EHP Benefits Summary – 2026

Akron General ONA and USW

Benefit Program Features		EHP Cleveland Clinic, Quality Alliance, and Florida-aligned providers	OUT OF NETWORK
Annual Deductible	Single Family	None None	
Out-of-Pocket Maximum	Single Family	$3,950 $7,900	
Medical Benefit Program Features			
PCP Office Visit (Family Practice, Internal Medicine, Gynecology, Obstetrics and Pediatrics)		100% of Allowed Amount	Not Covered
PCP Virtual Visits		100% of Allowed Amount	Not Covered
Specialist Office Visits		100% of Allowed Amount after $35 copay (no referral required)	Not Covered
Specialist Virtual Visits		100% of Allowed Amount after $35 copay	Not Covered
Maternity Care		$350 copay/admission, then 100% of Allowed Amount	Not Covered
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	Not Covered
Outpatient Hospital Services Radiology, i.e. X-rays, Ultrasounds, Mammograms MRI/PET/CT Scans (non-emergent)[1]		100% of Allowed Amount 100% of Allowed Amount $75 copay, then 100% of Allowed Amount	Not Covered Not Covered Not Covered
Outpatient Surgeries/Procedures Ambulatory surgery centers, hospital and outpatient hospital locations)		$75 copay, then 100% of Allowed Amount (Copay does not apply to Akron General ONA)	Not Covered
Laboratory/Diagnostic Tests		100% of Allowed Amount	Not Covered
Emergency Department Emergency Care / 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
Medical Supplies and Durable Medical Equipment		80% of Allowed Amount	Not Covered
Skilled Nursing Care[1] 60 Days per Benefit Year		$350 copay/admission, then 100% of Allowed Amount	Not Covered
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	Not Covered Not Covered Not Covered
Home Health Care[1] 60 Visits per Benefit Year		100% of Allowed Amount	Not Covered

Copay/Coinsurance Information:

- Copays are the responsibility of the member and are due at the time services are rendered.
- **All** specialty in-person and virtual visits require a $35 copay.
- If a nurse practitioner or physician assistant work in a specialty office, a $35 copayment is applied.
- All copayments and coinsurance listed on this chart accumulate to your out-of-pocket maximum except for copayments for bariatric surgery and the Autism School.
- **Retirees 65 and over:** Deductible, copayments and coinsurance do not apply except for coinsurance for hearing aids and Acupuncture.

1. **Precertification** required.

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

EHP Benefits Summary – 2026, Akron General ONA and USW (continued)

Medical Benefit Program Features	*EHP* Cleveland Clinic, Quality Alliance, and Florida-aligned providers	*OUT OF NETWORK*
Acupuncture Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after $35 copay	Not Covered
Chiropractic Maximum of 10 Visits/Benefit Year	100% of Allowed Amount after a $35 copay	Not Covered
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
Dental – Implants for certain medical conditions or recent accidents/injuries	100% of Allowed Amount	Not Covered
Family Planning	100% of Allowed Amount	Not Covered
Infertility Treatment[1]	100% of Allowed Amount 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		
Physician Office Visits	100% of Allowed Amount after a $35 copay	Not Covered
Outpatient Coverage Outpatient (OP Visits)[2] Psychological and Neuro-Psychological Testing[3]	 100% of Allowed Amount 100% of Allowed Amount	Not Covered
Outpatient Telemedicine/ Virtual Consultation	100% of Allowed Amount after $35 copay	Not Covered
Inpatient Coverage[1]	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Intensive Outpatient (OP)	100% of Allowed Amount	Not Covered
Partial Hospitalization Programs (PHP)[1]	100% of Allowed Amount	Not Covered
Residential Treatment[1]	$350 copay/admission, then 100% of Allowed Amount	Not Covered
Transcranial Magnetic Stimulation (TMS)[1]	100% of Allowed Amount	Not Covered

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 8 hours of testing are automatically reimbursed without precertification. Testing must be done by trained Behavioral Health Specialists.
4. Hearing aids are only covered when provided by Cleveland Clinic in Ohio only. There is no coverage for any other provider.

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

Deductible/Copay/Coinsurance Information:

- Copays are the responsibility of the member and are due at the time services are rendered.
- **All** specialty in-person and virtual visits require a $35 copay.
- If a nurse practitioner or physician assistant work in a specialty office, a $35 copayment is applied.
- All copayments and coinsurance listed on this chart accumulate to your out-of-pocket maximum except for copayments for bariatric surgery and the Autism School.
- **Retirees 65 and over:** Deductible, copayments and coinsurance do not apply except for coinsurance for hearing aids and Acupuncture.

Any *unauthorized* programs, services or visits will not be covered by the health plan 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.

EHP Prescription Drug Benefit

Administered Through CVS Caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2026

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 % Coinsurance 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 % Coinsurance 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 % Coinsurance?	Yes $3 Min./$50 Max. 30 Day Supply		No	Yes No Minimum/ $50 Maximum per Month Supply	No	No
Retail Pharmacies: Is there a Minimum or Maximum to the Rx % Coinsurance?	Yes $5 Min./$50 Max. - 30 Day Supply		No	N/A	No	No
CVS Caremark Mail Service Program: Is there a Minimum or Maximum to the Rx % Coinsurance?	Yes $15 Min./$150 Max. - 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]	Coinsurance 20%			No	No	N/A
Pharmacies[9] **in the Retail Network**	Cleveland Clinic Pharmacies, 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.*** For **initial fills and refills** of specialty medications: members residing in states where Cleveland Clinic Community Pharmacies are located or Cleveland Clinic Specialty Pharmacy is licensed, are required to use Cleveland Clinic Community Pharmacies or the Cleveland Clinic Specialty Pharmacy.

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-G7), continuous glucose monitors (with the exception of Dexcom and 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, Dexcom products, FreeStyle Libre products, Omnipod Dash and Omnipod 5 G6-G7. 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. For **refills** of non-specialty maintenance medications: members residing in states where Cleveland Clinic Community Pharmacies are located or where Cleveland Clinic Home Delivery is licensed, are required to use Cleveland Clinic Community Pharmacies or Cleveland Home Delivery Pharmacy rather than the CVS Caremark Mail Service Program (acute prescriptions or first fills of non-specialty maintenance medications may be filled at Cleveland Clinic Pharmacies or CVS retail pharmacies).