

# HBP Benefits Summary for 2025

Benefit Program Features		<i>EHP PLUS</i>	<i>OUT OF NETWORK</i>
		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	
<b>Medical Benefit Program Features</b>			
<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> <b>Outpatient Surgery/Procedure:</b> 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 *(does not apply to Akron General ONA and USW)	Not Covered Not Covered 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	<i>EHP PLUS</i>	<i>OUT OF NETWORK</i>
	Cleveland Clinic Quality Alliance (QA), Florida Clinically Integrated Network (CIN), and Aetna Select Open Access Networks	
<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 (Habilitative)</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</b> <sup>1</sup>	100% of Allowed Amount Lifetime Maximum (LTM) (\$15,000 Medical, \$6,000 Pharmacy)	Not Covered
<b>Hearing Aids</b> <sup>4</sup>	50% of Charge up to \$3,500/Ear – Limited to one aid per Ear every 3 years	Not Covered
<b>Organ Transplant</b> <sup>1</sup> Transplant Lifetime Maximum Out-of-Pocket Maximum	100% of Allowed Amount Unlimited See previous page	Not Covered
<b>Behavioral Health Benefit Program Features</b>		
<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</b> <sup>1</sup>	\$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)</b> <sup>1</sup>	100% of Allowed Amount	Not Covered
<b>Residential Treatment</b> <sup>1</sup>	\$350 copay/admission, then 100% of Allowed Amount	Not Covered
<b>Transcranial Magnetic Stimulation (TMS)</b> <sup>1</sup>	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.

# Non-Medicare Retiree HBP Prescription Drug Benefit

## Administered Through CVS Caremark

The Following Is a Summary Overview of the Prescription Drug Benefit for 2025 (Retirees under 65)

Categories	TIER 1	TIER 2	TIER 3	TIER 4	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
	Preferred Generics (Non-Specialty)	Preferred Brands (Non-Specialty)	Non-Preferred Brands and Generics (Non-Formulary)	Specialty Brand/Generic Drugs (Hi-Tech)		
<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 Cleveland Clinic Pharmacies:</b> up to 90-Day Supply	15%	25%	45%	20%	Member Pays 100% of the Discounted Price	Not Available through Rx Plan
<b>Member % Co-insurance 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 Available through Rx Plan
<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>	No	No	No	No	No	No
<b>Components of Each Category</b>			<b>Brand Name Drugs</b> See the <b>EHP Prescription Drug Benefit 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 Benefit Formulary</b>	<b>Discounted Drugs</b> See the <b>EHP Prescription Drug Benefit Formulary</b>	<b>Over-the-Counter Drugs</b> See the <b>EHP Prescription Drug Benefit Formulary</b>
<b>Prior Authorization Required</b>	See the <b>EHP Prescription Drug Benefit Formulary</b> for list of pharmaceuticals requiring prior authorization				No	N/A
<b>Diabetic Supplies<sup>7</sup> Asthma Delivery Devices<sup>7</sup> and 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 Minute Clinics 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 Benefit Formulary*.

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.

# Medicare Eligible and Approved HBP Prescription Drug Benefit

*Administered Through SilverScript®*

The Following Is a Summary Overview of the Prescription Drug Benefit for 2025 (Retirees 65 and over)

Categories	TIER 1	TIER 2	TIER 3	TIER 4
	Generic Rx	Preferred Brands (Formulary)	Non-Preferred Brands (Non-Formulary)	Specialty Drugs (Hi-Tech)
Annual Deductible	\$200 Individual (Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)			
Member % Co-insurance Cleveland Clinic Pharmacies: Outpatient: up to 90-Day Supply Specialty & Home Delivery: up to 90-Day Supply	15%	25%	45%	20%
Member % Co-insurance CVS Caremark Retail: up to 90-Day Supply Mail Service Program: up to 90-Day Supply	20%	30%	50%	20%
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
CVS Caremark Retail up to 90-Day Supply: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$5 Minimum/ \$75 Maximum per Month Supply	Yes \$5 Minimum/ \$75 Maximum per Month Supply	No	N/A
CVS Caremark Mail Service: Is there a Minimum or Maximum to the Rx % Co-insurance?	Yes \$15 Minimum/ \$225 Maximum 90-Day Supply	Yes \$15 Minimum/ \$225 Maximum 90-Day Supply	No	Yes No Minimum/ \$100 Maximum per Month Supply
Out-of-pocket Maximum?	After the deductible has been met: \$2,000 Maximum Out-of-Pocket			
Components of Each Category	Generic Drugs	Brand Drugs		Specialty Drugs
	You will be sent a copy of the SilverScript's Preferred Drug List. You may also contact SilverScript to request a copy of the Preferred Drug List by calling the toll-free number on your SilverScript card.  Medicare Part B vs. Medicare Part D Please note: Most medications are covered under Medicare Part D, but there are some medications that can be covered under both Medicare Part B (i.e., the Medicare outpatient benefit) or Medicare Part D (i.e., the Medicare prescription drug benefit) depending on what the drug is used for and how it is administered. Please consult the SilverScript Prescription Drug Formulary or contact SilverScript using the toll-free phone number on the back of your SilverScript card for more information regarding Medicare Part B vs. Medicare Part D medications.			
Major Chains in the Retail Network	ACME, Cleveland Clinic Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy), Costco, CVS, Discount Drug Mart, Giant Eagle, K-Mart, Marc's, Medicine Shoppe, Rite Aid, Target, Walgreens, Wal-Mart, plus other chains and independent pharmacies.			

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**Note:** Effective January 1, 2018, diabetic testing supplies will no longer be covered under the Medicare Part D program. They will now be covered under Medicare Part B.

Contact SilverScript at 866.693.4617 or visit [clevelandclinic.silverscript.com](http://clevelandclinic.silverscript.com) to obtain the SilverScript Request for Medicare Drug Coverage Determination for Prior Authorization form.