

# HBP Benefits Summary for 2025

Benefit Program Features		EHP PLUS	OUT OF NETWORK
		Cleveland Clinic Quality Alliance (QA), Florida Clinically Integrated Network (CIN), and Aetna Select Open Access Networks	
<b>Annual Deductible</b>	Single Family	None None	
<b>Out-of-Pocket Maximum</b>	Single Family	\$3,950 \$7,900	
Medical Benefit Program Features			
<b>PCP Office Visit</b> (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)		100% of Allowed Amount	Not Covered
<b>PCP Virtual Visits</b>		100% of Allowed Amount	Not Covered
<b>Specialist Office Visits</b>		100% of Allowed Amount after \$35 copay (no referral required)	Not Covered
<b>Specialist Virtual Visits</b>		100% of Allowed Amount after \$35 copay	Not Covered
<b>Maternity Care</b>		\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Routine (Annual) Physical Exam by Primary Care Physician</b>		100% of Allowed Amount	Not Covered
<b>Routine (Annual) Vision Exam</b>		100% of Allowed Amount after \$35 copay	Not Covered
<b>Inpatient Hospital Services<sup>1</sup></b>		\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Outpatient Hospital Services</b> Radiology – MRI/CT Scans (non-emergent) <sup>1</sup>		100% of Allowed Amount 100% of Allowed Amount	Not Covered Not Covered
<b>Outpatient Surgery/Procedure:</b> Ambulatory surgery centers, hospital and outpatient hospital locations		\$75 copay, then 100% of Allowed Amount \$75 copay*, then 100% of Allowed Amount *(does not apply to Akron General ONA and USW)	Not Covered Not Covered
<b>Laboratory/Diagnostic Tests</b>		100% of Allowed Amount	Not Covered
<b>Emergency Department</b> Emergency Services / ER Hospital Admission Urgent Care		100% after \$250 copay / \$350 if admitted 100% after \$50 copay	100% after \$250 copay / \$350 if admitted 100% after \$50 copay
<b>Medical Supplies and Durable Medical Equipment</b>		80% of Allowed Amount	Not Covered
<b>Skilled Nursing Care<sup>1</sup></b> 60 Days per Benefit Year		\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Acute Inpatient Rehab<sup>1</sup></b> 60 Days per Benefit Year		\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Long-Term Acute Care<sup>1</sup></b> 60 Days per Benefit Year		\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Hospice</b> Symptom Management Respite Care		100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	Not Covered Not Covered Not Covered
<b>Home Health Care<sup>1</sup></b> 60 Visits per Benefit Year		100% of Allowed Amount	Not Covered
<b>Acupuncture</b> Maximum of 10 Visits/Benefit Year		100% of Allowed Amount after \$35 copay	Not Covered
<b>Chiropractic</b> Maximum of 10 Visits/Benefit Year		100% of Allowed Amount after \$35 copay	Not Covered

All copayments and coinsurance listed on this chart accumulate to your out-of-pocket maximum with the exception of copayments for bariatric surgery and the Autism School.  
**Retirees 65 and Over:** Copayments and coinsurance do not apply with the exception of coinsurance for hearing aids and Acupuncture.

1. Precertification required.

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

## HBP Benefits Summary (continued)

Medical Benefit Program Features	EHP PLUS	OUT OF NETWORK
	<b>Cleveland Clinic Quality Alliance (QA), Florida Clinically Integrated Network (CIN), and Aetna Select Open Access Networks</b>	
<b>Therapy Services (Rehabilitative)</b> Occupational/Speech/Physical	100% of Allowed Amount after a \$10 copay. 30 Visits per Therapy per Calendar Year	Not Covered
<b>Therapy Services (Habiltiative)</b> Physical/Occupational/Speech Apraxia, Autism, Autism Spectrum Disorder, Cerebral Palsy, Developmental Delay and Spina Bifida	100% of Allowed Amount (No visit limitation)	Not Covered
<b>Dental</b> – Implants <sup>1</sup> for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
<b>Family Planning</b> (See Coverage Clarifications) Voluntary Abortion	100% of Allowed Amount 100% of Allowed Amount	Not Covered 100% of Allowed Amount
<b>Infertility Treatment<sup>1</sup></b>	100% of Allowed Amount Lifetime Maximum (LTM) (\$15,000 Medical, \$6,000 Pharmacy)	Not Covered
<b>Hearing Aids<sup>4</sup></b>	50% of Charge up to \$3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
<b>Organ Transplant<sup>1</sup></b> Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
Behavioral Health Benefit Program Features		
<b>Physician Office Visits</b>	100% of Allowed Amount after a \$35 copay	Not Covered
<b>Outpatient Coverage</b> Outpatient (OP Visits) <sup>2</sup> Psychological and Neuro-Psychological Testing <sup>3</sup>	100% of Allowed Amount 100% of Allowed Amount	Not Covered
<b>Outpatient Telemedicine/Virtual Consultation</b>	100% of Allowed Amount after \$35 copay	Not Covered
<b>Inpatient Coverage<sup>1</sup></b>	\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Intensive Outpatient (OP)</b>	100% of Allowed Amount	Not Covered
<b>Partial Hospitalization Programs (PHP)<sup>1</sup></b>	100% of Allowed Amount	Not Covered
<b>Residential Treatment<sup>1</sup></b>	\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Transcranial Magnetic Stimulation (TMS)<sup>1</sup></b>	100% of Allowed Amount	Not Covered

All copayments and coinsurance listed on this chart accumulate to your out-of-pocket maximum with the exception of copayments for bariatric surgery and the Autism School.

**Retirees 65 and Over:** Copayments and coinsurance do not apply with the exception of coinsurance for hearing aids and Acupuncture.

1. Precertification required.

2. The Outpatient coverage for the 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.

3. Psychological and Neuro Psychological Testing: Up to eight hours testing are automatically covered without precertification. Neuro-Psychological Testing: Testing is covered in Tier 1 only, by trained Behavioral Health Specialists.

4. Hearing aids are only covered when provided by a Cleveland Clinic provider. There is no coverage for any other provider.

*Note: Prior authorization, precertification 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 services.**

# HBP Prescription Drug Benefit

Administered Through CVS Caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2025

Categories	TIER 1 Preferred Generics (Non-Specialty)	TIER 2 Preferred Brands (Non-Specialty)	TIER 3 Non-Preferred Brands and Generics (Non-Formulary)	TIER 4 Specialty Brand and Drugs (Hi-Tech)	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
<b>Annual Deductible</b>	\$200 Individual \$400 Family	<i>(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)</i>			No	No
<b>Member % Co-insurance</b> <b>Cleveland Clinic Pharmacies:</b> up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Covered by Rx Plan – Use Discount Card
<b>Member % Co-insurance</b> <b>CVS Store Pharmacies:</b> 30-Day Supply <b>Mail Service Program:</b> 90-Day Supply	20%	30%	50%	20%	Member Pays 100% of the Discounted Price	Not Covered by Rx Plan – Use Discount Card
<b>Cleveland Clinic Pharmacies including Specialty &amp; Home Delivery:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$3 Minimum/ \$50 Maximum per Month Supply	Yes \$3 Minimum/ \$50 Maximum per Month Supply	No	Yes No Minimum/ \$50 Maximum per Month Supply	No	No
<b>Retail Pharmacies:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$5 Minimum/ \$50 Maximum per Month Supply	Yes \$5 Minimum/ \$50 Maximum per Month Supply	No	N/A	No	No
<b>CVS Caremark Mail Service Program:</b> Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$15 Minimum/ \$150 Maximum 90-Day Supply	Yes \$15 Minimum/ \$150 Maximum 90-Day Supply	No	Yes No Minimum/ \$100 Maximum per Month Supply	No	No
<b>Is there an Annual Out-of-pocket Maximum?</b>	<b>After Deductible Has Been Met:</b> \$3,950 Individual / \$7,900 Family Combined Maximums for Retail, Specialty and Home Delivery				No	No
<b>Components of Each Category</b>			<b>Brand Name Drugs</b> See the <b>EHP Prescription Drug Formulary</b>	<b>Specialty Drugs<sup>5,6</sup></b> See complete list of Specialty Drugs, PrudentRx Solution Specialty Medication, and Medications in the EHP Copay Card Assistance Program in the <b>EHP Prescription Drug Formulary</b>	<b>Discounted Drugs</b> See the <b>EHP Prescription Drug Formulary</b>	<b>Non-Covered and Over-the-Counter Drugs</b> See the <b>EHP Prescription Drug Formulary</b>
<b>Prior Authorization Required</b>	See the <b>EHP Prescription Drug Formulary</b> for list of pharmaceuticals requiring prior authorization				No	N/A
<b>Diabetic Supplies<sup>7</sup></b> <b>Asthma Delivery Devices<sup>7</sup></b> and <b>Prescription Vitamins<sup>8</sup></b>	Co-insurance 20%			No	No	N/A
<b>Pharmacies<sup>9</sup> in the Retail Network</b>	CVS store pharmacies (including CVS pharmacies located in Target stores. CVS MinuteClinics are not included.)					

**Note:** Benefit Program includes generic oral contraceptives.

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

6. There are 3 options for obtaining medications in the category listed above. The options are: 1. **Cleveland Clinic Pharmacies**, 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.**

7. Diabetic Supplies – All diabetic supplies covered, except for most insulin pumps and insulin pump supplies (with the exception of Omnipod Dash, Omnipod 5 G6), continuous glucose monitors (with the exception of FreeStyle Libre products), and continuous glucose monitor 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, injection pens, FreeStyle Libre products, and Omnipod Dash. Members with type 1 diabetes who are under 18 years of age will have no out-of-pocket expense for their insulins and diabetic supplies covered under the prescription drug benefit. **Asthma Delivery Devices** – Includes spacers used with asthma inhalers.

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

9. 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.