HBP Benefits Summary for 2025

Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance and Florida Clinically Integrated Networks	*TIER 2* Aetna Select Open Access Network
Annual Deductible Single Family **Out-of-Pocket Maximum** Single Family	 None None $3.950 $7,900	 $500 $1,500 $4,750 $9,500
Medical Benefit Program Features		
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)	100% of Allowed Amount	$25 copay, then 70% of Allowed Amount (after deductible)
PCP Virtual Visits	100% of Allowed Amount	$25 copay, then 70% of Allowed Amount (after deductible)
Specialist Office Visits	100% of Allowed Amount after $35 copay (no referral required)	$50 copay, then 70% of Allowed Amount (after deductible)
Specialist Virtual Visits	100% of Allowed Amount after $35 copay	$50 copay, then 70% of Allowed Amount (after deductible)
Maternity Care	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Routine (Annual) Physical Exam by Primary Care Physician **Routine (Annual) Vision Exam**	100% of Allowed Amount 100% of Allowed Amount after $35 copay	Not Covered Not Covered
Inpatient Hospital Services[1]	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admissions, then 70% of Allowed Amount (after deductible)
Outpatient Hospital Services Radiology – MRI/CT Scans (non-emergent)[1] **Outpatient Surgery/Procedure:** Ambulatory surgery centers, hospital and outpatient hospital locations	100% of Allowed Amount 100% of Allowed Amount $75 copay, then 100% of Allowed Amount $75 copay, then 100% of Allowed Amount	70% of Allowed Amount (after deductible) 70% of Allowed Amount (after deductible) $75 copay, then 70% of Allowed Amount (after deductible) $75 copay, then 70% of Allowed Amount (after deductible)
Laboratory/Diagnostic Tests	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Emergency Department Emergency Services Urgent Care	 100% after $250 copay 100% after $50 copay	 100% after $250 copay 100% after $50 copay
Medical Supplies and Durable Medical Equipment	80% of Allowed Amount	80% of Allowed Amount (after deductible)
Skilled Nursing Care[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Acute Inpatient Rehab[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Long-Term Acute Care[1] 60 Days per Benefit Year	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Hospice Symptom Management Respite Care	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount
Home Health Care[1] 60 Visits per Benefit Year	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Acupuncture Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after $35 copay	$35 copay, then 70% of Allowed Amount (after deductible)
Chiropractic Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after $35 copay	Not Covered

1. Precertification required.

HBP Benefits Summary (continued)

Medical Benefit Program Features	*TIER 1* Cleveland Clinic Quality Alliance and Florida Clinically Integrated Networks	*TIER 2* Aetna Select Open Access Network
Therapy Services (Rehabilitative) Occupational/Speech/Physical	100% of Allowed Amount after a $10 copay. 30 Visits per Therapy per Calendar Year	Not Covered
Therapy Services (Habilitative) Physical/Occupational/Speech Apraxia, Autism, Autism Spectrum Disorder, Cerebral Palsy, Developmental Delay and Spina Bifida	100% of Allowed Amount (No visit limitation)	Not Covered
Family Planning (See Coverage Clarifications) Voluntary Abortion	100% of Allowed Amount 100% of Allowed Amount	Not Covered 100% of Allowed Amount
Infertility Treatment[1]	100% of Allowed Amount Lifetime Maximum (LTM) ($15,000 Medical, $6,000 Pharmacy)	Not Covered
Hearing Aids[4]	50% of Charge up to $3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant[1] Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
Behavioral Health Benefit Program Features		
Outpatient Coverage Outpatient (OP Visits)[2] Office Visits Psychological and Neuro-Psychological Testing[3]	 100% of Allowed Amount $35 copay, then 100% of Allowed Amount 100% of Allowed Amount	 100% of Allowed Amount (after deductible) $50 copay, then 70% of Allowed Amount (after deductible) Not Covered
Outpatient Telemedicine/Virtual Consultation	100% of Allowed Amount after $35 copay	$50 copay, then 70% of Allowed Amount (after deductible)
Inpatient Coverage[1]	$350 copay/admission, then 100% of Allowed Amount	$350 copay/admission, then 70% of Allowed Amount (after deductible)
Intensive Outpatient (OP)[1]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	70% of Allowed Amount (after deductible)
Residential Treatment[1]	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[1]	100% of Allowed Amount	Not Covered

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

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
Annual Deductible	$200 Individual $400 Family	*(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)*			No	No
Member % Co-insurance Cleveland Clinic Pharmacies: up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Covered by Rx Plan – Use Discount Card
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 Covered by Rx Plan – Use Discount Card
Cleveland Clinic Pharmacies including Specialty & Home Delivery: 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
Retail Pharmacies: 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
CVS Caremark Mail Service Program: 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
Is there an Annual Out-of-pocket Maximum?	**After Deductible Has Been Met:** $3,950 Individual / $7,900 Family Combined Maximums for Retail, Specialty and Home Delivery				No	No
Components of Each Category			**Brand Name Drugs** See the ***EHP Prescription Drug Formulary***	**Specialty Drugs**[5, 6] See complete list of Specialty Drugs, PrudentRx Solution Specialty Medication, and Medications in the EHP Copay Card Assistance Program in the ***EHP Prescription Drug Formulary***	**Discounted Drugs** See the ***EHP Prescription Drug Formulary***	**Non-Covered and Over-the-Counter Drugs** See the ***EHP Prescription Drug Formulary***
Prior Authorization Required	See the ***EHP Prescription Drug Formulary*** for list of pharmaceuticals requiring prior authorization				No	N/A
Diabetic Supplies[7] **Asthma Delivery Devices**[7] **and Prescription Vitamins**[8]	Co-insurance 20%			No	No	N/A
Pharmacies[9] **in the Retail Network**	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.