Frenship ISD
Pharmacy Schedule of Benefits
Preferred Provider Organization
Custom $300 Deductible Rx Plan
FIS3RXP1

The following is a summary of the copayment amounts members must pay when receiving the covered pharmacy benefits listed below. If you have any questions or would like more information about the Issuer's pharmacy benefits go to **BSWHealthPlan.com** or contact Customer Service, Monday through Friday, 7:00 AM – 7:00 PM CT, at **844.633.5325, TTY Line 711**.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression, or health status in the administration of the plan, including enrollment and benefit determinations.

Plan Year	Contract Year	
	Participating Provider	***Non-Participating Provider***
Pharmacy Deductible	$300 per Member $600 per Family	$300 per Member $600 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments and Coinsurance.*	Integrated with Medical	Integrated with Medical
Annual Maximum	Unlimited	
Member may be balance billed and will be responsible for Non-Participating Provider balance billing charges over the Usual and Customary Rate. The balance billing charges will not be applied toward the Maximum Out-of-Pocket.		

Pharmacy Benefit	***Participating Provider Member Copayment***		***Non-Participating Provider Member Copayment***
	30-day Standard	*90-day Maintenance**	
ACA preventive drugs	No charge, deductible does not apply	No charge, deductible does not apply	50% after deductible
Tier 1 Preferred generic drugs	50% after deductible	50% after deductible	50% after deductible
Tier 2 Preferred brand name drugs	50% after deductible	50% after deductible	50% after deductible
Tier 3 Non-preferred generic drugs and non-preferred brand name drugs	50% after deductible	50% after deductible	50% after deductible

Pharmacy Benefit	*Participating Provider Member Copayment*		*Non-Participating Provider Member Copayment*
	30-day Standard	*90-day Maintenance**	
Specialty Tier 1 Specialty preferred generic drugs	50% after deductible	Not covered	50% after deductible
Specialty Tier 2 Specialty preferred brand name drugs	50% after deductible	Not covered	50% after deductible
Specialty Tier 3 Specialty non-preferred brand name drugs	50% after deductible	Not covered	50% after deductible
Preferred diabetic test strips for blood glucose monitors	50% after deductible	50% after deductible	50% after deductible
Non-preferred diabetic test strips for blood glucose monitors	50% after deductible	50% after deductible	50% after deductible

*Maintenance drugs are allowed up to a 90-day supply if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of $25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the applicable brand name drug copayment plus the difference in cost of the brand name drug and generic equivalent drug.