

# Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into [www.premera.com](http://www.premera.com) to find drug costs and coverages specific to your plan.

<b>PHARMACY PLAN</b>	
<b>PC: PHARMACY - \$15/\$35 - \$150 DEDUCTIBLE</b>	
<b>PRESCRIPTION DRUGS</b>	
<b>Formulary Drug List</b>	Preferred A2 Tier 1 = generic Tier 2 = brands
<b>Annual Benefit Maximum</b>	Unlimited
<b>Individual Deductible PCY</b>	\$150 ded waived for generics
<b>Family Deductible PCY</b>	No Family Deductible
<b>Out of Network (Non-participating retail pharmacies)</b>	Cost Share, then 40% (to allowable)
<b>Out of Pocket Maximum</b>	Applies to the medical out of pocket maximum
<b>Retail Cost Shares</b>	Tier 1 = \$15 Tier 2 = \$35
<b>Mail Cost Shares</b>	Tier 1 = \$37 Tier 2 = \$87
<b>Day Supply</b>	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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.*