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www.WellSpanPopHealth.com

WELLSPAN HEALTH
Population Health Services

WellSpan Population Health Services
Important Notation to Formulary Listing

The content contained in the Capital Rx Liberty formulary is subject to the terms for these medications in the Summary Plan Description (SPD).

The link to the formulary is on our website under the Information about Pharmacy section.

www.wellspanpophealth.org

If you have questions, please feel free to contact Capital Rx at (844)306-5008 or WellSpan Population Health Services at the number above.

Thank you.

WellSpan Population Health Services

WellSpan Health
Pharmacy Benefit Plan Design

Formulary: Liberty • Customer Care: 1-844-306-5008

Capital Rx

Please see below for WellSpan Health plan design offerings. For questions about what plan you are in, please contact Capital Rx at 1-844-306-5008 **(effective 1-1-2024).**

HIGH DEDUCTIBLE PHARMACY PLAN		
Plan Detail	**Benefit**	**Detail**
Deductible: (Individual / Family)	$1,600 / $3,200	Your deductible is combined with your medical plan.
Annual Out of Pocket Max: (Individual / Family)	$6,000/$12,000	Your maximum out of pocket is combined with your medical plan
Retail Copay		
	1 - 34 Days	**1 - 34 Days (In-House Pharmacy)**
Tier 1 (Generic)	30% coinsurance	$10
Tier 2 (Preferred Brand)	35% with $40 minimum	$40
Tier 3 (Non-Preferred Brand)	50% with $65 minimum	$65
Specialty (1-30 Days)		
20% with a maximum of $150		
Mail Order Copay		
	35 - 100 Days	
Tier 1 (Generic)	$20	
Tier 2 (Preferred Brand)	$80	
Tier 3 (Non-Preferred Brand)	$130	

Special Coverage Rules:

- **In addition to medications included under provisions of the Affordable Care Act, generic preventive high blood pressure, cardiovascular, diabetes and high cholesterol drugs are not subject to the plan deductible and covered at 100%.**

General Therapeutic Categories

Inclusions		Exclusions	
Acne	IV Injectables	Abortifacients	Miscellaneous Medical Supplies
ADHD	Narcolepsy	Allergen Extracts *	Ostomy Supplies
Anaphylactic Kits	Sexual Dysfunction (oral)	Anabolic Steroids Blood Products	OTC
Chemotherapy Drugs	Tobacco Cessation	Blood Pressure Supplies Cell & Gene Therapy Cosmetic	Respiratory Devices
Contraceptives (exclude implants)	Spacers	Fertility Drugs *	Sexual Dysfunction (non-oral)
Hemophilia Agents	Syringes (other than Insulin)	* See Medical Plan	Nutritional Diet Supplements
Immune Serums	Vaccines		Metabolic Infant Formula
Injectables	Vitamins (prenatal)		Vitamins (multi)
Insulin Pump & Supplies	Weight Loss (generics)		Weight Loss (Brand)

PLUS PHARMACY PLAN		
Plan Detail	**Benefit**	**Detail**
Deductible: (Individual / Family)	Not Applicable	
Annual Out of Pocket Max: (Individual / Family)	$3,000/$5,250	Your maximum out of pocket is not combined with your medical plan
Retail Copay		
	1 - 34 Days	**1 - 34 Days (In-House Pharmacy)**
Tier 1 (Generic)	20% coinsurance	$10
Tier 2 (Preferred Brand)	35% with $35 minimum	$35
Tier 3 (Non-Preferred Brand)	50% with $60 minimum	$60
Specialty (1-30 Days)		
20% with a maximum of $150		
Mail Order Copay		
	35 - 100 Days	
Tier 1 (Generic)	$20	
Tier 2 (Preferred Brand)	$70	
Tier 3 (Non-Preferred Brand)	$120	
Special Coverage Rules:		
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General Therapeutic Categories			
Inclusions		**Exclusions**	
Acne ADHD Anaphylactic Kits Chemotherapy Drugs Contraceptives (exclude implants) Hemophilia Agents Immune Serums Injectables Insulin Pump & Supplies	IV Injectables Narcolepsy Sexual Dysfunction (oral) Tobacco Cessation Spacers Syringes (other than Insulin) Vaccines Vitamins (prenatal) Weight Loss (generics)	Abortifacients Allergen Extracts * Anabolic Steroids Blood Products Blood Pressure Supplies Cell & Gene Therapy Cosmetic Fertility Drugs * * See Medical Pllan	Miscellaneous Medical Supplies Ostomy Supplies OTC Respiratory Devices Sexual Dysfunction (non-oral) Nutritional Diet Supplements Metabolic Infant Formula Vitamins (multi) Weight Loss (Brand)

STANDARD PHARMACY PLAN		
Plan Detail	**Benefit**	**Detail**
Deductible: (Individual / Family)	Not Applicable	
Annual Out of Pocket Max: (Individual / Family)	$3,000/$5,250	Your maximum out of pocket is not combined with your medical plan
Retail Copay		
	1 - 34 Days	**1 - 34 Days (In-House Pharmacy)**
Tier 1 (Generic)	30% coinsurance	$10
Tier 2 (Preferred Brand)	35% with $40 minimum	$40
Tier 3 (Non-Preferred Brand)	50% with $65 minimum	$65
Specialty (1-30 Days)		
20% with a maximum of $150		
Mail Order Copay		
	35 - 100 Days	
Tier 1 (Generic)	$20	
Tier 2 (Preferred Brand)	$80	
Tier 3 (Non-Preferred Brand)	$130	

Special Coverage Rules:

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General Therapeutic Categories

Inclusions		Exclusions	
Acne	IV Injectables	Abortifacients	Miscellaneous Medical Supplies
ADHD	Narcolepsy	Allergen Extracts *	Ostomy Supplies
Anaphylactic Kits	Sexual Dysfunction (oral)	Anabolic Steroids Blood Products	OTC
Chemotherapy Drugs	Tobacco Cessation	Blood Pressure Supplies Cell & Gene Therapy Cosmetic	Respiratory Devices
Contraceptives (exclude implants)	Spacers	Fertility Drugs *	Sexual Dysfunction (non-oral)
Hemophilia Agents	Syringes (other than Insulin)	* See Medical Plan	Nutritional Diet Supplements
Immune Serums	Vaccines		Metabolic Infant Formula
Injectables	Vitamins (prenatal)		Vitamins (multi)
Insulin Pump & Supplies	Weight Loss (generics)		Weight Loss (Brand)

Welcome to the Liberty Formulary

Capital Rx

At Capital Rx, your health is our top priority. We prepared the Liberty Formulary (drug list) to ensure that you have access to a robust offering that meets your needs. This list of drugs is covered by your pharmacy prescription benefit. Some drugs on this list that display as covered on the formulary, may not be covered if your plan does not include coverage of certain categories. If you have any questions regarding your specific coverage, please call the number on the back of your member ID card.

The Liberty formulary is:

- Based on the recommendations of a committee of highly skilled physicians and pharmacists that review drugs regulated by the United States Food and Drug Administration (FDA)
- Inclusive of drugs regulated by the United States Food and Drug Administration (FDA)
- Ensures clinical efficacy, safety, and cost considerations
- Evaluated for financial considerations based on the review of market trends and driving the lowest net cost products where applicable
- Subject to change throughout the year

Please note: drugs the FDA newly approves will not be covered until the committee has been able to fully evaluate them.

Your pharmacy prescription benefit covers many prescription drugs, but some exclusions may apply. An alternative covered drug will be available if a drug is not covered. Drugs that have not received FDA approval or over-the-counter (OTC) equivalents may not be covered.

Please use this list as a guide to talk to your doctor about prescribing covered medications that are appropriate for you, as this may lower your out-of-pocket costs. For the most up to date version of the Liberty Formulary, please visit www.cap-rx.com.

How to Navigate this List:

Each prescription drug product is placed in a Tier from 1 to 3 that determines your cost-share:

- Generic (Tier 1)
- Preferred Brands (Tier 2)
- Non-Preferred Brands (Tier 3)

Generic drugs are displayed in *lowercase italicized lettering*. Brand drugs are displayed in UPPERCASE LETTERING. Brand drugs may be removed from your drug list after a generic equivalent becomes available. Generic drugs generally have the lowest cost share.

Drugs that do not appear on this list are excluded under the Liberty Formulary. If your prescribed medication is not covered, please contact your doctor to see if a covered alternative is right for you. If your prescriber determines that you require a drug that is not covered on the Liberty Formulary, a drug exception request with clinical documentation may be submitted.

If your plan offers a prescription drug benefit for preventive drugs listed under the Affordable Care Act or a Health Savings Account, the drugs will be flagged below. These drugs may be available at $0 or a lower cost share than regularly tiered drugs depending on your benefit.

Additional restrictions may apply and will be indicated next to the drug on the list below. Some drugs may only be covered for members within a certain age range or gender due to recommendations based on FDA-approved labeling and clinical practice guidelines. Some drugs are subject to prior authorization, step therapy, or quantity limits. Please reference the legend below for more information.

Formulary changes occur on a quarterly basis. Once a new generic is launched, the brand will be excluded from formulary two quarters following the date of the generic medication launch.

Medications with a Specialty Drug flag are used to treat complex medical conditions (e.g., hepatitis, multiple sclerosis, and hemophilia) and require special handling, administration, and member care management. Depending on your pharmacy benefit design, specialty drugs may be part of a benefit with specific coverage and copay requirements that differ from drugs in Tiers 1 – 3. If you do not have a defined specialty benefit, your copay may be based on whether the drug is generic or BRAND, therefore Tier 1 or Tier 3 copays may apply.

Note that some drug classes may be excluded by your plan or not covered on your pharmacy benefit. If you have questions about your coverage, please call the number on the back of your member ID card

For the most up-to-date Formulary Drug list visit our website at cap-rx.com.