



Prescription Drug Summary of Benefits: 01/01/2025 – 12/31/2025
Formulary E4, 6/30/50/100 (with Senior Rx Plus)

El Paso County

About this plan

How much is the monthly premium?

Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

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Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: \$0

Stage 2 Initial Coverage Stage

Below is your payment responsibility until the amount paid by you for covered prescriptions reaches your Drug Plan Maximum Out of Pocket of \$2,000.

| Retail Pharmacy | Standard Network Pharmacy | | Mail-Order Pharmacy |
|-----------------------------|---------------------------|-------------------|--|
| | per 30-day supply | per 90-day supply | per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies) |
| Tier 1: Generics | \$6 | \$15 | \$15 |
| Tier 1: Select Generics | \$0 | \$0 | \$0 |
| Tier 2: Preferred Drugs | \$30 | \$75 | \$75 |
| Tier 3: Non-Preferred Drugs | \$50 | \$125 | \$125 |
| Tier 4: Specialty Drugs | \$100 | N/A | \$100 |

Stage 3 Catastrophic Coverage Stage

Your responsibility for payment of covered drugs changes once you reach your Drug Plan Maximum Out of Pocket of \$2,000.

| Retail and Mail-Order Pharmacies | Up to a 90-day supply |
|---|-----------------------|
| Tier: All Part D Covered Prescription Drugs | \$0 |

- Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.
- Important Message About What You Pay for Insulin:** You won't pay more than \$35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

Extra Covered Drugs Benefits Chart

| Pharmacy | Retail Pharmacy | Mail-Order Pharmacy |
|---|---|---------------------|
| | per 30-day supply | per 90-day supply |
| Cough and Cold DESI Vitamins and Minerals | See Drug List for complete list of drugs covered | |
| Tier 1: Generics | \$6 | \$15 |
| Tier 2: Preferred Drugs | \$30 | \$75 |
| Tier 3: Non-Preferred Drugs | \$50 | \$125 |
| Erectile Dysfunction (ED) | Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days. | |
| Tier 1: Generics | \$6 | \$15 |
| Tier 2: Preferred Drugs | \$30 | \$75 |
| Tier 3: Non-Preferred Drugs | \$50 | \$125 |

| Pharmacy | Retail Pharmacy | Mail-Order Pharmacy |
|---------------------------|----------------------------|----------------------------|
| | per 30-day supply | per 90-day supply |
| Other Non-Part D Coverage | Copay or coinsurance | |
| Contraceptive Devices | \$30 per Covered Device | \$30 per Covered Device |