PREMERA HMO

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 to find drug costs and coverages specific to your plan.

PHARMACY PLAN	**PC: PHARMACY HMO - $10/$25/$45/30%**
PRESCRIPTION DRUGS	
Formulary 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 Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	Tier 1 = $10 Tier 2 = $25 Tier 3 = $45 Tier 4 = 30%
Mail Cost Shares	Tier 1 = $25 Tier 2 = $62.50 Tier 3 = $45 Tier 4 = 30%
Day Supply	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 HMO. 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.

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