

Cleveland Clinic
Employee Health Plan Bulletin
October 2020 Retirees Under 65

In This Issue

RHP Coverage Changes	
Effective January 1, 2021	1
Medical Benefits	1
Prescription Drug Benefit	1
RHP Provider Networks	2
New Mutual Health Services	
Mobile App Available	2
Retirees HBP Benefits Summary	3
Non-Medicare HBP Prescription Drug Benefit	5
Other Important Information	6
Dependent Eligibility Processes	6
Medicare Coordination	6
New US Preventative Services Task Force Mandated Coverage	7
More About Your Coverage	7
Pharmacy Management Program	7
Case Coordination Programs	7
Comparing Cleveland Clinic RHP Prescription Drug Coverage with the Medicare Prescription Drug Benefit (Medicare Part D)	8

This issue of My RHP Health Connections is part of your 2021 Open Enrollment materials. It provides information about the 2021 medical and prescription drug changes in addition to other health plan offerings. To get the most value out of your health plan benefits, please refer to your summary plan description and other resources at our website, clevelandclinic.org/healthplan.

RHP Coverage Changes Effective January 1, 2021

Medical Benefits

- The co-pay for MRI's and CT scans will increase from \$50 to \$75 when received as an outpatient.
- Inpatient admission co-pays will increase from \$250 to \$350. The ER co-pay will remain at \$250. **Note:** If a member has an ER visit and is admitted, the ER co-pay is waived and the member is responsible for a \$350 copayment.
- The transgender benefits will be expanded to include gender-affirming surgeries.

Prescription Drug Benefits

The following medications will be added to the Specialty Drug Copay Card Program on Jan. 1, 2021.

Brukinsa	Nurtec ODT	Sivextro
Fulphila	Orenitram	Spritam
Fycompa	Oxbryta	Ubrelvy
Inrebic	Oxtellar XR	Udenyca
Koselugo	Pemazyre	Zeposia
Nourianz	Reyvow	Ziextenzo
Nubeqa	Rozlytrek	

As a reminder, for those specialty medications included in the Copay Card Assistance Program, the member's co-payment will be adjusted upward to maximize the financial benefit offered by the pharmaceutical manufacturer. This adjustment will be offset by the copay card, such that members will have no additional out-of-pocket expense above and beyond what they are currently paying for their specialty medication. The benefit of the manufacturer's copay card will be applied to your pharmacy benefit annual deductible, but these amounts will not be applied toward your annual out-of-pocket maximum. In the event the manufacturer alters or discontinues a specialty medication's copay card assistance program, the member's cost share will revert back to the benefit design outlined on page 2 of the *Cleveland Clinic Retiree Health Plan Prescription Drug Benefit Handbook*.

RHP Provider Networks

The EHP offers two different networks to choose from, Tier 1 and Tier 2. The Tier you select determines the amount of coverage you will receive. To receive the maximum coverage, use Tier 1 providers. Following is a description of each tier.

- **Tier 1 Provider Network:** Consists of providers in the Cleveland Clinic Quality Alliance (QA) network. The QA includes Cleveland Clinic and regional hospitals, including participating physicians credentialed by the Cleveland Clinic Community Physician Partnership. The Tier 1 Network includes providers from Cleveland Clinic main campus, family health centers and regional hospitals and includes primary care physicians, specialists, behavioral health providers and ancillary providers such as laboratory and physical therapy services.

There is no deductible in the Tier 1 network and most services are covered at 100 percent after applicable co-payment. Tier 1 providers can be found at clevelandclinic.org/healthplan. Under “The Plan” tab click on “Find a Practitioner,” then click on “Tier 1” and search by name, specialty and so on.

- **Tier 2 Provider Network:** Consists of providers in the MMO SuperMed network (within the state of Ohio) and Aetna® Open Choice® PPO network (outside the state of Ohio). Tier 2 benefits include an annual deductible of \$500 for single coverage and \$1,500 for family coverage. After the deductible is met, all inpatient, outpatient services and laboratory/diagnostic services will reimburse at 70% after any applicable co-payment with the exception of emergency services. Tier 2 providers can be accessed by visiting MutualHealthServices.com/CCHS and choosing the applicable network you would like to search.

New Mutual Health Services Mobile App Available

Mutual Health Services (MHS), our third party administrator (TPA) for the health plan, now offers a mobile app so you can access medical benefit information on the go.

You can:

- Check your benefit coverage.
- Review your healthcare claims.
- View your member ID card information.
- Monitor your deductible and out-of-pocket expenses.

The free app is available on the Apple App Store or Google Play store by searching for Cleveland Clinic EHP mobile app. For technical support, call 1.800.218.2205 (Help Desk) or contact MHS at MHSCCHSEHPContactUs@MutualHealthServices.com

Points to remember:

- Some services are covered only in the Tier 1 network. Please refer to the Summary Plan Description on our website at clevelandclinic.org/healthplan
- It is the member’s responsibility to verify the provider’s tier participation each time services are obtained. To confirm a provider’s participation or to request a list of providers by physician specialty in your area, call the ONE HR Service Center at 216.448.2247, Option 2 or toll-free at 877.688.2247. You can also contact our third party administrator, Mutual Health Services, toll-free at 800.451.7929. ■

New ID Cards for 2021

The EHP will be issuing new medical ID cards for 2021 to reflect the changes made to the co-pays. **DO NOT** throw away your old cards until you receive your new cards which should arrive in early January.



Retirees HBP Benefits Summary

	TIER 1	TIER 2
BENEFIT PROGRAM FEATURES	Cleveland Clinic Quality Alliance Network	MMO SuperMed ¹ and Aetna [®] Open Choice [®] PPO Networks
Annual Deductible: Single / Family Out-of-Pocket Maximum: Single / Family	None / None \$3,950 / \$7,900	\$500 / \$1,500 None / None
MEDICAL BENEFIT PROGRAM FEATURES		
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetric and Pediatrics)	100% of Allowed Amount	100% of Allowed Amount
Specialist Office Visits	100% of Allowed Amount after \$35 copay (no referral required)	\$50 co-pay, then 70% of Allowed Amount (after deductible)
Maternity Care	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission, then 70% of Allowed Amount (after deductible)
Routine (Annual) Physical Exam by Primary Care Physician	100% of Allowed Amount	Not Covered
Routine (Annual) Vision Exam	100% of Allowed Amount	Not Covered
Inpatient Hospital Services²	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission, then 70% of Allowed Amount (after deductible)
Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent) ²	100% of Allowed Amount 100% of Allowed Amount \$75 co-pay	70% of Allowed Amount (after deductible) 70% of Allowed Amount (after deductible) \$75 co-pay, then 70% of Allowed Amount (after deductible)
Laboratory/Diagnostic Tests	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Emergency Department Emergency Care Urgent Care	100% after \$250 co-pay 100% after \$50 co-pay	100% after \$250 co-pay 100% after \$50 co-pay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	80% of Allowed Amount
Skilled Nursing Care² – 60 Days per Benefit Year	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission, then 70% of Allowed Amount (after deductible)
Acute Inpatient Rehab – 60 Days per Benefit Year	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission, then 70% of Allowed Amount (after deductible)
Long-Term Acute Care – 60 Days per Benefit Year	\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Hospice² Symptom Management – 10 Days per Benefit Year	100% of Allowed Amount 100% of Allowed Amount	100% of Allowed Amount 100% of Allowed Amount
Respite Care 10 Days/Benefit Year	100% of Allowed Amount	100% of Allowed Amount
Home Health Care² – 60 Visits per Benefit Year	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Acupuncture – Maximum of 10 Visits/Benefit Year	50% of Allowed Amount	Not Covered
Chiropractic – Maximum of 20 Visits/Benefit Year	First 10 visits: 100% of Allowed Amount after \$35 co-pay; Second 10 visits: 50% of Allowed Amount (Children under 16 require prior authorization)	Not Covered

For Tier 1, co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for bariatric surgery, hearing aids, Autism School, Outreach Program and Social SPIES Program.

2. Prior authorization required for all IOP and PHP services in Tier 1, Tier 2 or Tier 3 network (exception Tier 1 providers psychiatric and chemical dependency). Eating disorders require prior authorization for IOP/PHP in Tier 1/Tier 2/Tier 3.

1. MMO SuperMed network within the state of Ohio and Aetna[®] Open Choice[®] PPO network outside the state of Ohio.

Cleveland Clinic Retiree Health Plan

Retirees HBP Benefits Summary CONTINUED

	TIER 1	TIER 2
MEDICAL BENEFIT PROGRAM FEATURES	Cleveland Clinic Quality Alliance Network	MMO SuperMed ¹ and Aetna [®] Open Choice [®] PPO Networks
Therapy Services Occupational/Speech/Physical 35 Visits per Therapy per Benefit Year	First 20 visits: 100% of Allowed Amount after \$10 co-pay, Second 15 visits: 50% of Allowed Amount	First 20 visits: 100% of Allowed Amount after \$10 co-pay and after deductible, Second 15 visits: 50% of Allowed Amount
Dental – Surgical extractions for soft/bony impactions, or dental implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning³	100% of Allowed Amount	Not Covered
Infertility – Diagnostic Only	100% of Allowed Amount	Not Covered
Hearing aids	50% of Charge up to \$3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant² Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	70% of Allowed Amount (after deductible) Not Covered Not Covered
BEHAVIORAL HEALTH BENEFIT PROGRAM FEATURES		
Outpatient Coverage Outpatient (OP Visits ⁴) Psychological and Neuro-Psychological Testing ⁵	\$35 co-pay, then 100% of Allowed Amount 100% of Allowed Amount	\$50 co-pay, then 100% of Allowed Amount (after deductible) Not Covered
Inpatient Coverage²	\$350 co-pay/admission, then 100% of Allowed Amount	\$350 co-pay/admission, then 70% of Allowed Amount
Intensive Outpatient (OP)²	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Partial Hospitalization Programs (PHP)²	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Residential Treatment² – 60 Days per Benefit Year	\$350 co-pay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)² 36 Therapy Related Visits per Benefit Year	100% of Allowed Amount	Not Covered

For Tier 1, co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for bariatric surgery, hearing aids, Autism School, Outreach Program and Social SPIES Program.

1. MMO SuperMed network within the state of Ohio and Aetna[®] Open Choice[®] PPO network outside the state of Ohio.
2. Prior authorization required for all IOP and PHP services in Tier 1, Tier 2 or Tier 3 network (exception Tier 1 providers psychiatric and chemical dependency). Eating disorders require prior authorization for IOP/PHP in Tier 1/Tier 2/Tier 3.
3. Marymount employees are subject to family planning exclusions including abortion, vasectomy, Norplant, Depo Provera, IUD, tubal ligation, and oral contraceptives, except if clinically appropriate.

4. The Outpatient Coverage for Behavioral Health Benefit Program 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 school meetings by outpatient behavioral health practitioners.

5. Psychological Testing: Up to six hours testing are automatically covered without prior authorization. Neuro-Psychological Testing: Up to eight hours testing are automatically covered without prior authorization. Testing is covered in Tier 1 only, by trained Behavioral Health Specialists.

Note: Prior authorization, precertification, predetermination and prior approval are often used interchangeably.

Any unauthorized programs, services, or visits will not be covered by The HBP under any circumstances and the subsequent charges will be the financial responsibility of the member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency care.

Non-Medicare HBP Prescription Drug Benefit Administered Through CVS/caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2021

CATEGORIES	TIER 1 Preferred Generics	TIER 2 Preferred Brands	TIER 3 Non-Preferred Brands and Generics (Non-Formulary)	TIER 4 Specialty Drugs (Hi-Tech)	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
Annual Deductible	\$200 Individual (Waived for generic prescriptions if obtained) \$400 Family from a Cleveland Clinic Akron General Pharmacy				No	No
Member % Co-insurance Cleveland Clinic/Akron Gen. Pharmacies: up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
Member % Co-insurance CVS Store Pharmacies – 30 Day Supply Mail Service Program – 90-Day Supply	20%	30%	50%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
Cleveland Clinic/Akron Gen. Pharmacies including Specialty & Home Delivery: Is there a Min. or Max. to the Rx % Co-insurance?	Yes \$3 Minimum/ \$50 Maximum per Month Supply	Yes \$3 Minimum/ \$50 Maximum per Month Supply	No	Yes \$3 Minimum/ \$50 Maximum per Month Supply	No	No
Retail Pharmacies: Is there a Min. or Max. to the Rx % Co-insurance?	Yes \$5 Minimum/ \$50 Maximum per Month Supply	Yes \$5 Minimum/ \$50 Maximum per Month Supply	No	N/A	No	No
CVS/caremark Mail Service Program: Is there a Min. or Max. to the Rx % Co-insurance?	Yes \$15 Minimum/ \$150 Maximum per 90-Day Supply	Yes \$15 Minimum/ \$150 Maximum per 90-Day Supply	No	Yes No Minimum/ \$100 Maximum per Month Supply	No	No
Is there an Annual Out-of-Pocket Maximum?	No	No	No	No	No	No
Components of Each Category			Brand Name Drugs See the <i>Retiree Prescription Drug Benefit and Formulary Handbook</i>	Specialty Drugs^{6,7} See complete list of Specialty Drugs and Copay Card Assistance Program See the <i>Retiree Prescription Drug Benefit and Formulary Handbook</i>	Lifestyle Drugs See the <i>Retiree Prescription Drug Benefit and Formulary Handbook</i>	Over-the-County Drugs See the <i>Retiree Prescription Drug Benefit and Formulary Handbook</i>
Prior Authorization Required	See the <i>EHP Prescription Drug Benefit and Formulary Handbook</i> for List of Pharmaceuticals Requiring Prior Authorization				No	No
Diabetic Supplies⁸, Asthma Delivery Devices⁸ and Prescription Vitamins⁹	Co-insurance 20%			No	No	No
Pharmacies¹⁰ in the Retail Network	Cleveland Clinic/Akron General Pharmacies (including Weston and Akron General Medical Center), Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Home Delivery Pharmacy, CVS store pharmacies (including CVS pharmacies located in Target stores), Caremark Mail Service, Caremark Specialty Pharmacy					

Note: Benefit Program Includes: generic oral contraceptives – covered for Marymount HBP participants for clinical appropriateness only under the HBP.

7 Certain specialty medications are included in the Copay Card Assistance Program. Please refer to the Prescription Drug Benefit and Formulary Handbook.

8 There are 3 options for obtaining medications in the category listed above. The options are: 1. Cleveland Clinic Pharmacies in Akron, Cleveland and Cleveland Clinic Weston Pharmacy, 2. Cleveland Clinic Specialty Pharmacy, and 3. CVS/caremark Specialty Drug Program. Specialty Drug prescription orders (first fill and refills) are limited to a one month supply.

9 Diabetic Supplies – Insulin and all diabetic supplies covered, except for insulin pumps and insulin

pump supplies (which are covered under the medical benefit). Diabetic supplies covered under the prescription drug benefit include: needles purchased separately, test strips, lancets, glucose meters, syringes, lancing devices, and injection pens. Asthma Delivery Devices — Includes spacers used with asthma inhalers.

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

11 Members can use any Cleveland Clinic pharmacy or any CVS store pharmacy for obtaining acute care medications (e.g., single course of antibiotic therapy) and for the first fill of maintenance medications but must use a Cleveland Clinic Pharmacy or CVS/caremark Mail Service Program for all maintenance medications.

Other Important Information

Dependent Eligibility Processes

1. New Enrollees

After they enroll in the plan for the first time, all employees (new hires or those with longer service) need to provide documentation that proves dependent eligibility. The plan accepts these documents:

Spouse

- Copy of marriage license, or
- Copy of page 1 of your most recent tax return (make sure to cross out wage information)

Children under age 26

Natural born children:

- Copy of birth certificate or one of the following:
 - Copy of page 1 of your most recent tax return (make sure to cross out wage information)
 - Copy of court-issued qualified medical child support order (QMCSO) (if applicable)
 - Copy of divorce decree (if applicable)

Stepchildren/Custodial:

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

Adopted Children:

- Adoption papers

2. Coordination of Benefits (COB)

All members are expected to complete the COB process when they enroll, each year in January and if they experience a life event change. Here's how the process works:

- If the employee/dependent(s) has other insurance, the COB form can be completed online via the ONE HR:Workday and Portal or the completed form can either be faxed or mailed to our Third-Party Administrator, Mutual Health Services. The form is available on our website at www.clevelandclinic.org/healthplan.
- If the employee/dependent(s) does not have other insurance, they can complete the information online via the ONE HR: Workday and Portal or they can call

Mutual Health Services and the information will be updated during the call.

Employees have one year to complete the COB process. As long as the COB process remains uncompleted, claims for covered dependents will be denied. The member will receive a COB form with each dependent's first claim statement until the COB process is complete.

If a member does not respond within 45 days, Mutual Health Services will send an *Explanation of Benefits (EOB)* form explaining that all claims for dependents will be denied until the COB form is completed.

If the member still has not completed the COB process by the end of the year, he or she will be financially responsible for all the dependent claims submitted that year.

Medicare Coordination

When you or your covered dependent become Medicare eligible, it is important for you to enroll in Medicare Part B. The Health Benefit Program (HBP) 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 percent of your physicians' bills (out of your pocket) because the HBP pays only 20 percent (what Medicare does not pay) as the secondary insurance.

3. Life Event Changes

Members whose legal marital status changes (for example, through divorce or death of a spouse) or who have changes in the number of their dependents will need to verify the changes and dependent eligibility with the proper documentation. This ensures that only eligible dependents are enrolled in the plan. If you have questions about this, please call the ONE HR Service Center at 216.448.2247 or toll-free at 877.688.2247. ■

Reminder: Social Security Numbers are Required

Under Healthcare Reform, Cleveland Clinic is required to report to the government the Social Security numbers of each member on the health plan. When enrolling your dependents in the health plan, make sure to include their Social Security numbers. If already enrolled, you can update Social Security numbers for your health plan dependents on the ONE HR: Workday and Portal.

RHP Coverage Changes Effective January 1, 2021 CONTINUED

New US Preventive Services Task Force Mandated Coverage

1. Two medications used in the prevention of breast cancer, anastrozole and exemestane, will be covered at no member cost, if the member's individual medical condition meets the criteria set forth by the United States Preventive Services Task Force. Members or providers can contact EHP Pharmacy Management at 216.986.1050, option 4, or 888.246.6648, option 4, for more information and to obtain the specific prior authorization form they will need to submit for evaluation. EHP Pharmacy Management can also be reached via email at EHPRxMgmt@ccf.org.
2. Medications used for pre-exposure prophylaxis (PrEP) in members at high risk for HIV infection will be provided at no member cost if the use is for PrEP. If the use is for treatment of HIV infection or for post-

exposure prophylaxis, the member's co-payment will be adjusted upward to maximize the financial benefit offered by the pharmaceutical manufacturer as part of the Specialty Drug Copay Card Assistance Program. Truvada will remain the preferred agent, with Descovy being the alternative product. Both Truvada and Descovy will continue to require prior authorization. Coverage requests approved for PrEP will be coded in the pharmacy claims adjudication system such that the member's annual pharmacy deductible and any co-insurance are waived.

Please refer to the EHP Pharmacy Benefits link on the Cleveland Clinic Employee Health Plan's website for ongoing updates regarding your pharmacy benefit program. If you have any questions, please contact EHP Pharmacy Management at 216.986.1050, option 4, or 888.246.6648, option 4, or via email at EHPRxMgmt@ccf.org. ■

More About Your Coverage

Pharmacy Management Program

The EHP Pharmacy Coordination Department administers six programs that assist members in using prescription medications safely and effectively.

- Quantity Level Limits
- Prior Authorization
- Mandatory Statin Cost Reduction Program
- Mandatory Maintenance Drug Program
- Step Therapy Program
- Specialty Drug Benefit

For details about each program, visit our website at www.clevelandclinic.org/healthplan and click on "Plan Offerings."

Case Coordination Programs

Case Coordination Programs give members telephone access to a registered nurse or a licensed social worker or

counselor when they need help with a range of complex medical or behavioral health needs such as:

- Progressive neurological conditions
- Anxiety disorders
- Childhood disorders
- Dual diagnoses (both psychiatric and chemical dependence)
- Eating disorders
- Mood disorders
- Psychotic disorders
- Substance abuse

Case coordination also can help members with network access issues and referrals to community services.

Members can refer themselves or be referred by their physician or family for evaluation.

To get more information about case coordination, call the EHP Medical Management Department at 216.986.1050 or toll-free at 888.246.6648. ■

Comparing Cleveland Clinic RHP Prescription Drug Coverage with the Medicare Prescription Drug Benefit (Medicare Part D)

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) includes a prescription drug program to Medicare (Medicare Part D) for individuals who are enrolled in Medicare.

The Retiree Health Plan (RHP) has determined that your existing coverage with the RHP is, as good as standard Medicare coverage. In many cases, coverage under the RHP actually exceeds the standard Medicare coverage.

It is important that you evaluate both the RHP Prescription Drug Benefit 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 members who are Medicare eligible receive a “Creditable Coverage” letter upon the date of eligibility. 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 your Total Rewards Department.

It is important to note that if you enroll in a different Medicare Part D plan, you may no longer participate in the Cleveland Clinic Retiree Health Plan. You will lose your Cleveland Clinic medical and pharmacy plans and

will not be eligible to return to the Cleveland Clinic RHP in the future.

Medicare eligible RHP members include:

- RHP members age 65 or over enrolled in Medicare
- Retirees under age 65 who are disabled and eligible for Medicare
- Dependents, such as spouses, of RHP members who are enrolled in Medicare
- Disabled dependents (e.g., children) eligible for Medicare
- Active Medicare-eligible employees and their Medicare-eligible dependents who are enrolled in Medicare
- Long-term disability (LTD) recipients eligible for Medicare

More detailed information about the Medicare prescription drug plans that offer prescription drug coverage is available on Medicare’s website at www.medicare.gov or by calling Medicare toll-free at 800.MEDICARE (800.633.4227). TTY users should call toll-free at 877.486.2048.

Additional information about the RHP Prescription Drug Benefit and the Medicare Prescription Drug Benefit is included in the Retiree Summary Plan Description (SPD) and Prescription Drug Benefit and Formulary Handbook available on our website at www.clevelandclinic.org/healthplan.

Please contact the ONE HR Service Center with further questions at 216.448.2247 or toll-free at 877.688.2247. ■