Taipei Economic and Cultural Representative Office
in the United States

Invitation to Tender for Group Health Insurance Contract

I. Procurement Object

Group health insurance service contract ("the Contract")for Taipei Economic and Cultural Representative Office in the United States ("TECRO") and its subsidiary offices ("TECO") except for TECO in Honolulu and Guam.

II. Insured Persons

A. TECRO/TECO full time employees and their dependents, which include spouse, eligible child and parents. "Eligible child" means minors; physically or mentally disabled sons or daughters without earning capacity; and unmarried sons or daughters under the age of 26 and still in school.

B. Total accounts of TECRO/TECO current group health insurance as of August 31, 2024:

1. Employee only: **174** accounts (**174** persons);
2. Employee plus spouse or child(ren): **98** accounts(**196**persons); AND
3. Family: **97** accounts (**364** persons).

C. A quoted total price in a tender must be based on the accounts listed above and it must also contain monthly premium for each type of accounts.

III. Contract Dates

A. 01/01/2025-12/31/2025 (US calendar day)

B. TECRO has the option to renew the Contract for 1 year (01/01/2026-12/31/2026) provided that:

1. TECRO is satisfied with the performance of the coverage under the Contract; AND
2. The renewed Contract Price is agreed by both sides before October 15, 2025 after negotiation of the renewal.

IV. Procurement Budget:

A. 2025: US$ 4,768,062.00

1. The maximum premium for monthly rate for an employee only account shall be no higher than US$ 581.00
2. The maximum monthly premium for an employee plus spouse or child(ren) account and a family account shall be calculated based on the carrier's formula for the calculation of the maximum premium for the employee only account.

B. 2026: US$ 4,768,062.00

1.Provided that TECRO decides to renew the Contract for the year of 2026.

2.2025 maximum monthly premium aforesaid applies to 2026.

C. Any quoted total price of tender that is over the procurement budget will not be considered.

V. **Health Insurance Carrier/Broker**

A. Basic requirements: the Contract reaches the threshold for large procurement under the Government Procurement Act (the "Act") of ROC (Taiwan). To comply with the Act, TECRO will review basic requirements for a health insurance carrier/broker ("carrier/broker") before evaluating its tender. A prospective carrier/broker shall submit documents to prove that:

1. It is licensed to provide health insurance service in the United States; AND
2. It has had at least one group health insurance contract with foreign embassies/consulates within the last 5 years.

B. A carrier may permit no more than one broker to submit its tender to TECRO on behalf of the carrier. A broker must submit no more than one tender to TECRO on behalf of the carrier. This does not preclude industry practices of business contacts and insurance proposal quotes between carriers and brokers before they formally submit tenders to TECRO.

VI. **Procurement Procedure**

A. The procurement of the Contract adopts "The Most Advantageous Tender" rule pursuant to subparagraph 9 of paragraph 1 of Article 22 of the Act.

B. TECRO will form a selection committee ("the Committee") of 5 persons to review tenders submitted by carriers/brokers.

C. TECRO will review the basic requirements listed in Paragraph V. above to determine whether a carrier/broker is qualified to submit its tender to TECRO. Qualified carries/brokers must make presentations to and take questions from the Committee on the date designated by TECRO.

D. The Committee will evaluate each carrier/broker's tender in accordance with the selection criteria listed in Paragraph VIII below. The total evaluation score is 100 points and an "ordinal ranking" method will be adopted by turning the scores of all carriers/brokers into the ranking for each member of the Committee. The rankings of the same carrier/broker among the Committee members will be combined and the one with lowest figure will be the first priority carrier/broker for price negotiation. If two or more carriers/brokers have the same lowest figure, the Committee will choose the quoted price to determine the priority among the carriers/brokers.

E. TECRO may award the Contract to the 1st priority carrier/broker provided that the quoted total price in its tender is below the procurement budget listed in Paragraph IV above and that TECRO accepts the quoted total price. If the quoted total price is below the procurement budget

but TECRO is not satisfied with the price, TECRO will negotiate the final price with the 1st priority carrier/broker before awarding the Contract. If TECRO cannot reach an agreement with the 1st priority carrier/broker on the final price, TECRO will move to the 2nd priority carrier/broker and negotiate the final price for its tender, and so on. TECRO will only negotiate with any qualified carriers/brokers one time on the final price of its tender for the year of 2021.

F. The Committee may award the Contract in its' sole discretion.

G. TECRO does not have a contractual relationship with any carriers/brokers until TECRO signs the Contract.

VII. Benefit Requirements

A. For benefit requirements please contact TECRO HR officer.

B. The benefit summary of the tender submitted to TECRO must be a PPO medical program. A comparison between the benefit requirements in the Addendum and the tender's benefit summary must be submitted for the Committee's review.

C. The Committee will evaluate the insurance carrier/broker's tender and benefit summary in accordance with selection criteria in Paragraph VIII below to determine which tender has the priority for price negotiation.

D. Parents living in the same household of TECRO/TECO eligible employees may enroll in the group health insurance plan in separate account. Diplomatic employees' parents living in Taiwan may also enroll in the plan if they come to the United States for a short family visit.

E. Prevention of medical fraud

No employees or dependents may enroll in the group health insurance plan if their main purpose of coming to the United States or joining this plan is to seek medical treatment. The insurance carrier/broker must inform TECRO of the aforesaid or other serious medical fraud cases it discovers.

VIII. Selection Standard

A. Selection Criteria

Evaluation items	Sub-evaluation items	Score Distribution
Professional Service Team	Human resources	15
	Number of in-network medical providers	
Service Quality	Procedure of enrollment and claims	20

	Customer service for claims and medical advice	
	Broker Services	
Capability of Group Health Insurance	Foreign embassies/consulates clients	10
	Fortune 500 companies clients	
Soundness of Proposals	Completeness of proposals	15
	Proposal is more favorable than the benefit summary required by TECRO	
Quoted Price Reasonableness	Premium Calculation	40
	Premium Reasonableness	
	Reward(credit back)	
Total Score		100

B. Any tender with a total score of less than 70 will not be considered further.

IX.**Submission of Tender**:

A. Please contact TECRO HR officer to request information of tender preparation.

Telephone number: 202-895-1843

Email: tecroHR@mofa.gov.tw

Mr. Gene Li / Acting Deputy Director

B. Submission of tender is strictly limited to regular mail, courier service or personal delivery. Electric transmission of tender WILL NOT be accepted.

C. The tender must be sealed and received by TECRO not later than 05:00pm on November 25, 2024 (ET). Please address the tender as follows:

Administrative Division (Group Health Insurance Tender)

Taipei Economic and Cultural Representative Office in the United States

4201 Wisconsin Avenue, N.W. Washington, DC 20016

D. A tender must contain following documents:

1. Group health insurance service proposal

The proposal must contain the information required in this invitation to tender.

2. One copy of draft contract.

3. Statement of the tender (form provided by TECRO).

4. Price list of the tender (form provided by TECRO).

5. A carrier/broker's basic requirement documents listed in Paragraph V. above.

E. Proposals received after the deadline WILL NOT be considered.

F. TECRO will hold a meeting in its office to open sealed tenders it received at 10:00am on the next business day of the submission deadline.

X. **Enrollment Procedure and Effectiveness of Coverage**

A. The coverage of diplomatic employees and their dependents shall become effective upon their arrivals at the port of entries in the United States if they decide to enroll in the plan.

B. The coverage of eligible locally-hired employees and their dependents (parents not included with some exceptions) shall become effective 90 days after the commencement of employment with TECRO/TECO if they choose to enroll in the plan

XI. **Premium Payment Period**

TECRO will pay insurance premium in a 3-month period and will adjust its payment according to new enrollments and withdrawals.

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Lifetime Maximum	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	60%	80%	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the Provider's normal charge for a similar service or supply; or a percentage of Charges made by Providers of such service or supply in the geographic area where the service is received. These Charges are compiled in a database We have selected. **Note:** The Provider may bill You for the difference between the Provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.			
Policy Year Medical Deductible Individual Family Maximum	 $700 2 times the individual Deductible	 $700 2 times the individual Deductible	 $1,400 2 times the individual Deductible
Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.			
Out-of-Pocket Maximum Individual Family Maximum	 $5,000 2 times the individual Out-of-Pocket Maximum	 $4,000 2 times the individual Out-of-Pocket Maximum	 $8,000 2 times the individual Out-of-Pocket Maximum
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.			
Physician's Services Physician's Office Visit - Primary Care Physician Office Visit – Specialist Surgery Performed In the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections	 60%, No Deductible 60%, No Deductible 60%, After Deductible 60%, No Deductible 60%, No Deductible	 100%, No Deductible, $20 Copay 100%, No Deductible, $30 Copay 80%, After Deductible 100%, No Deductible, $20 Copay 100%, No Deductible, $30 Copay	 60%, No Deductible, $30 Copay 60%, No Deductible, $40 Copay 60%, After Deductible 60%, No Deductible, $30 Copay 60%, No Deductible, $40 Copay
Preventive Care Routine Preventive Care – all ages Immunizations – all ages	 100% not subject to Plan Deductible or Copayments 100% not subject to Plan Deductible or Copayments	 100% not subject to Plan Deductible or Copayments 100% not subject to Plan Deductible or Copayments	 60%, No Deductible 60%, No Deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Visits/Consultations	60%, After Deductible	80%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	60%, After Deductible	80%, After Deductible	60%, After Deductible
Inpatient Services at Other Heath Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Policy Year Maximum of 120 day limit.	60%, After Deductible	80%, After Deductible	60%, After Deductible
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	60%, After Deductible	80%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	60%, After Deductible	80%, After Deductible	60%, After Deductible
Emergency and Urgent Care Services			If You have a true Emergency Medical Condition, the benefits will be paid at the U.S. Participating Provider Rate
Hospital Emergency Room	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	60%, After Deductible	80%, After Deductible	60%, After Deductible
Urgent Care Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	60%, After Deductible	80%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	60%, After Deductible	80%, After Deductible	60%, After Deductible
Ambulance	60%, After Deductible	80%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Laboratory and Radiology Services (Includes pre-admission testing)			
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Independent X-ray and/or Lab Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Independent Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Office visits in addition to the global maternity fee	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Laboratory, Radiology Services and or Advance Radiological Imaging	60%, After Deductible	80%, After Deductible	60%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	60%, After Deductible	80%, After Deductible	60%, After Deductible
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined	60%, After Deductible	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	60%, After Deductible	80%, After Deductible	60%, After Deductible
Elective	60%, After Deductible	80%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Infertility Expenses – Basic Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Infertility Expenses – Comprehensive Limited Benefit – See benefit description for specific coverages and exclusions. Pre-authorization is required.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Family Planning/Contraception Management See benefit description for specific coverages			
For Women			
Physician's Office Visit	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Inpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Outpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Physician's Services	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
For Men			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Obesity/Bariatric Surgery Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Organ Transplant Services Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% of Reasonable Expenses after Plan Deductible	100% of Reasonable Expenses after Plan Deductible	Not Covered
Transgender Services See benefit description for covered services. Pre-authorization is required			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Nutritional Evaluation Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Nutritional Formulas	60%, After Deductible	80%, After Deductible	60%, After Deductible
Acupuncture Physician's office visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Chiropractic Care/Spinal Manipulations Physician's office visit Policy Year Maximum of 20 visit limit.	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Annual Physical/Executive Health Screening for Services not covered as Preventive Care Policy Year Maximum of $500	60%, After Deductible	80%, After Deductible	60%, After Deductible
Telehealth	60%, No Deductible	100%, No Deductible, $30 Copay	60%, No Deductible, $40 Copay
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an Injury			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
TMJ Treatment	60%, After Deductible	80%, After Deductible	60%, After Deductible
Diabetic Equipment	60%, After Deductible	80%, After Deductible	60%, After Deductible
Durable Medical Equipment	60%, After Deductible	80%, After Deductible	60%, After Deductible
External Prosthetic Appliances	60%, After Deductible	80%, After Deductible	60%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	60%, After Deductible	80%, After Deductible	60%, After Deductible
Mental Health			
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $30 Copay	60%, No Deductible, $40 Copay
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Psycho-Educational Testing	60%, After Deductible	80%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Substance Abuse Health			
Inpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $30 Copay	60%, No Deductible, $40 Copay
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Hearing Benefit One Examination per 12 month period	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 36 months	60%, After Deductible	80%, After Deductible	60%, After Deductible
Home Health Care Services Policy Year Maximum of 120 visit limit.	60%, After Deductible	80%, After Deductible	60%, After Deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit.	60%, After Deductible	80%, After Deductible	60%, After Deductible
Hospice Care Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Infusion Therapy			
Outpatient Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	80%, After Deductible	60%, After Deductible
Short Term Rehabilitative Therapy Policy Year Maximum of 30 visit limit for all therapies combined.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $40 Copay	60%, No Deductible, $50 Copay
Outpatient Hospital Facility	60%, After Deductible	80%, After Deductible	60%, After Deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.			

Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for You and Your Insured Dependents. The Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the Schedule of Benefits and as described in the Prescription Drug Coverage section of this Certificate. To receive Prescription Drug Benefits, You and Your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments. Benefits are limited as described in the Prescription Drug section of this Certificate and are subject to the Medical "Exclusions" section of this Certificate.

The following are applicable to all Prescription Drug benefits:

- The Prescription drug designation is as per generally-accepted industry sources and adopted by Us and is subject to change

Prescription Drugs Purchased Outside of the United States	
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply	
Tier 1 Prescription Drugs – Generic	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply	
Tier 1 Prescription Drugs – Generic	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.

Prescription Drugs Purchased Inside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
	Participating Retail Pharmacy	**Non Participating Retail Pharmacy**
Tier 1 Prescription Drugs – Generic	$20 Copayment per Prescription or refill Deductible does not apply	$20 Copayment per Prescription or refill Deductible does not apply
Tier 2 Prescription Drugs – Preferred Brand	$45 Copayment per Prescription or refill Deductible does not apply	$45 Copayment per Prescription or refill Deductible does not apply
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 1 month supply is $200.	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 1 month supply is $200.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
	Participating Provider Mail Order Pharmacy	**Non-Participating Mail Order Pharmacy**
Tier 1 Prescription Drugs – Generic	$60 Copayment per Prescription or refill Deductible does not apply	**Not Covered**
Tier 2 Prescription Drugs – Preferred Brand	$135 Copayment per Prescription or refill Deductible does not apply	**Not Covered**
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 3 month supply is $600.	**Not Covered**