

## BENEFITS AT-A-GLANCE: DRUG

All costs are for participating providers only. Please see your Guide to Benefits for information on providers outside our network.

|                                                                                               | Drug (483)                                     |
|-----------------------------------------------------------------------------------------------|------------------------------------------------|
|                                                                                               | Member Cost                                    |
| Maximum Out-of-Pocket                                                                         | Single: \$3,600<br>Family: \$4,200             |
| <b>1-30-day supply from pharmacies</b>                                                        |                                                |
| Tier 1: mostly Generic drugs                                                                  | \$10 copayment                                 |
| Tier 2: mostly Preferred Formulary Drugs                                                      | \$20 copayment                                 |
| Tier 3: mostly Non-Preferred Formulary Drugs                                                  | \$20 copayment<br>plus \$45 Tier 3 cost share  |
| Tier 4: mostly Preferred Formulary Specialty Drugs                                            | 20% coinsurance                                |
| Tier 5: mostly Non-Preferred Formulary Specialty Drugs                                        | 25% coinsurance                                |
| <b>84-90-day supply from participating pharmacies or mail-order prescription drug program</b> |                                                |
| Tier 1: mostly Generic drugs                                                                  | \$20 copayment                                 |
| Tier 2: mostly Preferred Formulary Drugs                                                      | \$45 copayment                                 |
| Tier 3: mostly Non-Preferred Formulary Drugs                                                  | \$45 copayment<br>plus \$135 Tier 3 cost share |
| Tier 4: mostly Preferred Formulary Specialty Drugs                                            | Not covered                                    |
| Tier 5: mostly Non-Preferred Formulary Specialty Drugs                                        | Not covered                                    |

To learn more about HMSA's drug tiers, please visit [hmsa.com/drug-list](https://hmsa.com/drug-list).

## Key Terms

| Term                                        | Definition                                                                                                                                                                                                               |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cost Share</b>                           | A portion of the total drug cost you are required to pay in addition to a copayment or coinsurance.                                                                                                                      |
| <b>Drug Tiers</b>                           | The way in which HMSA categorizes drug types that are covered under the plan. The common categories are generic, preferred, brand name, and specialty drugs.                                                             |
| <b>Formulary</b>                            | A list of drugs that are covered under your drug plan. For a detailed list, please visit <a href="https://hmsa.com/drug-list">hmsa.com/drug-list</a> .                                                                   |
| <b>Mail-Order Prescription Drug Program</b> | Program where you can get prescription drugs from our mail-order provider at the best prices possible and have medications delivered to your home. For more information, visit <a href="https://hmsa.com">hmsa.com</a> . |
| <b>Annual Copayment Maximum</b>             | The maximum amount you have to pay for covered services (your deductibles, copayments, and coinsurance) in a calendar year before your health plan pays 100 percent of the cost of covered benefits.                     |

Understand important information about your plan: This "benefits at-a-glance"-summary provides a basic overview and comparison of a few of the benefits. Benefits and costs are based on the terms and conditions of your plan, specific exclusions and limitations, coordination of benefits, privacy, third party liability, eligibility requirements, and appeal rights, none of which are described here. For a complete description, see your Guide to Benefits, and any riders, certificates, or amendments. To dispute a decision made by HMSA related to benefits, reimbursement, or any other decision or action by HMSA, please follow the instructions at [hmsa.com/appeals](https://hmsa.com/appeals).