


# Pharmacy Program Summary of Benefits

Formulary 3 ■ 5-Tier ■ Integrated Deductible ■ \$10/25/45 ■ Specialty 50%/50%

Plan Feature	Amount You Pay	Description
<b>Deductible</b>	See medical summary of benefits for annual deductible amount	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
<b>Out-of-Pocket Maximum</b>	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
<b>Preventive Drugs</b> (up to a 34-day supply)	\$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
<b>Oral Chemotherapy Drugs and Diabetic Supplies</b> (up to a 34-day supply)	\$0 (not subject to deductible except for HSA/HRA plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
<b>Generic Drugs (Tier 1)</b> (up to a 34-day supply)	\$10	Generic drugs are covered at this copay level.
<b>Preferred Brand Drugs (Tier 2)</b> (up to a 34-day supply)	\$25	All preferred brand drugs are covered at this copay level.
<b>Non-preferred Brand Drugs (Tier 3)</b> (up to a 34-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
<b>Preferred Specialty Drugs (Tier 4)</b> (up to a 34-day supply)	50% up to a \$100 maximum	You pay 50% coinsurance up to a maximum of \$100 for all preferred specialty drugs. <b>Benefits for covered Specialty drugs are available when purchased by mail order.</b>
<b>Non-preferred Specialty Drugs (Tier 5)</b> (up to a 34-day supply)	50% up to a \$150 maximum	You pay 50% coinsurance up to a maximum of \$150 for all non-preferred specialty drugs. <b>Benefits for covered Specialty drugs are available when purchased by mail order.</b>
<b>Maintenance Drugs</b> (up to a 90-day supply)	Generic: \$20 Preferred Brand: \$50 Non-preferred Brand: \$90 Preferred Specialty: 50% up to a \$200 maximum Non-preferred Specialty: 50% up to a \$300 maximum	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy.  Maintenance preferred and non-preferred specialty drugs up to a 90-day supply you pay 50% coinsurance up to a maximum copay. <b>Benefits for covered Specialty drugs are available when purchased by mail order.</b>
<b>Restricted Generic Substitution</b>	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay or coinsurance.	
 <p>Visit <a href="http://carefirst.com/rx">carefirst.com/rx</a> for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.</p>		

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: VA/CFBC/RX3 (R. 1/18) • VA/CF/RX3 (R. 1/18)



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