conditions.
10. Family planning services.
11. Genetic testing.
12. Infusion for migraine.
13. Left Ventricular Assist Device (LVAD).
14. Neurofeedback and Biofeedback.
15. Nutritional counseling.
16. Outpatient cardiac rehabilitation programs.
17. Protein Sparing Modified Fast (PSMF) diet.
18. Psychological and Neuro-psychological testing.
19. RAST (allergy blood) testing.
20. Routine health maintenance tests, routine screening tests, and standard immunizations.
21. Sclerotherapy or vein stripping for varicose veins.
22. Services for long-term acute care.
23. Services for routine eye and hearing examinations.
24. Services for treatment of sleep apnea.
25. Services provided for autism by the Cleveland Clinic Center for Autism.
26. Services provided for the evaluation and conformity of hearing aids.
27. Surgical extractions for soft/bony dental impactions.
28. Temporomandibular Joint Syndrome (TMJ).
29. Treatment for reduction mammoplasty.
30. Vestibular testing battery.

Coverage Clarification

The following pages (25 through 33) provide detailed benefit coverage clarification information about EHP Total Care behavioral health and medical services. This information complements and further explains the Benefits Summary Charts on pages 18 and 19. Behavioral health, which is listed first, includes all services for mental health and substance abuse. For behavioral health care level information, see Behavioral Health Levels of Care in Section Six, Definition of Terms (page 64). Medical services (pages 27 to 33), from bariatric surgery to vestibular testing, are defined and include additional information about coverage criteria and co-payments.

Behavioral Health Services

ADHD Summer Treatment Program

Full benefit coverage applies only if the child and parent each complete their designated portions of the program. Prior authorization and a clinical appropriateness review are required. EHP Total Care coverage for the Summer Treatment Program is \$2,000. The member is responsible for the difference between what the EHP 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

EHP Total Care will cover school, outreach program services, and the summer camp portion of Social SPIES for Autism when provided by the Cleveland Clinic Center for Autism. A Financial Needs Assessment must be completed prior to determining EHP coverage. Members are required to notify EHP 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 prior authorization 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, EHP 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 EHP Total Care would both be responsible for \$23,510 [$\$67,020 - \$20,000 = \$47,020 \times 50\% = \$23,510$].

- **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. Prior authorization for outpatient therapy and parent education is covered under the behavioral health outpatient benefit and count against the 35 outpatient visit maximum. EHP 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 the EHP Total Care covers and the billed charges for the summer camp portion of the program. The Social SPIES program can be contacted for details.

Full Spectrum Light Boxes

For Seasonal Affective Disorder. Prior authorization and a clinical appropriateness review are required. Coverage is 80%. The member is responsible for all shipping and handling charges. Call the EHP Medical Management Department regarding supplier information. EHP 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. Prior authorization is required. Members are required to participate in Case Coordination to obtain this benefit.

Pain Management

Members in pain management programs that have a psychiatric component should contact the EHP Medical Management Department for prior authorization if the program is in Tier 2. Tier 2 behavioral health counseling sessions require prior authorization through the EHP Medical Management Department.

Psychological and Neuro-psychological Testing

Psychological Testing

Up to six hours of testing are automatically reimbursed without prior authorization. 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 EHP 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 prior authorization. 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 EHP 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 EHP Total Care.

Approval for Residential Treatment will be determined by the Chief Medical Officer on an individual case basis, following a review for clinical appropriateness. 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 30 day limit. Tier 1 reimbursement is 80/20% and Tier 2 is 70/30% after deductible.

Medical Services

Bariatric Surgery

To be eligible for this benefit, a member must be a participant in EHP Total Care for a minimum of two consecutive years. **Second surgeries will not be covered (whether covered under EHP Total Care or any other plan).**

- Prior authorization is required through the EHP Medical Management Department. The member must call the EHP Medical Management Department when the workup begins to initiate the prior authorization process.
- To be eligible for surgery, the member must meet the EHP Total Care's established clinical criteria. A member may qualify for surgery through the Bariatric Center, **BUT NOT** meet EHP 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. Members must be enrolled in appropriate EHP Coordinated Care Programs and must be in both for six months prior to surgery.
- 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 \$35 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 \$300 to \$400.
- An upfront \$2,750 co-payment is required for the surgical procedure.
- Repeat or revision bariatric surgeries are not covered.

Botox for Migraine

Botox for chronic migraine requires prior authorization and will be approved when at least three preventive medications have been tried (member must be compliant) and failed over a period of at least 90 days. The request must come from either a neurologist or headache clinic within Tier 1.

Breast Reconstruction

Breast reconstruction is covered at 100% for a member who elects a breast reconstruction in connection with a mastectomy due to cancer or as prophylaxis. Services include the initial reconstruction of the removed breast or breasts, and surgical revisions as needed on the reconstructed breast or breasts. If the breast is intact and “unaffected,” coverage is limited to one surgery if needed to produce a symmetrical appearance. 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 EHP Total Care for standard intraocular lenses. If the member chooses to receive the Crystalens or ReSTOR lenses, EHP Total Care will only pay up to the contracted rate for standard intraocular lenses. Crystalens and 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 prior authorization 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 prior authorization by the EHP Medical Management Department. If prior authorization 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 Clinically Appropriate Surgery

If a member chooses to have cosmetic surgery at the same time they are having surgery that is clinically appropriate, 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 Allowed Amount 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 clinically appropriate procedure requires hospitalization, hospital days will be covered at 100%.
- If the usual course of the clinically appropriate 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 EHP 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 EHP Total Care when **ALL** of the following conditions are met:

- Implants are determined to be clinically appropriate and the medical need is primarily caused by a specific medical condition or a recent (within one year) accident or injury. If clinical appropriateness is determined due to an accident or injury within one year, the patient **MUST** have been an EHP Total Care member at the time of the accident or injury to be eligible for coverage. Congenitally missing teeth are covered for dental implant replacement.
- Prior authorization 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 EHP 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 EHP 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, EHP 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 EHP Total Care unless the dental procedure is one of the two procedures listed above. 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 prior authorization 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 EHP Total Care.

4. Dental procedures such as root canals, crowns, caps, re-implantation, etc. are **NOT** covered under EHP 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 clinically appropriate.

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/Transfers

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, Definitions of Terms pages 65 and 67 respectfully. A co-payment is required for any emergency department visit that does **not** result in an admission. Observation stays in the hospital are **not** considered admissions.

Emergency transport to an emergency room is always covered.

Transfers from Within a 50-Mile Radius of the Cleveland Clinic Main Campus

EHP Total Care will cover the transfer of our members from out-of-network facilities within a 50-mile radius of the Cleveland Clinic main campus. Total Care requires members, family members or the admitting hospital/emergency room staff to contact the Cleveland Clinic transfer center at 1-866-721-9803 if the member requires admission to a non-Cleveland Clinic facility. This number is on the back of your medical ID card.

If a member is mentally incapacitated, and in the absence of family members who can make the contact, hospital staff can make the contact when possible. In the event that a member is admitted, the EHP Medical Management Department will make a determination if a transfer will be required.

Failure to contact the transfer center, if it was feasible, prior to admission, or refusal to accept the transfer to a Cleveland Clinic facility when indicated by the transfer center or Medical Management, may result in Tier 2 coverage or no coverage for the admission.

Transfers from Outside a 50-Mile Radius of the Cleveland Clinic Main Campus

EHP Total Care **may** transfer members from a non-network facility outside of a 50-mile radius of the Cleveland Clinic main campus to a Cleveland Clinic facility. All cases will be reviewed by the EHP Medical Director for appropriateness of transfer. If the member or family member would like to **request** a transfer, they should contact the Cleveland Clinic transfer center at 1-866-721-9803 or Case Coordination at 1-888-246-6648 to request a transfer.

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 clinical appropriateness 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 \$250 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 prior authorization for any other age group, but is **NOT** covered for travel or when required for school.

Gardasil and **Cervarix** are vaccines for HPV and are covered for males and females age 9 to 26.

Infertility

Coverage for infertility is limited to diagnostic services only.

Infusion for Migraine

Infusion for migraine requires prior authorization 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 prior authorization 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.

EHP 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, EHP 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, EHP 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 clinically appropriate 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 Employee Health Plan Total Care. Contact the Benefits Department at 216-448-0600.

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 prior authorization through the EHP Medical Management Department. Members in programs that have a psychiatric component should contact the EHP Medical Management Department for prior authorization of that component of their pain management program if the program is in Tier 2. Tier 2 Behavioral Health counseling sessions require prior authorization 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.

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 EHP 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 clinical appropriateness includes but is not limited to consultation and x-ray. Prior authorization 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 prior authorization requirement.

Physical*

26 visits per calendar year are covered after a \$10 co-payment per visit. There is no prior authorization requirement.

Speech*

26 visits per calendar year are covered after a \$10 co-payment per visit. There is no prior authorization requirement.

Note: Additional visits require prior authorization and a \$10 co-payment per visit is still applicable.

**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 and conduct disorders. Refer to Prior Authorization and Concurrent Review for Clinical Appropriateness rules on page 21 for more information.*

Vestibular Testing Battery

Vestibular testing battery, used by some physicians to determine the causes of dizziness and vertigo, requires prior authorization. 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.

Case Coordination

Cleveland Clinic Employee Health Plan (EHP) 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 Case Coordination Programs 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. Members requesting more than 35 outpatient visits in a calendar year for behavioral health or substance abuse must agree to participate in EHP Coordinated Care (see below).

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.

Coordinated Care

EHP Medical Management offers Chronic Disease Management, Health Promotion, and Rare Disease Management programs that address the self-management needs of members with chronic illnesses. Conversations with a Registered Nurse Care Coordinator will assist you in learning ways to stay feeling your best and will work closely with you and your doctors to provide you with valuable information about your condition, including ways to monitor progress and prevent complications. EHP 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 are designed to compliment your doctor's care, reinforcing recommendations so you stay healthier between office visits. The programs are offered at no extra cost to you and participation is completely voluntary.

If you have a condition addressed by one of the Coordinated Care programs and would like to join a program, please call the EHP Medical Management Department 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. A referral from your physician is not necessary.

Chronic Disease Management

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

- Monthly phone assessment interviews from a Registered Nurse Care Coordinator
- Educational mailings
- Referral to community resources
- Referral to informative websites

Each program has hurdles to achieve toward self-management success. Upon enrollment, you will qualify for incentives including reimbursement for any needed screening equipment such as a glucometer, blood pressure cuff, bathroom scale, peak flow meter, and/or diabetes testing supply co-payments. After passing all the hurdles to self-management success, any office visit co-payment receipt you have incurred after enrollment that is less than 12 months old will qualify for reimbursement as well.

Continued program compliance can earn you prescription co-payment reimbursement for some or all of your medications. Chronic Disease Management programs are outlined below. Contact the EHP Medical Management Department for more details.

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. Children receive a free computer game that teaches valuable information in a format designed just for them.

Chronic Kidney Disease

This program is designed to help members learn what can be done to postpone or even prevent the need for dialysis treatments.

Depression (for adults and children)

Learn how working with an appropriate therapist, along with the right medications, can help you balance a more effective response to depressed mood stressors and triggers.

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.

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.

Hyperlipidemia (High Cholesterol)

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.

Hypertension (High Blood Pressure)

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

Migraine (for adults and children)

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

Weight Management (for adults and children)

Members can participate in a Tier 1 hospital-based outpatient weight management program and reach weight loss goals through the EHP Wellness Program offering.

The EHP Medical Management Department can be reached at 216-986-1050 or 1-888-246-6648 during regular business hours of 8 a.m.-4:30 p.m. Monday through Friday, excluding holidays. A confidential voicemail box is available to accept non-urgent messages after hours.

Health Promotion Programs

Pre-Diabetes

Learn the important yet simple lifestyle changes you can start to prevent or postpone the onset of diabetes.

Prenatal Care

Learn about timely topics during each trimester of your pregnancy, stay on time with your prenatal doctor visits and earn your delivery co-payment back when you share your birth details with us.

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 EHP Total Care is partnered with **Accordant**, a CVS Caremark Company, to provide 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. Incentives are also available for these programs. Details are available through the Case Coordinator.

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
- Ulcerative Colitis

The EHP Medical Management Department can be reached at 216-986-1050 or 1-888-246-6648 during regular business hours of 8 a.m.–4:30 p.m. Monday through Friday, excluding holidays. A confidential voicemail box is available to accept non-urgent messages after hours.