



Davidson College
Effective January 1, 2019

Choice Plus Plan

	1-31 Day <u>Supply Retail</u>	90 Day <u>Supply Mail</u>
Preventive Generic	\$15	\$38
Generic Medications	\$ 20	\$ 50
Preferred Brand Medications	\$ 35	\$ 87.50
Non-Preferred Brand Medications	\$ 60	\$ 150
Specialty Medications*	\$150	N/A

Deductible: \$100 Individual/\$300 Family

Maximum Out of Pocket (MOOP): \$3,000 Individual/\$9,000 Family

The calendar year deductible applies to pharmacy only. Once met, your covered prescriptions are subject to the copays above.

The calendar year Maximum Out of Pocket (MOOP) applies to pharmacy and medical. Each individual family member must meet the individual MOOP unless the family MOOP has been met by the covered family members.

HSA Choice Plus Plan

	1-31 Day <u>Supply Retail</u>	90 Day <u>Supply Mail</u>
Preventive Generic	20% Deductible Waived	20% Deductible Waived
Generic Medications	20% coinsurance	20% coinsurance
Brand Medications	30% coinsurance	30% coinsurance
Non-Preferred Brand Medications	30% coinsurance	30% coinsurance
Specialty Medications	30% coinsurance	N/A

Deductible: \$2,700 Individual/\$6,500 Family

Maximum Out of Pocket (MOOP): \$6,000 Individual/\$12,000 Family

The calendar year deductible applies to pharmacy and medical. Each individual family member must meet the individual deductible unless the family deductible has been met by any two or more covered family members. Once met, your covered prescriptions are subject to the coinsurance above. The deductible applies to the MOOP.

The calendar year Maximum Out of Pocket (MOOP) applies to pharmacy and medical. Each individual family member must meet the individual MOOP unless the family MOOP has been met by the covered family members.

***Specialty Medications:** Specialty medications are limited to 30-day supply and must be ordered from Express Scripts at 1-800-803-2523. Specialty medications may require prior authorization and quantity limits may apply. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Generic Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.

DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below

DRUGS COVERED* (continued)

- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips for testing, Disposable insulin needles/syringes and lancets
- Contraceptives: Oral, transdermal, intravaginal, implantable devices, injectable, diaphragms, IUD's and extended cycle products
- ADD/ADHD Medications
- Androgens and Anabolic Steroids (prior authorization required)
- Topical Acne Medications
- Impotency Medications (quantity limits apply)
- Narcolepsy Medications (prior authorization required)
- Growth Hormones (prior authorization required)
- Migraine medications (quantity limits apply)
- Hypnotics (quantity limits apply)
- Pain/Narcotics (quantity limits apply)
- Gastrointestinal-Antiemetics (quantity limits apply)
- Topical Analgesic Pain Patches (quantity limits apply)
- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription

EXCLUSIONS*

- Biologicals, Vaccines, Immunization Agents
- Blood Products and Serums
- Cosmetic agents: Anti-wrinkle agents, Pigmenting & De-Pigmenting, Hair growth stimulants and hair removal products
- Compounded medication of which at least one ingredient is a legend drug
- Compounded prescriptions that use ingredients such as bulk chemicals and powders
- Anti-obesity/Appetite Suppression medications
- Infertility Medications
- Nutritional Supplements
- Formulary Exclusion List
- OTC Products unless notes above
- Therapeutic devices or appliances unless listed as a covered product.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a physician's office, licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

***This is not an inclusive list but is a representation of the most commonly used medications. Contact member services for specific drug coverage information.**

For Prescription Drug Card Member Services Call RxBenefits at 1-800-334-8134
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Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Member Services via phone at 1-800-334-8134 or by emailing RxHelp@RxBenefits.com. If you have specific drug questions, you can register at www.Express-Scripts.com to check drug costs and coverage.

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