$5/$20/$35 with Coinsurance

Prescription Drug Plan Schedule of Benefits 2019

This benefit and payment chart is a summary of covered services and supplies. *Please refer to the entire Prescription Drug Plan Certificate for additional benefits, limitations, and exclusions.*

! = An exclamation point next to a drug means precertification is required.

Benefit	Coinsurance/Copayment		
	Participating 30-Day Retail Pharmacy	Participating 90-Day Retail Pharmacy	Participating 90-Day Mail Order Pharmacy
Prescription Drugs and Medications			
Generic	$5	$10	$10
Preferred Brand Name	$20	$45	$45
Non-Preferred Brand Name	$35	$75	$75
All Prescriptions over $250 (per 30-day supply)	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost
Chemotherapy – Oral Drugs			
!Chemotherapy – Oral	None	Not Covered	Not Covered
Contraceptives			
Contraceptive Diaphragms / Cervical Caps	None	None	None
Contraceptives – Oral			
Generic	None	None	None
Preferred	$20	$45	$45
Insulin			
Preferred	$20	$45	$45
Non-Preferred	$35	$75	$75
Diabetic Drugs and Supplies			
Diabetic Supplies			
Preferred	None	None	None
Non-Preferred	$35	$75	$75
Diabetic Drugs			
Generic	None	None	None
Preferred	$5	$10	$10
Non-Preferred	$35	$75	$75
All Prescriptions over $250 (per 30-day supply)	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost
Spacers and Peak Flow Meters for Asthma			
Spacers and Peak Flow Meters	None	Not Covered	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs			
USPSTF Recommended	None	Not Covered	Not Covered

% = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

Out-of-Pocket Maximum. The maximum out-of-pocket deductible, copayment, and coinsurance amounts you pay in a calendar year for Prescription Drugs and Supplies vary when combined with a Medical Plan as follows.

- Comprehensive Plus: $5,350 per person and $8,700 per family
- Option Plus Two: $4,850 per person and $7,200 per family
- Option Plus One: $6,750 per person and $12,900 per family

Note: If you go to a non-participating mail-order pharmacy, no coverage is provided. If you go to a non-participating retail or specialty pharmacy, you must pay the total amount up front and submit a claim to HMAA. HMAA will reimburse you based on the in-network negotiated price minus applicable copayments and coinsurance. You will be responsible for any remaining balance over the eligible charge up to the full billed amount. All prescriptions of $1,000 or more, and all compounded medications, require precertification.

$12/$24/$48 with Coinsurance

Prescription Drug Plan Schedule of Benefits 2019

This benefit and payment chart is a summary of covered services and supplies. *Please refer to the entire Prescription Drug Plan Certificate for additional benefits, limitations, and exclusions.*

! = An exclamation point next to a drug means precertification is required.

Benefit	Coinsurance/Copayment		
	Participating 30-Day Retail Pharmacy	Participating 90-Day Retail Pharmacy	Participating 90-Day Mail Order Pharmacy
Prescription Drugs and Medications			
Generic	$12	$24	$24
Preferred Brand Name	$24	$48	$48
Non-Preferred Brand Name	$48	$96	$96
All Prescriptions over $250 (per 30-day supply)	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost
Chemotherapy – Oral Drugs			
!Chemotherapy – Oral	None	Not Covered	Not Covered
Contraceptives			
Contraceptive Diaphragms / Cervical Caps	None	None	None
Contraceptives – Oral			
Generic	None	None	None
Preferred	$24	$48	$48
Insulin			
Preferred	$24	$48	$48
Non-Preferred	$48	$96	$96
Diabetic Drugs and Supplies			
Diabetic Supplies			
Preferred	None	None	None
Non-Preferred	$48	$96	$96
Diabetic Drugs			
Generic	None	None	None
Preferred	$12	$24	$24
Non-Preferred	$48	$96	$96
All Prescriptions over $250 (per 30-day supply)	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost	Greater of Copayment or 20% of ingredient cost
Spacers and Peak Flow Meters for Asthma			
Spacers and Peak Flow Meters	None	Not Covered	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs			
USPSTF Recommended	None	Not Covered	Not Covered

% = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

Out-of-Pocket Maximum. The maximum out-of-pocket deductible, copayment, and coinsurance amounts you pay in a calendar year for Prescription Drugs and Supplies vary when combined with a Medical Plan as follows.

- Comprehensive Plus: $5,350 per person and $8,700 per family
- Option Plus Two: $4,850 per person and $7,200 per family
- Option Plus One: $6,750 per person and $12,900 per family

Note: If you go to a non-participating mail-order pharmacy, no coverage is provided. If you go to a non-participating retail or specialty pharmacy, you must pay the total amount up front and submit a claim to HMAA. HMAA will reimburse you based on the in-network negotiated price minus applicable copayments and coinsurance. You will be responsible for any remaining balance over the eligible charge up to the full billed amount. All prescriptions of $1,000 or more, and all compounded medications, require precertification.

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