# Drug Benefit Highlights

**Drexel University CDHP Rx $10/$30/$50**

## Covered Services

### Benefits per Calendar Year
- Deductible
- Out-of-Pocket Maximum
- Formulary

### Retail Pharmacy
- Tier 1 Generic Drugs
- Tier 2 Preferred Brand
- Tier 3 Non-Preferred Drugs

### Dispensing Limits

### Mail Order Pharmacy
Available for maintenance drugs
- Tier 1 Generic Drugs
- Tier 2 Preferred Brand Drugs
- Tier 3 Non-Preferred Drugs

### Dispensing Limits

## Your Costs (You pay)

### In-Network
- Medical deductible applies. Combined with Medical Premium
- Tier 1 Generic Drugs: $10 after deductible
- Tier 2 Preferred Brand: $30 after deductible
- Tier 3 Non-Preferred Drugs: $50 after deductible

### Out-of-Network
- Medical deductible applies. Combined with Medical Premium
- Tier 1 Generic Drugs: 30% Reimbursement after deductible
- Tier 2 Preferred Brand Drugs: 30% Reimbursement after deductible
- Tier 3 Non-Preferred Drugs: 30% Reimbursement after deductible

### Retail Pharmacy

### Dispensing Limits

### Mail Order Pharmacy
Available for maintenance drugs

### Dispensing Limits

## Drug Coverage

### ACA Preventive Drugs
- Compound Medications
- Contraceptives
- Diabetic Supplies (i.e., test strips)
- Glucometers (no copayment/coinsurance required at participating pharmacies after deductible)
- Injectable Fertility Drugs
- Insulin
- Insulin Needles and Syringes
- Lancets (no copayment/coinsurance required at participating pharmacies after deductible)
- Prescribed Tobacco Cessation Drugs (RX and OTC)
- Allergy Serum
- Blood, Blood Plasma
- Drugs used for Cosmetic Purposes
- Investigational/Experimental Drugs
- Non-Federal Legend Drugs

### In-Network
- Covered
- Covered
- Covered
- Covered
- Covered
- *Not Covered*
- Covered
- Covered
- Covered
- Covered

### Out-of-Network
- Covered
- Covered
- Covered
- Covered
- Covered
- Not Covered
- Covered
- Covered
- Covered
- Covered

*Medications not required for Advanced Reproductive treatments are covered under the RX plan*

Reference ID: 1004995801012023
| Over-The-Counter Drugs (Non-Prescription) | Not covered | Not covered |
| Weight Control Drugs | Not covered | Not covered |

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](http://www.ibx.com).

2. Up to a 90-day supply of drugs to treat chronic conditions available at any participating retail pharmacy or mail for same cost share.

3. 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](http://www.ibx.com/LGBooklet) or call 1-800-ASK-BLUE (TTY: 711).

Your program includes the HDHP Preventive Enhancement benefit for a defined list of drugs. For the drugs on the preventive drug list, the deductible does not apply and you are only responsible for paying the copayment or coinsurance.

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.

The pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on [www.ibx.com](http://www.ibx.com) by selecting the Find a Participating Pharmacy feature.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. [www.ibx.com](http://www.ibx.com)
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.