

# Prescription Drug Benefits At-A-Glance

## Benefit Features

## Member Responsibility

### Prescription Drugs

Generic Equivalent ( <i>Low Drug Copayment</i> ) . . . . .	\$5 copayment
Formulary Brand Name ( <i>Medium Drug Copayment</i> ) . . . . .	\$15 copayment
Non-Formulary Brand Name or Compounded Prescriptions ( <i>High Drug Copayment</i> ) . . . . .	\$30 copayment

### Birth Control

Generic Equivalent ( <i>Low Drug Copayment</i> ) . . . . .	\$5 copayment
Formulary Brand Name ( <i>Medium Drug Copayment</i> ) . . . . .	\$15 copayment
Non-Formulary Brand Name or Compounded Prescriptions ( <i>High Drug Copayment</i> ) . . . . .	\$30 copayment

### Diabetic Supplies

Insulin Syringes . . . . .	\$5 copayment
Test strips, lancets, glucose monitors . . . . .	Refer to your medical benefits ( <i>reference Durable Medical Equipment</i> )

### Definitions

*Formulary Brand Name:* A listing of brand name outpatient prescription drugs selected on the basis of effectiveness and cost. This list is subject to periodic review and modification.

*Generic Equivalent:* A chemically equivalent form of a brand name drug for which the patent has expired. You pay the lowest drug copayment when you receive a generic drug.

*Non-Formulary Brand Name:* Brand name outpatient prescription drugs outside of UnitedHealthcare's formulary.

### Application of Drug Copayments

Drug copayments for outpatient prescription drugs do not apply toward the medical maximum out-of-pocket expense or deductible, if applicable.

### Limitations

Prescription quantity shall be limited to the amount ordered by the attending physician. Quantity per prescription fill or refill shall not exceed a 30-day supply or such other day supply as authorized by UnitedHealthcare. However, items on the 90-day supply list may be dispensed in quantities up to a maximum of 90-day supply through mail order and three (3) copayments for each 90-day supply through retail. UnitedHealthcare reserves the right to establish criteria and require prior authorization for certain outpatient prescription drugs.

### Benefit Exclusions

Non-covered items include, but are not limited to: medications available over the counter (OTC), unless (1) such OTC medication has been designated by UnitedHealthcare as eligible for coverage as if it were an outpatient prescription drug, and (2) such OTC medication is obtained with a prescription from an attending physician • growth hormone • therapeutic or prosthetic devices • drugs used for cosmetic purposes • drugs used to enhance physical or mental performance • treatment or supplies to promote smoking cessation • dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional formulas and supplements • drugs used for the treatment of infertility • drugs used for experimental purposes.

This document is provided as a brief summary and is not intended to be a complete description of the benefit plan. After you become covered, you will be issued an evidence of coverage (Subscriber Agreement or Summary Plan Description) describing your coverage in greater detail. The evidence of coverage will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this *Prescription Drug Benefits At-A-Glance*, and the evidence of coverage, the language of the evidence of coverage controls.