

Drug Benefit Highlights

LDC Silver-Lab Dis Cncl H&W Fund

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/Family		\$2,000/\$4,000	Not covered
Plan Maximum Out-of-Pocket before coinsurance applies (Per Family) ²		\$7,500	Not covered
Coinsurance after Plan Maximum Out-of-Pocket is met (Only applies to non-specialty tier prescriptions) ²		50%	Not covered
Formulary ³		Premium	
Dispense as Written (DAW) Provision ⁴		Mandatory Generic	
Retail Pharmacy		In-Network	Out-of-Network
Tier 1 Generic Drugs		\$10	Not covered
Tier 2 Preferred Brand Drugs		\$25	Not covered
Tier 3 Non-Preferred Drugs		\$50	Not covered
Tier 4 Specialty Brand /Weight loss and Diabetes Drugs ⁵		\$100	Not covered
Dispensing Limits		30 day supply max	Not covered
Mail Order Pharmacy Available for maintenance drugs		In-Network	Out-of-Network
Tier 1 Generic Drugs		\$20	Not covered
Tier 2 Preferred Brand Drugs		\$50	Not covered
Tier 3 Non-Preferred Drugs		\$100	Not covered
Tier 4 Specialty Brand Only Drugs		Not covered	Not covered
Tier 4 Weight loss and Diabetes Drugs ⁶		\$200	Not covered
Dispensing Limits		90 day supply max	Not covered
Mandatory Mail for Maintenance Drugs ⁷		Yes	Not covered
Drug Coverage		In-Network	Out-of-Network
ACA Preventive Drugs ⁸		Covered	Not covered
Compound Medications		Covered	Not covered
Contraceptives		Covered	Not covered
Diabetic Supplies (i.e., test strips)		Covered	Not covered
Glucometers		Covered	Not covered
Insulin		Covered	Not covered
Insulin Needles and Syringes		Covered	Not covered
Lancets		Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)		Covered	Not covered
Weight Control Drugs		Covered	Not covered
Allergy Serum		Not 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

- 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 \$7,500 is the maximum out-of-pocket the plan pays before 50% coinsurance applies. It is a family maximum unless a single individual is covered. 50% coinsurance will not apply to generic specialty or prescriptions named under Tier 4 Specialty Brand.
- 3 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.
- 4 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.
- 5 Tier also includes the following weight loss medications: Wegovy and Saxenda and diabetes drugs: Oxempic, Trulicity, Victoza, Rybelsus and Bydureon. Coverage is subject to change as formulary updates occur.
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- 7 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 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.
- 8 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 1-888-678-7012.

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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