PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Fred Hutchinson Cancer Center
Group Number: 9000090 & 9000091

Effective Date: 07/01/2023

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**PLAN** A: **PPO - $450/650 10/30% $1750 $25 -** PLUS*	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$450 PCY	$650 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	30%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	$1,750 PCY	$4,000
Office Visit Cost Share	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Not Covered
Immunizations (Unlimited)	Covered in Full	Covered in Full, paid to Billed Charges
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICE OPTIONS		

MEDICAL PLAN	PLAN B: PPO - $450/650 10/30% $1750 $25 - PRIME*	
	IN-NETWORK	**OUT-OF-NETWORK**
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Other Professional Diagnostic Imaging	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Professional Diagnostic Major Imaging	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then 30%
FACILITY CARE OPTIONS		
Inpatient Facility	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Inpatient Professional Services	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Outpatient Surgery Facility	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Skilled Nursing Facility (180 days PCY; includes room and board, and facility billed professional and ancillary fees)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Inpatient: 10 days; Respite: 240 hours; 12 month limit)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Hospice Care (Inpatient: 10 days; Respite: 240 hours; 12 month limit)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum

MEDICAL PLAN	PLAN B: PPO - $450/650 10/30% $1750 $25 - PRIME*	
	IN-NETWORK	**OUT-OF-NETWORK**
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence for Knee & Hip Total Joint Replacement (Not Including Partial & Revisions) (Excluded)	Excluded	Excluded
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions) (Excluded)	Excluded	Excluded
Centers of Excellence for Radiology (Member Outreach Excluded)	Excluded	Excluded
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging (Unlimited)	$450 PCY Deductible, 0% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	Not Covered
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay then $450 PCY Deductible and 10% Coinsurance; all cost shares apply to the $1,750 PCY Out of Pocket Maximum	$150 Copay then $450 PCY Deductible and 10% Coinsurance; all cost shares apply to the $1,750 PCY Out of Pocket Maximum
Emergency Room Physician	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (Acupuncture, Manipulation, Massage Therapy: Combined 60 visits PCY)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Manipulations (Spinal and other) (Acupuncture, Manipulation, Massage Therapy: Combined 60 visits PCY)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum

MEDICAL PLAN	PLAN B: PPO - $450/650 10/30% $1750 $25 - PRIME*	
	IN-NETWORK	**OUT-OF-NETWORK**
REHABILITATION & NEURO		
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech, and Chronic Pain (60 visits PCY combined limit for outpatient services)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Transplants (Unlimited up to member annual max)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Vision Hardware ($200 PCY)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PCY Under age 19)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full
Routine Hearing Exam (1 PCY)	$25 Copay	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

*This plan is self-funded by Fred Hutchinson Cancer Center, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

Fred Hutchinson Cancer Center

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Office Visit Cost Share	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Not Covered
Immunizations (Unlimited)	Covered in Full	Covered in Full, paid to Billed Charges
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
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Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum

MEDICAL PLAN	PLAN A: PPO - $450/650 10/30% $1750 $25 - PLUS*	
	IN-NETWORK	**OUT-OF-NETWORK**
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Professional Diagnostic Major Imaging	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then 30%
FACILITY CARE OPTIONS		
Inpatient Facility	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Inpatient Professional Services	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Outpatient Surgery Facility	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Skilled Nursing Facility (180 days PCY; includes room and board, and facility billed professional and ancillary fees)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Inpatient: 10 days; Respite: 240 hours; 12 month limit)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Hospice Care (Inpatient: 10 days; Respite: 240 hours; 12 month limit)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		

MEDICAL PLAN	PLAN A: PPO - $450/650 10/30% $1750 $25 - PLUS*	
	IN-NETWORK	**OUT-OF-NETWORK**
Centers of Excellence for Knee & Hip Total Joint Replacement (Not Including Partial & Revisions) (Excluded)	Excluded	Excluded
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions) (Excluded)	Excluded	Excluded
Centers of Excellence for Radiology (Member Outreach Excluded)	Excluded	Excluded
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging (Unlimited)	$450 PCY Deductible, 0% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	Not Covered
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay then $450 PCY Deductible and 10% Coinsurance; all cost shares apply to the $1,750 PCY Out of Pocket Maximum	$150 Copay then $450 PCY Deductible and 10% Coinsurance; all cost shares apply to the $1,750 PCY Out of Pocket Maximum
Emergency Room Physician	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (Acupuncture, Manipulation, Massage Therapy: Combined 60 visits PCY)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Manipulations (Spinal and other) (Acupuncture, Manipulation, Massage Therapy: Combined 60 visits PCY)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
REHABILITATION & NEURO		

MEDICAL PLAN	PLAN A: PPO - $450/650 10/30% $1750 $25 - PLUS*	
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Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech, and Chronic Pain (60 visits PCY combined limit for outpatient services)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$450 PCY Deductible, then 10% Coinsurance, applies to $1,750 PCY Out of Pocket Maximum	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Transplants (Unlimited up to member annual max)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
Vision Hardware ($200 PCY)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PCY Under age 19)	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum	$25 Copay, applies to the $1,750 PCY Out of Pocket Maximum
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full
Routine Hearing Exam (1 PCY)	$25 Copay	$650 PCY Deductible, then 30% Coinsurance, applies to $4,000 Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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Fred Hutchinson Cancer Center

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Effective Date: 07/01/2023

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN	**RETAIL $10/$30/$50/30% MAIL $20/$60/$50/$30%***
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	$10/$30/$50/30%
Mail Cost Shares	$20/$60/$50/30%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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