Western Pennsylvania Teamsters & Employers Welfare Fund
884458 High Option

	2022 Community Blue Medicare PPO Summary of Benefits	
	Community Blue Medicare PPO In-Network	**Community Blue Medicare PPO Out-of-Network**
Important Information		
Premium and Other Important Information	You pay a monthly premium of $187. In addition, you keep paying your Medicare Part B premium. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. For more information about Part B premiums based on income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
Plan Deductible	$250	
In Network Out-of-Pocket Maximum (does not include Part D Drugs)	$2,000	
Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,400	
Covered Medical and Hospital Benefits		
Note:	Services with a 1 may require prior authorization.	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services) Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You pay: 10% Coinsurance for each stay.	You pay: 20% Coinsurance for each stay.
Outpatient Hospital/Ambulatory Surgery Center[1]	You pay: 10% Coinsurance	You pay: 20% Coinsurance

Services with a 1 may require prior authorization

Western Pennsylvania Teamsters & Employers Welfare Fund

885977 Low Option

	2022 Community Blue Medicare PPO Summary of Benefits	
	Community Blue Medicare PPO In-Network	Community Blue Medicare PPO Out-of-Network
Important Information		
Premium and Other Important Information	You pay a monthly premium of $157. In addition, you keep paying your Medicare Part B premium. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. For more information about Part B premiums based on income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
Plan Deductible	$1,000	
In Network Out-of-Pocket Maximum (does not include Part D Drugs)	$2,000	
Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,400	
Covered Medical and Hospital Benefits		
Note:	Services with a 1 may require prior authorization.	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services) Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You pay: 10% Coinsurance for each stay.	You pay: 20% Coinsurance for each stay.
Outpatient Hospital/Ambulatory Surgery Center[1]	You pay: 10% Coinsurance	You pay: 20% Coinsurance

Services with a 1 may require prior authorization

Benefit	In-Network	Out-of-Network
Doctor Office Visits Office visit copays do not apply to the annual deductible if applicable	You pay: $20 Copay Primary Care Physician visit You pay: $25 Copay Specialist visit	You pay: 20% Coinsurance Primary Care Physician visit You pay: 20% Coinsurance Specialist visit
Preventive Services	You pay: $0 copay Our plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer Screening, Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes Screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots,Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	
Emergency Care You may go to any emergency room if you reasonably believe you need emergency care.	You pay $50 Copay for each emergency room visit. Worldwide coverage for emergency and urgently needed care. If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.	
Urgent Care This is **not** emergency care	You pay: $40 Copay	

Services with a 1 may require prior authorization

Doctor Office Visits Office visit copays do not apply to the annual deductible if applicable	You pay: $20 Copay Primary Care Physician visit You pay: $25 Copay Specialist visit	You pay: 20% Coinsurance Primary Care Physician visit You pay: 20% Coinsurance Specialist visit
Preventive Services	You pay: $0 copay Our plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer Screening, Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes Screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots,Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	
Emergency Care You may go to any emergency room if you reasonably believe you need emergency care.	You pay $50 Copay for each emergency room visit. Worldwide coverage for emergency and urgently needed care. If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.	
Urgent Care This is **not** emergency care	You pay: $40 Copay	

Services with a 1 may require prior authorization

Diagnostic Tests, Lab, Radiology Services[1] Such as MRIs and CT Scans and X-rays	You pay: 10% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 10% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 10% Coinsurance for standard imaging services. You pay: 10% Coinsurance for advanced imaging services. You pay: $0 Copay for therapeutic radiology services.	You pay: 20% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 20% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 20% Coinsurance for standard imaging services You pay: 20% Coinsurance for advanced imaging services. You pay: 20% Coinsurance for therapeutic radiology services.
Hearing Services Medicare covered Exam to diagnose and treat hearing and balance issues	You pay: $25 Copay	You pay: 20% Coinsurance
Hearing Services Routine Exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum.	You pay: $25 Copay	You pay: 20% Coinsurance
	$499 copay per aid per year for TruHearing Advanced. $799 copay per aid per year for TruHearing Premium.	$500 allowance for hearing aids every 3 years from any other provider.
Dental Services[1] Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.	Medicare covered dental benefits you pay: $25 Copay.	Medicare covered dental benefits you pay: 20% Coinsurance.
Vision Medicare covered Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay: $25 Copay $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	You pay: 20% Coinsurance $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.

Services with a 1 may require prior authorization

Diagnostic Tests, Lab, Radiology Services[1] Such as MRIs and CT Scans and X-rays	You pay: 10% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 10% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 10% Coinsurance for standard imaging services. You pay: 10% Coinsurance for advanced imaging services. You pay: $0 Copay for therapeutic radiology services.	You pay: 20% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 20% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 20% Coinsurance for standard imaging services You pay: 20% Coinsurance for advanced imaging services. You pay: 20% Coinsurance for therapeutic radiology services.
Hearing Services Medicare covered Exam to diagnose and treat hearing and balance issues	You pay: $25 Copay	You pay: 20% Coinsurance
Hearing Services Routine Exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum.	You pay: $25 Copay	You pay: 20% Coinsurance
	$499 copay per aid per year for TruHearing Advanced. $799 copay per aid per year for TruHearing Premium.	$500 allowance for hearing aids every 3 years from any other provider.
Dental Services[1] Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.	Medicare covered dental benefits you pay: $25 Copay.	Medicare covered dental benefits you pay: 20% Coinsurance.
Vision Medicare covered Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay: $25 Copay $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	You pay: 20% Coinsurance $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.

Services with a 1 may require prior authorization

Routine Vision	Routine eye exam (for up to 1 every year) you pay: $0 Copay Eye Wear Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.	You pay: $50 Copay for routine eye exams. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.
Mental Health Care[1] Office visit copays do not apply to the annual deductible.	Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital . Inpatient stay you pay: 10% Coinsurance Outpatient group therapy visit you pay: $25 Copay Outpatient individual therapy visit you pay: $25 Copay	Inpatient stay you pay: 20% Coinsurance Outpatient group therapy visit you pay: 20% Coinsurance Outpatient individual therapy visit you pay: 20% Coinsurance
Skilled Nursing Facility (SNF)[1] Medicare-certified skilled nursing facility	You pay: 10% Coinsurance per admission for days 1-100. No prior hospital stay is required.	You pay: 20% Coinsurance per admission for days 1-100. No prior hospital stay is required.
Physical Therapy[1]	You pay: $25 Copay for Medicare-covered Physical Therapy visits.	You pay: 20% Coinsurance for Medicare-covered Physical Therapy visits.

Services with a 1 may require prior authorization

Routine Vision	Routine eye exam (for up to 1 every year) you pay: $0 Copay Eye Wear Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.	You pay: $50 Copay for routine eye exams. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.
Mental Health Care[1] Office visit copays do not apply to the annual deductible.	Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital . Inpatient stay you pay: 10% Coinsurance Outpatient group therapy visit you pay: $25 Copay Outpatient individual therapy visit you pay: $25 Copay	Inpatient stay you pay: 20% Coinsurance Outpatient group therapy visit you pay: 20% Coinsurance Outpatient individual therapy visit you pay: 20% Coinsurance
Skilled Nursing Facility (SNF)[1] Medicare-certified skilled nursing facility	You pay: 10% Coinsurance per admission for days 1-100. No prior hospital stay is required.	You pay: 20% Coinsurance per admission for days 1-100. No prior hospital stay is required.
Physical Therapy[1]	You pay: $25 Copay for Medicare-covered Physical Therapy visits.	You pay: 20% Coinsurance for Medicare-covered Physical Therapy visits.

Services with a 1 may require prior authorization

Ambulance Services[1] Medically necessary ambulance services	You pay: 10% Coinsurance	Emergency - You pay: 10% Coinsurance Non-Emergency - You pay: 20% Coinsurance
Transportation (Routine)[1] Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	You pay: $10 Copay per trip.	You pay: 50% Coinsurance for out-of-network transportation services.
Part B Drugs[1] Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs. In-network Part B covered chemotherapy drugs and other in-network Part B covered Drugs	You pay: 10% Coinsurance	You pay: 20% Coinsurance
Acupuncture Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain	You pay: $25 Copay for Medicare-covered Acupuncture visits.	You pay: 20% Coinsurance for Medicare-covered Acupuncture visits.
Chiropractic Care[1] Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)	You pay: $20 Copay	You pay: 20% Coinsurance
Diabetes Supplies and Services[1] includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes	You pay: 10% Coinsurance Diabetes self-management training you pay: $0 Copay. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	You pay: 20% Coinsurance

Services with a 1 may require prior authorization

Service	In-Network	Out-of-Network
Ambulance Services[1] Medically necessary ambulance services	You pay: 10% Coinsurance	Emergency - You pay: 10% Coinsurance Non-Emergency - You pay: 20% Coinsurance
Transportation (Routine)[1] Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	You pay: $10 Copay per trip.	You pay: 50% Coinsurance for out-of-network transportation services.
Part B Drugs[1] Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs. In-network Part B covered chemotherapy drugs and other in-network Part B covered Drugs	You pay: 10% Coinsurance	You pay: 20% Coinsurance
Acupuncture Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain	You pay: $25 Copay for Medicare-covered Acupuncture visits.	You pay: 20% Coinsurance for Medicare-covered Acupuncture visits.
Chiropractic Care[1] Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)	You pay: $20 Copay	You pay: 20% Coinsurance
Diabetes Supplies and Services[1] includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes	You pay: 10% Coinsurance Diabetes self-management training you pay: $0 Copay. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	You pay: 20% Coinsurance

Services with a 1 may require prior authorization

Durable Medical Equipment[1] Includes wheelchairs, prosthetics, oxygen, etc.	You pay: 10% Coinsurance for durable medical equipment. You pay: 10% Coinsurance for oxygen and oxygen supplies.	You pay: 20% Coinsurance for durable medical equipment. You pay: 20% Coinsurance for oxygen and oxygen supplies.
Foot Care *(podiatry services)* Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	You pay: $25 Copay	You pay: 20% Coinsurance
Home Health Care[1]	You pay: 10% Coinsurance	You pay: 20% Coinsurance
Outpatient Rehabilitation[1] **Cardiac Rehabilitation** (maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks), **Occupational Therapy, Physical Therapy, Speech and Language Therapy**	You pay: $0 Copay for Cardiac (heart) Rehabilitation services. You pay: $25 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.	You pay: 20% Coinsurance for Cardiac (heart) Rehabilitation services. You pay: 20% Coinsurance for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.
Over the Counter Drug Allowance	Not Covered	
Renal Dialysis Services to Treat Kidney Disease	You pay: $0 Copay	You pay: 20% Coinsurance
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes	You pay: 50% of the cost for out-of-network health/wellness services after a $500 deductible.
Hospice	You pay: $0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	

Services with a 1 may require prior authorization

Durable Medical Equipment[1] Includes wheelchairs, prosthetics, oxygen, etc.	You pay: 10% Coinsurance for durable medical equipment. You pay: 10% Coinsurance for oxygen and oxygen supplies.	You pay: 20% Coinsurance for durable medical equipment. You pay: 20% Coinsurance for oxygen and oxygen supplies.
Foot Care *(podiatry services)* Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	You pay: $25 Copay	You pay: 20% Coinsurance
Home Health Care[1]	You pay: 10% Coinsurance	You pay: 20% Coinsurance
Outpatient Rehabilitation[1] Cardiac Rehabilitation (maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks), **Occupational Therapy, Physical Therapy, Speech and Language Therapy**	You pay: $0 Copay for Cardiac (heart) Rehabilitation services. You pay: $25 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.	You pay: 20% Coinsurance for Cardiac (heart) Rehabilitation services. You pay: 20% Coinsurance for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.
Over the Counter Drug Allowance	Not Covered	
Renal Dialysis Services to Treat Kidney Disease	You pay: $0 Copay	You pay: 20% Coinsurance
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes	You pay: 50% of the cost for out-of-network health/wellness services after a $500 deductible.
Hospice	You pay: $0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	

Services with a 1 may require prior authorization

884458 High Part D Prescription Drug Benefits

DRUG

You pay the following until total yearly drug costs reach $4,430. Total yearly drug costs are the total drug cost paid by both you and a part D plan.

Initial Coverage

Preferred Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Mail Order

Tier	Up to 90 Day Supply
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply

Coverage Gap

Preferred Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Mail Order

Tier	Up to 90 Day Supply
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. You will remain in the coverage gap until your costs (includes the 70% manufacturer discount) total $7,050. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost or $3.95 copayment for a generic $9.85 copayment for all other drugs.

Formulary

Incentive

For questions about this plan's benefits or costs, please contact Community Blue Medicare PPO. Call 1-866-456-7739, (TTY users call 711), seven days a week, between 8 a.m. and 8 p.m. EST. Please have Reference Code 22CBP884458 ready when you call.

885977 Low Part D Prescription Drug Benefits

DRUG

You pay the following until total yearly drug costs reach $4,430. Total yearly drug costs are the total drug cost paid by both you and a part D plan.

Initial Coverage

Preferred Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Mail Order

Tier	Up to 90 Day Supply
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply

Coverage Gap

Preferred Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available

Mail Order

Tier	Up to 90 Day Supply
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. You will remain in the coverage gap until your costs (includes the 70% manufacturer discount) total $7,050. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost or $3.95 copayment for a generic $9.85 copayment for all other drugs.

Formulary

Incentive

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