Town and BOE of Simsbury

2025 Summary of Benefits

Formulary E3, 5/15/15 (with Senior Rx Plus) Prescription Drug Plan

Anthem.com

How much is the monthly premium?	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Formulary:	E3
Supplemental gap coverage:	Not Applicable
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
Maximum Out of Pocket Limit	$2,000

Stage 2: Initial Coverage Stage

	Standard retail cost sharing		Mail order cost sharing
Tier	**One-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 Select Generics	$0 copay per prescription	$0 copay per prescription	$0 copay per prescription
Tier 1 Generics	$5 copay per prescription	$15 copay per prescription	$10 copay per prescription
Tier 2 Preferred Brands	$15 copay per prescription	$45 copay per prescription	$30 copay per prescription
Tier 3 Non-Preferred Drugs, including Specialty Drugs	$15 copay per prescription	$45 copay per prescription	$30 copay per prescription

Stage 3: Coverage Gap Stage

Benefits have been paid by your Group Part D plan and this plan for covered prescription drugs, you will be responsible for the amounts shown above.

Stage 4: Catastrophic Coverage Stage

	Retail and Mail-Order Cost Sharing
Tier	
Tier 1 Generics	$0 copay per prescription
Tier 2 Brand-Name Drugs	$0 copay per prescription
Tier 1 Select Drugs	$0 copay per prescription

Your 2025 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. These drugs do not count towards your Drug Plan Maximum Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold Vitamins and Minerals	See Drug List for complete list of drugs covered
• Generics	$5 copay
• Preferred Brands	$15 copay
• Non-Preferred Drugs	$15 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$5 copay
• Preferred Brands	$15 copay
• Non-Preferred Drugs	$15 copay

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
Cough and Cold Vitamins and Minerals	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$30 copay
• Non-Preferred Drugs	$30 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$30 copay
• Non-Preferred Drugs	$30 copay