IdealCare Platinum

Pharmacy Benefits Schedule of Coverage

The following information summarizes the benefits described in your Evidence of Coverage. It is important that you carefully read it so you are aware of plan requirements, provisions and limitations and exclusions.

*This health plan may synchronize refills for maintenance medications and pro-rate any cost-sharing amount charged for a prescription drug dispensed in a quantity that is less than a 30-day supply.

A Health Maintenance Organization (HMO) may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. In addition, a reasonable copayment option may not exceed 50% of the total cost of services provided.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$0 Individual/$0 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy)	$2,500 Individual/$5,000 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Preventive, includes Vaccinations obtained at the Pharmacy (Tier 1)	100% of Allowed Amount	No coverage for Out-of-Network Services
Generic (Tier 2)	100% of Allowed Amount after a $10 Copayment per 30 day supply	No coverage for Out-of-Network Services
Preferred (Tier 3)	100% of Allowed Amount after a $10 Copayment per 30 day supply	No coverage for Out-of-Network Services
Non-preferred (Tier 4)	100% of Allowed Amount after a $10 Copayment per 30 day supply	No coverage for Out-of-Network Services
Specialty Drugs (Tier 5)	100% of Allowed Amount after a $100 Copayment per 30 day supply	No coverage for Out-of-Network Services

*Please see your Evidence of Coverage (EOC) for more information or contact the Pharmacy Help line at 1-866-333-2757.