2021 Freedom Blue PPO Summary of Benefits

Residents of the following counties: Barbour, Berkeley, Brooke, Cabell, Doddridge, Fayette, Greenbrier, Hampshire, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Marion, Mason, Mercer, Mingo, Monongalia, Nicholas, Ohio, Pendleton, Putnam, Ritchie, Summers, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt, Wood, and Wyoming, **please click here.**

Residents of the following counties: Berkeley, Doddridge, Harrison, Jefferson, Marshall, Mineral, Morgan, Ohio, Ritchie, Taylor, Upshur, and Wood, **please click here.**

Residents of the following counties: Cabell, Clay, Kanawha, Lincoln, Logan, Putnam, and Wayne, **please click here.**

HIGHMARK WEST VIRGINIA

Region 2 West Virginia Counties - North WV

Freedom Blue PPO Distinct

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Berkeley, Doddridge, Harrison, Jefferson, Marshall, Mineral, Morgan, Ohio, Ritchie, Taylor, Upshur and Wood

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Freedom Blue PPO, call 1-866-739-1899 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Freedom Blue PPO Distinct (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-Of-Network Benefit

The Out-Of-Network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

West Virginia

	Freedom Blue PPO Distinct
Premium	$35
Deductible	$0
Max Out-Of-Pocket	$7,550 IN; $10,000 Catastrophic
Inpatient Hospital Stay	$450 Copay Per Admit IN*; $500 Copay Per Admit OON
Outpatient Hospital Coverage	ASC[1]: $225 Copay IN*; $350 Copay OON Facility: $300 Copay IN*; $350 Copay OON
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	$90 Copay IN/OON
Urgently Needed Services	$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 Copay IN*; $20 Copay OON Outpatient: $10 Copay IN*; $20 Copay OON
X-Rays/ Advanced Imaging	X-ray: $25 Copay IN*; $35 Copay OON Advanced Imaging: $340 Copay IN*; $350 Copay OON
Hearing Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance IN/OON (Per Year)
Dental Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum $500 allowance IN/OON (Per Year)
Vision Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: $425 Copay/day (days 1-3), $0 Copay/day (days 4-90) IN*; $500 Copay/day (days 1-3), $0 Copay/day (days 4-90) OON Outpatient: $40 Copay IN*; $50 Copay OON
Skilled Nursing Facility	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	$35 Copay IN*; $35 Copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $250 Copay IN**; Non-Emergent: 30% Coinsurance OON
Transportation	$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
OTC	$25 Allowance Once Per Quarter IN/OON
Routine Podiatry	$35 Copay IN; $35 Copay OON (10 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
Formulary	Performance

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Freedom Blue PPO Distinct

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$21 Copay
Tier 2 (Generic)	Not Applicable	$45 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$15 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$12 Copay
Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

HIGHMARK WEST VIRGINIA

Highmark Senior Solutions Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Solutions Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Senior Solutions Company. Highmark Blue Cross Blue Shield West Virginia provides post-sale administrative communications for these companies.
Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company are independent licensees of the Blue Cross and Blue Shield Association.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-866-739-1899 (TTY users may call 711) for more information.

SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program.
TruHearing is a registered trademark of TruHearing, Inc.

HIGHMARK WEST VIRGINIA

Region 2 West Virginia Counties - South WV

Freedom Blue PPO Distinct

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Cabell, Clay, Kanawha, Lincoln, Logan, Putnam and Wayne

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Freedom Blue PPO, call 1-866-739-1899 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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How to Find a Provider or Pharmacy

Freedom Blue PPO Distinct (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-Of-Network Benefit

The Out-Of-Network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

West Virginia

	Freedom Blue PPO Distinct
Premium	$25
Deductible	$0
Max Out-Of-Pocket	$7,550 IN; $10,000 Catastrophic
Inpatient Hospital Stay	$450 Copay Per Admit IN*; $500 Copay Per Admit OON
Outpatient Hospital Coverage	ASC[1]: $225 Copay IN*; $350 Copay OON Facility: $300 Copay IN*; $350 Copay OON
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	$90 Copay IN/OON
Urgently Needed Services	$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 Copay IN*; $20 Copay OON Outpatient: $10 Copay IN*; $20 Copay OON
X-Rays/ Advanced Imaging	X-ray: $25 Copay IN*; $35 Copay OON Advanced Imaging: $340 Copay IN*; $350 Copay OON
Hearing Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance IN/OON (Per Year)
Dental Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum $500 allowance IN/OON (Per Year)
Vision Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: $425 Copay/day (days 1-3), $0 Copay/day (days 4-90) IN*; $500 Copay/day (days 1-3), $0 Copay/day (days 4-90) OON Outpatient: $40 Copay IN*; $50 Copay OON
Skilled Nursing Facility	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	$35 Copay IN*; $35 Copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $250 Copay IN**; Non-Emergent: 30% Coinsurance OON
Transportation	$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
OTC	$25 Allowance Once Per Quarter IN/OON
Routine Podiatry	$35 Copay IN; $35 Copay OON (10 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
Formulary	Performance

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Freedom Blue PPO Distinct

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$21 Copay
Tier 2 (Generic)	Not Applicable	$45 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$15 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$12 Copay
Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

HIGHMARK WEST VIRGINIA

Highmark Senior Solutions Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Solutions Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Senior Solutions Company. Highmark Blue Cross Blue Shield West Virginia provides post-sale administrative communications for these companies.
Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company are independent licensees of the Blue Cross and Blue Shield Association.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program.
TruHearing is a registered trademark of TruHearing, Inc.

HIGHMARK WEST VIRGINIA

West Virginia Region 1 counties

Freedom Blue PPO Standard

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Barbour, Berkeley, Brooke, Cabell, Doddridge, Fayette, Greenbrier, Hampshire, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Marion, Mason, Mercer, Mingo, Monongalia, Nicholas, Ohio, Pendleton, Putnam, Ritchie, Summers, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt, Wood and Wyoming

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

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Freedom Blue PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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Out-Of-Network Benefit

The Out-Of-Network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

West Virginia

	Freedom Blue PPO Standard
Premium	$167
Deductible	$0
Max Out-Of-Pocket	$6,500 IN; $10,000 Catastrophic
Inpatient Hospital Stay	$150 Copay/day (days 1-7), $0 Copay/day (days 8-90) IN*; $150 Copay/day (days 1-7), $0 Copay/day (days 8-90) OON
Outpatient Hospital Coverage	ASC[1]: $100 Copay IN*; $100 Copay OON Facility: $200 Copay IN*; $200 Copay OON
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	$90 Copay IN/OON
Urgently Needed Services	$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 Copay IN*; $10 Copay OON Outpatient: $10 Copay IN*; $10 Copay OON
X-Rays/ Advanced Imaging	X-ray: $25 Copay IN*; $25 Copay OON Advanced Imaging: $100 Copay IN*; $100 Copay OON
Hearing Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance IN/OON (Per Year)
Dental Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
Vision Services	Medicare Covered: $35 Copay IN; $35 Copay OON. Routine: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit maximum applies to non-standard frames or a $150 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: $150 Copay/day (days 1-7), $0 Copay/day (days 8-90) IN*; $150 Copay/day (days 1-7), $0 Copay/day (days 8-90) OON Outpatient: $35 Copay IN*; $35 Copay OON
Skilled Nursing Facility	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	$35 Copay IN*; $35 Copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $225 Copay IN**; Non-Emergent: 30% Coinsurance OON
Transportation (up-to 24 one-way trips)	$10 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
Routine Podiatry	$35 Copay IN; $35 Copay OON (10 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
Formulary	Performance

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Freedom Blue PPO Standard

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$15 Copay
Tier 2 (Generic)	Not Applicable	$57 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$11 Copay	$33 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

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