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HEALTH MAINTENANCE ORGANIZATION (HMO)

SCHEDULE OF BENEFITS

Imperial Preferred Silver 94% CSR

IMPERIAL INSURANCE COMPANIES

SCHEDULE OF BENEFITS

This Schedule of Benefits lists the **deductibles**, **copayments** if any, which apply to the **eligible health services you** get under this plan. **You** should read this schedule to become aware of these and any limits that apply to the services.

How To Read Your Schedule of Benefits

- **You** must pay any **deductibles**, **copayments** if they apply.
- **You** must pay the full amount of any health care service **you** get that is not a **covered benefit**.
- This plan has limits for some **covered benefits**. For example, these could be:
  - Visit limits
  - Day limits
  - Dollar limits

IMPORTANT NOTE:

All **covered benefits** are subject to the **calendar year deductible**, **maximum out-of-pocket limit**, **copayments** or **coinsurance** unless otherwise noted in this Schedule of Benefits below.

How Your Deductible Works

This Schedule of Benefits shows the **deductible** amounts that apply to **your** plan. Once **you** have met **your deductible**, **we** will start sharing the cost when **you** get **eligible health services**. **Copayments** do not accumulate to **your deductible,** but do accumulate to **your maximum out-of-pocket limit**. **You** will continue to pay **copayments** or **coinsurance**, if any, for **eligible health services** after **you** meet **your deductible**.

How Your PCP Or Physician Office Visit Cost Share Works

You will pay the **PCP** cost share when **you** get **eligible health services** from the **PCP you** select. **You** will pay the **specialist** cost share when **you** get **eligible health services** from a network **PCP** that is not **your PCP**. If **you** did not select a **PCP you** will pay the **specialist** cost share for **eligible health services** from any network **PCP** or network **specialist**.

How Your Maximum Out-Of-Pocket Limit Works

This Schedule of Benefits shows the **maximum out-of-pocket limits** that apply to **your** plan. Once **you** reach **your maximum out-of-pocket limit**, **your** plan will pay for **eligible health services** for the remainder of that year.

How To Contact Us For Help

We are here to answer **your** questions. **You** can:

- Go to our website at **www.ImperialHealthPlan.com**
- Call the number on **your** ID card

Imperial Insurance Companies HMO **Policy** provides the coverage described in this Schedule of Benefits**.** This schedule replaces any Schedule of Benefits previously in use. Keep it with **your Policy**.



IMPERIAL INSURANCE COMPANIES

Plan Features –Deductible And Maximum Out-Of-Pocket Limits

Deductible

You Have To Meet **Your Deductible** Before This Plan Pays For Benefits.

Deductible	In-Network
Individual	$500
Family	$1,000

Deductible Waiver

The in-network **deductible** is waived for all of the following **eligible health services**:

- Preventive care and wellness
- Family planning services – female contraceptives
- Nutritional Support

Maximum Out-Of-Pocket Limit

Maximum Out-Of-Pocket Limit	In-Network
Individual	$1,750
Family	$3,500

General Coverage Provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible Provisions

- **Your deductible** may apply to **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.
- The **deductible** may not apply to certain **eligible health services**. **You** must pay any applicable cost share for **eligible health services** to which the **deductible** doesn't apply.

Individual Deductible

You pay for **eligible health services** each year before the plan begins to pay. This individual **deductible** applies separately to **you** and each covered dependent. Once **you** have reached the **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

Family Deductible

You pay for **eligible health services** each year before the plan begins to pay. After the amount paid for **eligible health services** reaches **your** family **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that **you** and each of **your** covered dependents incur towards the individual **deductible** must reach this family **deductible** in a year.

When this happens in a year, the individual **deductibles** for **you** and **your** covered dependents are met for the rest of the year.

Deductible Credit

If **you** paid part or all of **your deductible** under other coverage for the year that this plan went into effect, **we** will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If **we** ask, **you** must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Maximum Out-Of-Pocket Limit Provisions

- **Eligible health services** that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of **you** must meet **your maximum out-of-pocket limit** separately.

Individual Maximum Out-Of-Pocket Limit

Once **you** or **your** covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the rest of the year for that person.

Family Maximum Out-Of-Pocket Limit

Once **you** or **your** covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the remainder of the year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, **your** cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount. Certain costs that **you** incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care **provider**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Your Financial Responsibility And Decisions Regarding Benefits

We base **your** financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the **Policy**.

Eligible Health Services

1. Preventive Care And Wellness

Description	In-Network
Preventive care and wellness	$0 **copay**, no **deductible** applies

Preventive Care And Wellness includes:

- Routine physical exams performed at a **physician** office
- Preventive care immunizations performed at a facility or at a **physician** office
- Well woman preventive visits including routine gynecological exams and Pap smears) performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office
- Preventive screening and counseling services which includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - office visits
- Routine cancer screenings performed at a **physician**, **specialist** office or facility
- Prenatal care services - provided by an OB, GYN, or OB/GYN
- Comprehensive lactation support and counseling services - facility or office visits
- Breast feeding durable medical equipment - breast pump supplies and accessories
- Family planning services – female contraceptive counseling services office visit, devices, voluntary sterilization

Preventive Care And Wellness Benefit Limits

Routine Physical Exams

- Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- High risk Human Papillomavirus Virus (HPV) DNA testing

Preventive Care Immunizations

Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact **your physician.**

Well Woman Preventive Visits

Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Screening And Counseling Services

- Obesity and/or healthy diet
- Misuse of alcohol and/or drugs
- Use of tobacco products
- Sexually transmitted infection
- Genetic risk counseling for breast and ovarian cancer

Routine Cancer Screenings

Subject to any age; family history; and frequency guidelines as set forth in the most current:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- The comprehensive guidelines supported by the Health Resources and Services Administration

Lung cancer screenings that exceed the cancer-screening limit are covered under the *Outpatient Diagnostic Testing* section.

Prenatal Care Services

Review the *Maternity and Related Newborn Care* section of **your Policy**. It will give **you** more information on coverage levels for maternity care under this plan.

Comprehensive Lactation Support And Counseling Services

- Lactation counseling services either in a group or individual setting
- Lactation counseling services are covered under this benefit for the duration of the member's needs for counseling and support

Breast Feeding Durable Medical Equipment

See the *Breast Feeding Durable Medical Equipment* section of the **Policy** for limitations on breast pump and supplies.

Family Planning Services

Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

2. Physicians And Other Health Professionals

Physician Services/Primary Care Physician (PCP) Visit

Description	In-Network
PCP Office hours visits (non-surgical) non preventive care	$0 **copay**, no **deductible** applies
Telemedicine or **telehealth** consultation by a **Physician**	$0 **copay**, no **deductible** applies
Other Practitioner Office Visit	$0 **copay**, no **deductible** applies

Your Policy pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The eligible health service is medically necessary
- **You** get **your** care from:
  - **Your PCP**
  - Another **network provider** after **you** get a **referra**l from **your PCP**
- **You** or **your provider preauthorizes** the **eligible health service** when required

Specialist Office Visits

Description	In-Network
Office hours visit (non-surgical)	$5 **copay**, no **deductible** applies
Telemedicine or **telehealth** consultation by a **Specialist**	$5 **copay**, no **deductible** applies

Allergy Testing And Treatment

Description	In-Network
Performed at a **physician** or **specialist** office visit	10.00% **Coinsurance** after **deductible**

Immunizations That Are Not Considered Preventive Care

Description	In-Network
Immunizations that are not considered preventive care	10% **coinsurance** after **deductible**

Medical Injectables

Description	In-Network
Performed at a **physician** or **specialist** office	10% **coinsurance** after **deductible**

Physician Surgical Services

Description	In-Network
Inpatient surgical services	10.00% **Coinsurance** after **deductible**
Performed at a **physician** or **specialist** office	10.00% **Coinsurance** after **deductible**

3. Inpatient and Outpatient Hospital Services

Hospital Care

Description	In-Network
Inpatient **hospital**	10.00% **Coinsurance** after **deductible**

Private-Duty Nursing

Description	In-Network
Private-Duty Nursing	10% **coinsurance** after **deductible**
Limits	When provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, or Hospice Care Facility, limits for such facility services apply

Specialty Prescription Drugs

Description	In-Network
Performed in a **physician** office, outpatient department of a **hospital**, other outpatient facility that is not a **hospital**, or in the home	10% **coinsurance** after **deductible**

4. Extended Care Services

Outpatient Surgery

Description	In-Network
Physician/Surgical services performed in **hospital** outpatient department or other facility	10.00% **Coinsurance** after **deductible**
Outpatient Facility Fee (e.g., Ambulatory Surgical Center)	10.00% **Coinsurance** after **deductible**

Home Health Care

Description	In-Network
Outpatient	10.00% **Coinsurance** after **deductible**
Visit limit per year	Unlimited except for 1 social service consultation and 1 nutrition consultation

IMPORTANT NOTE:
Limited to 3 intermittent visits per day provided by a participating home health care agency. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Hospice Care

Description	In-Network
Inpatient services	10.00% **Coinsurance** after **deductible**
Outpatient services	10.00% **Coinsurance** after **deductible**
Respite Care Limit	5 Inpatient days or 5 Outpatient visits per 90 days

Skilled Nursing Facility

Description	In-Network
Inpatient facility	10.00% **Coinsurance** after **deductible**
Day limit per year	Coverage is limited to 100 days per calendar year

5. Emergency Services

A Separate **Hospital** Emergency Room (Or Comparable Facility/Freestanding Emergency Medical Care Facility) Or Urgent Care Cost Share Will Apply For Each Visit To An Emergency Room Or An Urgent Care **Provider**.

Description	In-Network
Hospital emergency room (or comparable facility/freestanding emergency medical care facility)	10.00% **Coinsurance** after **deductible**
Non-emergency care in a **hospital** emergency room (or comparable facility/freestanding emergency medical care facility)	Not covered

IMPORTANT NOTE:

Emergency Services are **covered the same out-of-network as in-network. Out-of-network providers** do not have a contract with **us**. **We** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of **your** cost share (**deductible**, **copayment**) as payment in full. **You** may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills **you** for an amount above **your** cost share, **you** are not responsible for paying that amount. **You** should send the bill to the address listed on the back of your ID card, and **we** will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. If **you** are admitted to a **hospital** as an inpatient right after a visit to an emergency room (or comparable facility/freestanding emergency medical care facility) and **you** have an emergency room **copay**, **your copay** will be waived.

6. Urgent Care Services

Description	In-Network
Urgent medical care at a free standing facility that is not a **hospital**	$10 **copay**, no **deductible** applies

7. Pregnancy and Maternity Care

Family Planning Services - Other

Voluntary Sterilization for Males

Description	In-Network
Inpatient	10% **coinsurance** after **deductible**
Outpatient	10% **coinsurance** after **deductible**

Maternity And Related Newborn Care

Inpatient Prenatal and Postnatal Care Services

Description	In-Network
Inpatient maternity and prenatal related services and supplies	$0 **copay**, no **deductible** applies

Delivery and Maternity Care Services

Description	In-Network
Inpatient and newborn care services and supplies	10.00% **Coinsurance** after **deductible**
Well Baby Visits and Care	$0 **copay** no **deductible** applies

IMPORTANT NOTE:

When **you** receive services from an OB, GYN or OB/GYN for prenatal care, **you** will not incur a cost share. However, **you** will incur a cost share for delivery and postpartum care services received by an OB, GYN or OB/GYN.

8. Pediatric

Pediatric Vision Care

Coverage is limited to covered persons through the end of the month in which the person turns 19

Routine Vision Exams (Including Refraction)

Description	In-Network
Performed by an ophthalmologist or optometrist	0% **coinsurance**, no **deductible** applies
Visit limit per year	Coverage is limited to 1 exam every 12 months

Pediatric Vision Care Services And Supplies

Coverage is limited to covered persons through the end of the month in which the person turns 19

Description	In-Network
Office visit for fitting of contact lenses	Not covered
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	0% **coinsurance**, no **deductible** applies

Limits

Description	Limit
Number of eyeglass frames per year	One set of eyeglass frames
Number of **prescription** lenses per year	One pair of **prescription** lenses
Number of **prescription** contact lenses per year	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set

IMPORTANT NOTE:

Refer to the *Pediatric Vision Care* section in the **Policy** for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both**.**

Pediatric Dental Care

Coverage is limited to covered persons through the end of the month in which the person turns 19

Description	In-Network
Diagnostic and Preventive Services	0% **coinsurance**, no **deductible** applies
Basic Services	10% **coinsurance**, no **deductible** applies
Major Services	10.00% **Coinsurance** after **deductible**
Medically Necessary Orthodontic Services	10.00% **Coinsurance** after **deductible**

9. Specific Therapies and Tests

Outpatient Diagnostic Testing

Description	In-Network
Diagnostic Complex Imaging Services	10.00% **Coinsurance** after **deductible**
Diagnostic Lab Work	$20 **copay**, no **deductible** applies
Diagnostic Radiological Services (x-rays)	$40 **copay**, no **deductible** applies

IMPORTANT NOTE:

Cost shares for diagnostic mammograms will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive Care And Wellness* section. Diagnostic mammograms are not subject to any age limitation.

IMPORTANT NOTE:

Even if **you** receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services **you** receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. **You** may receive a bill for services from these **out-of-network providers**, as **we** paid them at **our** usual and customary rate or at an agreed rate. **We** will work with the **providers** so that all **you** pay is your appropriate network level **copayments**. If **you** are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner please contact **us.**

Outpatient Therapies

Chemotherapy

Description	In-Network
Chemotherapy	10.00% **Coinsurance** after **deductible**

Outpatient Infusion Therapy

Description	In-Network
Performed in a **physician** office, person's home, outpatient facility, or outpatient department of a hospital	10.00% **Coinsurance** after **deductible**

Radiation Therapy (Therapeutic Radiology)

Description	In-Network
Radiation therapy	10.00% **Coinsurance** after **deductible**

Short-Term Cardiac And Pulmonary Rehabilitation Services

A visit is equal to no more than 1 hour of therapy.

Description	In-Network
Cardiac and pulmonary rehabilitation	10.00% **Coinsurance** after **deductible**
Limit	Unlimited

Short-Term Rehabilitation Therapy Services

A visit is equal to no more than 1 hour of therapy.

Outpatient Physical Therapy

Description	In-Network
Physical Therapy (PT)	$10 **copay**, no **deductible** applies
Visit limit per year	Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year

Outpatient Occupational Therapy

Description	In-Network
Occupational Therapy (OT)	$10 **copay**, no **deductible** applies
Visit limit per year	Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year

Outpatient Speech Therapy

Description	In-Network
Speech Therapy (ST)	$10 **copay**, no **deductible** applies
Visit limit per year	Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year

Chiropractic

Description	In-Network
Spinal manipulation (Chiro)	$20 **copay**, no **deductible** applies
Visit limit per year	Coverage is limited to 20 visits per calendar year

Habilitation Therapy Services

Description	In-Network
Physical, occupational, and speech therapies	10.00% **Coinsurance** after **deductible**
Visit limit per year	Coverage is limited to 120 visits per calendar year

10. Other Services and Conditions

Ambulance Service

Description	In-Network
Emergency **ambulance**	10.00% **Coinsurance** after **deductible**
Non-emergency **ambulance**	10.00% **Coinsurance** after **deductible**

IMPORTANT NOTE:

- **Out-of-network providers** do not have a contract with **us**. **We** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of **your** cost share (**copayment**), as payment in full. **You** may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills **you** for an amount above **your** cost share, **you** are not responsible for paying that amount.
- **You** should send the bill to the address listed on the back of **your** ID card, and **we** will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.

Clinical Trial Therapies (Experimental Or Investigational)

Description	In-Network
Clinical trial therapies (including routine patient costs)	10% **coinsurance** after **deductible**

Durable Medical Equipment (DME)

Description	In-Network
DME	10.00% **Coinsurance** after **deductible**
Limit	Single purchase of a type of DME every 3 years

Hearing Aids and Cochlear Implants and Related Services

Description	In-Network
Hearing aids	10.00% **Coinsurance** after **deductible**
Hearing aids limit	Single purchase of a type of Hearing Aid every 3 years
Cochlear implants and related services	10.00% **Coinsurance** after **deductible**
Replacement of cochlear implant external speech processor and controller components limit	Single purchase of a type of Hearing Aid every 3 years

Nutritional Support

Description	In-Network
Nutritional support	10% **coinsurance** after **deductible**
Limits	Special Food Products and Enteral Formulas subject to limit of 30 day supply 4 times per year

Biomarker Testing

Description	In-Network
Biomarker Testing	10.00% **Coinsurance** after **deductible**

Obesity (Bariatric) Surgery

Description	In-Network
Obesity (bariatric) **surgery**	10.00% **Coinsurance** after **deductible**
Limit	1 surgery per lifetime

Orthotic Devices

Description	In-Network
Orthotic devices	10% **coinsurance** after **deductible**

Prosthetic Devices

Description	In-Network
Prosthetic devices	10.00% **Coinsurance** after **deductible**
Limit	Single purchase of a type of prosthetic device every 3 years

Autism Spectrum Disorder

Description	In-Network
Autism spectrum disorder	$0 **copay**, no **deductible** applies
Applied behavior analysis	$0 **copay**, no **deductible** applies
Limit	None

Diabetic Equipment, Supplies And Education

Description	In-Network
Diabetic equipment, supplies, and education	10.00% **Coinsurance** after **deductible**

Temporomandibular Joint (TMJ) Treatment

Description	In-Network
Temporomandibular Joint (TMJ) treatment	10.00% **Coinsurance** after **deductible**

Behavioral Health

Mental Health Treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-Network
Inpatient mental health treatment	10.00% **Coinsurance** after **deductible**
Other inpatient mental health treatment services and supplies	10.00% **Coinsurance** after **deductible**
Outpatient mental health treatment visits to a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient mental health **telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient mental health **telemedicine** or **telehealth** visit	$0 **copay**, no **deductible** applies
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	$0 **copay**, no **deductible** applies

Substance Related Disorders Treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-Network
Inpatient **substance related disorders detoxification,** rehabilitation, and treatment in a **residential treatment facility**	10.00% **Coinsurance** after **deductible**
Other inpatient **substance related disorders detoxification** services and supplies, rehabilitation services and supplies, **residential treatment facility** services and supplies	10.00% **Coinsurance** after **deductible**
Outpatient **substance abuse** treatment visits to a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient **substance abuse telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 **copay**, no **deductible** applies
Outpatient **substance related disorders telemedicine** or **telehealth** visit	$0 **copay**, no **deductible** applies

Other outpatient **substance related disorders** services or **partial hospitalization treatment** and **intensive outpatient program**	$0 **copay**, no **deductible** applies

Reconstructive Surgery And Supplies

Description	In-Network
Reconstructive breast **surgery**	10.00% **Coinsurance** after **deductible**
Other reconstructive **surgery** and supplies	10.00% **Coinsurance** after **deductible**

Transplant Services

Description	In-Network
Services and supplies	10.00% **Coinsurance** after **deductible**

Treatment Of Infertility

Description	In-Network
Basic **infertility** services	10.00% **Coinsurance** after **deductible**
Limit	6 cycles per lifetime

Gender Affirming Care

Description	In-Network
Gender Affirming Care	10.00% **Coinsurance** after **deductible**

11. Prescription Drugs/Medications

Per Prescription Cost Share

Tier 1 - Preventive Care Drugs And Supplements

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill, no **deductible** applies
Limit	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the *How To Contact **Us** For Help* section.

Tier 2 - Generic Prescription Drugs

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	$0 **copay**, no **deductible** applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$0 **copay**, no **deductible** applies

Tier 3 - Preferred Brand-Name Prescription Drugs

Description	In-Network

For each 30 day supply filled at a **retail pharmacy**	10.00% **Coinsurance** after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	10.00% **Coinsurance** after **deductible**

Tier 4 - Non-Preferred Brand-Name Prescription Drugs

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	10.00% **Coinsurance** after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	10.00% **Coinsurance** after **deductible**

IMPORTANT NOTE:

- If the **negotiated charge** or usual and customary fee is less than your **copayment**, **you** may only be required to pay the lower cost.
- Tier 2, 3 and 4 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.

Tier 5 - Specialty Prescription Drugs

Description	In-Network
For each 30 day supply filled at a **specialty network pharmacy**	10.00% **Coinsurance** after **deductible**

Diabetic Supplies And Insulin

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug in the Schedule of Benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	Paid according to the tier of drug in the Schedule of Benefits, above

Orally Administered Anti-Cancer Medications

Description	In-Network
For each 30 day supply filled at a **retail pharmacy** or **specialty network pharmacy**	$0 per **prescription** or refill after **deductible**. Not to exceed $100 per prescription, including any **deductible.**

Outpatient Contraceptive Prescription Drugs And Devices

Description	In-Network
Female contraceptives that are **generic prescription drugs** and OTC drugs and devices. For each 30 day supply	$0 per **prescription** or refill, no **deductible** applies
Female contraceptives that are **brand-name prescription drugs** and devices. For each 30 day supply	Paid according to the tier of drug in the Schedule of Benefits, above

IMPORTANT NOTE:

For in-network coverage, **brand-name prescription drugs** and devices are covered at 100% when a generic is not available.

Risk Reducing Breast Cancer Prescription Drugs

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill, no **deductible** applies
Limit	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, see the *How To Contact **Us** For Help* section.

Tobacco Cessation Prescription And Over-The-Counter Drugs

Description	In-Network
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill, no **deductible** applies
Limit	• Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the Schedule of Benefits, above. • Coverage only includes a **generic prescription drug** when there is also a brand-name drug available. • Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How To Contact **Us** For Help* section.

IMPORTANT NOTE:

- See the *Outpatient Prescription Drugs, Other Services* section for more information on other prescription drug coverage under this plan.
- If **you** or **your prescriber** requests a covered **brand-name prescription drug** when a covered

generic prescription drug equivalent is available, **you** will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**.