# Davidson College
**Effective January 1, 2018**

## Choice Plus 750 Plan

<table>
<thead>
<tr>
<th></th>
<th>1-31 Day</th>
<th>90 Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supply Retail</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Medications</td>
<td>$15</td>
<td>$37.50</td>
</tr>
<tr>
<td>Preferred Brand Medications</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Non-Preferred Brand Medications</td>
<td>$60</td>
<td>$150</td>
</tr>
<tr>
<td>Specialty Medications*</td>
<td>$150</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Deductible:** $100 Individual/$300 Family  
**Maximum Out of Pocket (MOOP):** $3,000 Individual/$6,000 Family

The calendar year deductible applies to pharmacy only. Each individual family member must meet the individual deductible unless the family deductible has been met by any three or more covered family members. Once met, your covered prescriptions are subject to the copays listed 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 any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

## HSA Choice Plus HDHP Plan

<table>
<thead>
<tr>
<th></th>
<th>1-31 Day</th>
<th>90 Day</th>
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</thead>
<tbody>
<tr>
<td><strong>Supply Retail</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Medications</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Brand Medications</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Non-Preferred Brand Medications</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Specialty Medications</td>
<td>50% coinsurance</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Deductible:** $2,700 Individual/$5,400 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 three or more covered family members. Once met, your covered prescriptions are subject to the coinsurances listed above. The deductible applies to the MOOP. The calendar year Maximum Out of Pocket applies to pharmacy and medical. Each individual family member must meet the individual MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

*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.

**Generic Policy:** If your doctor writes a prescription stating that a Generic may be dispensed, and you choose the Brand name drug, you will pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. This expense does not apply to the deductible or MOOP.
DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below
- Compounded medication of which at least one ingredient is a legend drug
- 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*

- Biologics, Vaccines, Immunization Agents
- Blood Products and Serums
- Cosmetic agents: Anti-wrinkle agents, Pigmenting & De-Pigmenting, Hair growth stimulants and hair removal products
- 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. (These medications are covered under the medical benefit.)

*This is not an inclusive list but is a representation of the most commonly used medications. Contact member services for specific drug coverage information. To view the ESI formulary now, please access the Express Scripts website at www.express-scripts.com/NATPLSNATPREF14

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 if you have specific drug questions or register at www.Express-Scripts.com to check drug costs and coverage.

For Prescription Drug Card Member Services Call RxBenefits at 1-800-334-8134 or email at rxhelp@rxbenefits.com