

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
<b>Prescription Drugs and Medications</b>			
Generic	\$5	\$10	\$10
Preferred Brand Name	\$20	\$45	\$45
Non-Preferred Brand Name	\$35	\$75	\$75
All Prescriptions over \$150 (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
<b>Chemotherapy – Oral Drugs</b>			
!Chemotherapy – Oral	None	Not Covered	Not Covered
<b>Contraceptives</b>			
Contraceptive Diaphragms / Cervical Caps	None	None	None
Contraceptives – Oral			
Generic	None	None	None
Preferred	\$20	\$45	\$45
<b>Insulin</b>			
Preferred	\$20	\$45	\$45
Non-Preferred	\$35	\$75	\$75
<b>Diabetic Drugs and Supplies</b>			
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 \$150 (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
<b>Spacers and Peak Flow Meters for Asthma</b>			
Spacers and Peak Flow Meters	None	Not Covered	Not Covered
<b>U.S. Preventive Services Task Force (USPSTF) Recommended Drugs</b>			
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 Basic: \$5,350 per person and \$8,700 per family
- 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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Benefit	Coinsurance/Copayment		
	Participating 30-Day Retail Pharmacy	Participating 90-Day Retail Pharmacy	Participating 90-Day Mail Order Pharmacy
<b>Prescription Drugs and Medications</b>			
Generic	\$12	\$24	\$24
Preferred Brand Name	\$24	\$48	\$48
Non-Preferred Brand Name	\$48	\$96	\$96
All Prescriptions over \$125 (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
<b>Chemotherapy – Oral Drugs</b>			
!Chemotherapy – Oral	None	Not Covered	Not Covered
<b>Contraceptives</b>			
Contraceptive Diaphragms / Cervical Caps	None	None	None
Contraceptives – Oral			
Generic	None	None	None
Preferred	\$24	\$48	\$48
<b>Insulin</b>			
Preferred	\$24	\$48	\$48
Non-Preferred	\$48	\$96	\$96
<b>Diabetic Drugs and Supplies</b>			
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 \$125 (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
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