Independence

Drug Benefit Highlights

Freestanding Premium 15%/35%50%

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/EE+Child/Family	$4,000/$6,000	Not covered
Formulary[2]	Premium	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits[4]	90 day supply max	Not covered
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits	100 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	Not covered
Compound Medications	Covered	Not covered
Contraceptives	Covered	Not covered
Diabetic Supplies (i.e., test strips)	Covered	Not covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Insulin	Covered	Not covered
Insulin Needles and Syringes	Covered	Not covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Not covered
Allergy Serum	Covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Investigational/Experimental 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 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum, prior to receiving plan benefits.

2 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.

3 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

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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.

4 CVS90 Saver Plus - 90-day supply of drugs to treat chronic conditions must be obtained at CVS or mail for same cost share, except first two fills may be 30-day fills obtained at any participating retail pharmacy.

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 100-day supply. This benefit can save you time and money. If your doctor wants you to start the drug immediately, your 2 fill 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.

All covered self-administered specialty medications 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.

The pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.

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