

Drug Benefit Highlights

Select Drug Program \$15/\$35/\$50 Temple University

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible Individual/Family	\$0/\$0	\$0/\$0
Out-of-Pocket Maximum Individual/Family	Combined with Medical	Combined with Medical
Formulary	Select	
Retail Pharmacy	In-Network	Out-of-Network
Tier 1 Generic Drugs	\$15	30% Reimbursement
Tier 2 Preferred Brand	\$35	30% Reimbursement
Tier 3 Non-Preferred Drugs	\$50	30% Reimbursement
Dispensing Limits ¹	30 day supply max	30 day supply max
Mail Order Pharmacy Available for maintenance drugs	In-Network	Out-of-Network
Tier 1 Generic Drugs	\$30	Not covered
Tier 2 Preferred Brand Drugs	\$70	Not covered
Tier 3 Non-Preferred Drugs	\$100	Not covered
Dispensing Limits	90 day supply max	Not covered
Drug Coverage	In-Network	Out-of-Network
ACA Preventive Drugs ²	Covered	Covered
Compound Medications	Covered	Covered
Contraceptives	Covered	Covered
Diabetic Supplies (i.e., test strips)	Covered	Covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Retin-A (up to Age 35)	Covered	Covered
Allergy Serum	Not covered	Not covered
Biologicals, Investigational/Experimental Drugs	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Immunization Agents	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

¹ Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.

² Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY: 711).

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered. Drugs used to treat hemophilia are not covered.

All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.

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