Independence

Drug Benefit Highlights

Value Rx $5/$15/$35/$50/50% up to $500

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[1]	Value	
Dispense as Written (DAW) Provision[2]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$5	30% Reimbursement
Tier 2 Generic Drugs	$15	30% Reimbursement
Tier 3 Preferred Brand Drugs	$35	30% Reimbursement
Tier 4 Non-Preferred Drugs	$50	30% Reimbursement
Tier 5 Self-Administered Specialty Drugs	50% up to $500	Not covered
Dispensing Limits[3]	30 day supply max	30 day supply max
Mail Order Pharmacy **Available for maintenance drugs**	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$10	Not covered
Tier 2 Generic Drugs	$30	Not covered
Tier 3 Preferred Brand Drugs	$70	Not covered
Tier 4 Non-Preferred Drugs	$100	Not covered
Tier 5 Self-Administered Specialty Drugs	Not covered	Not covered
Dispensing Limits[4]	90 day supply max	Not covered
Mandatory Mail for Maintenance Drugs[5]	Yes	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[6]	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

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[1] Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto **www.ibx.com**.

[2] When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.

[3] 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.

[4] Up to a 90-day supply of drugs to treat chronic conditions available at Walgreens or mail for same cost share.

[5] All covered medications for chronic conditions (such as blood pressure medications) will be provided through our convenient mail order service, which allows you to order up to a 90-day supply. This benefit can save you time and money. If your doctor wants you to start the drug immediately, your initial supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through our convenient mail order service. Member cost sharing is indicated above.

[6] 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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