

North Central Indiana School Trust Effective October 1, 2020

Plan 1 & Plan 2

	<u>30 Day Supply Retail/Specialty*</u>	<u>90 Day Supply Mail</u>
Tier 1 - Generic Drugs	\$20	\$40
Tier 2 - Preferred Brand Name Drugs	\$40	\$80
Tier 3 - Non- Preferred Brand Name Drugs	\$80	\$160

Maximum Out of Pocket (MOOP): \$2,600 Individual/\$5,200 Family

The calendar year MOOP applies to pharmacy claims. Each individual family member must meet the single 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%. Generic dispense as written penalties do not apply to the MOOP.

Plan 3

Deductible: \$3,000 Individual/\$6,000 Family

The calendar year deductible applies to pharmacy and medical claims. 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 paid at 100%. Dispense as written penalties do not apply to the deductible. The deductible does apply to the Maximum Out of Pocket (MOOP).

	<u>30 Day Supply Retail/Specialty*</u>	<u>90 Day Supply Mail</u>
Tier 1 - Generic Drugs	\$0	\$0
Tier 2 - Preferred Brand Name Drugs	\$0	\$0
Tier 3 - Non- Preferred Brand Name Drugs	\$0	\$0

Maximum Out of Pocket (MOOP): \$3,000 Individual/\$6,000 Family

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%.

Plan 4

Deductible: \$6,000 Individual/\$12,000 Family

The calendar year deductible applies to pharmacy and medical claims. 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 paid at 100%. Dispense as written penalties do not apply to the deductible. The deductible does apply to the Maximum Out of Pocket (MOOP).

	<u>30 Day Supply Retail/Specialty*</u>	<u>90 Day Supply Mail</u>
Tier 1 - Generic Drugs	\$0	\$0
Tier 2 - Preferred Brand Name Drugs	\$0	\$0
Tier 3 - Non- Preferred Brand Name Drugs	\$0	\$0

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

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%.

***Specialty Medications:** Specialty medications are limited to 30 day supply and are subject to retail copays. Specialty medications must be ordered from Accredo Specialty Pharmacy at 1-800-803-2523 and may be subject to prior authorization, step therapy, and quantity limits.

Dispense As Written 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 copay plus the difference in cost between the generic and brand name drug. The Dispense As Written Policy does not apply if your doctor requires a brand name medication.

Medication costs exceeding \$1,000 per 30 day supply and \$3,000 per 90 day supply require prior authorization.

Some medications may require clinical prior authorization. If your medication requires a prior authorization, please contact 1-888-608-8851.

DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below
- Compound medications of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding \$300 per script may require prior authorization.
- 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 (quantity limits may apply)
- ADD/ADHD Medications
- Androgens and Anabolic Steroids (prior authorization may apply)
- Topical Acne Medications (prior authorization and step therapy may apply)
- Impotency Medications (prior authorization and quantity limits may apply)
- Narcolepsy Medications (prior authorization may apply)
- Growth Hormones (prior authorization and step therapy may apply)
- Migraine medications (quantity limits may apply)
- Hypnotics (quantity and step therapy limits may apply)
- Pain/Narcotics (prior authorization and quantity limits may apply)
- Gastrointestinal-Antiemetics (quantity limits may apply)
- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription

EXCLUSIONS* (These medications may be covered by your medical benefit)

- Biologicals, Non- ACA 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
- Topical Analgesic Pain Patches
- Nutritional Supplements
- Formulary Exclusion List
- OTC Products unless noted above
- Therapeutic devices or appliances unless listed as a covered product
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- 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.

For Prescription Drug Card Member Services Call RxBenefits at 1-800-334-8134



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

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.

Please Note: RxBenefits, Inc. does not provide legal advice. Nothing contained in this Summary of Benefits & Coverage or in any other documents provided by RxBenefits, Inc. should be construed, or relied upon, as legal advice. This document is a sample only and the content and calculations herein should be verified by the Employer/Plan Sponsor. It is the responsibility of the Employer/Plan Sponsor and not RxBenefits, Inc. to determine the contents of its group health plan document and related Summary of Benefits & Coverage. The Employer/Plan Sponsor should consult with its legal counsel regarding the contents of its group health plan and summary documents, and the legal requirements that may be applicable thereto.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000



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