

MissVIC Pharmacy Management Program – HSA Plan

ASO

07/01/16 – 06/30/17

Services provided through **Express Scripts** – Division Number ZZ8

	Retail Network Pharmacy For up to a 31 day supply	Home Delivery Network Pharmacy For up to a 90 day supply
Tier 1 (Generics)	\$10	\$25
Tier 2 (Preferred)	\$30	\$75
Tier 3 (Non Preferred)	\$50	\$125
Fertility Drugs	Not Covered	Not Covered

You may use your Express Scripts I.D. card or your United HealthCare I.D. card at retail pharmacies in the Express Scripts network. When using your UHC I.D. card, the Pharmacy information is on the front. You must tell the pharmacist that you have Express Scripts when filling a prescription as the UHC I.D. card does not indicate Express Scripts on the front of the card.

You may visit the website for the most up to date information on the Prescription Drug Listing at www.express-scripts.com through the Internet, or call the Customer Service Number on your I.D. card.

You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and contracted rates (Prescription Drug Cost) will not be available to you.

Annual Drug Deductible: Member: \$2,000 / Family: \$4,000

Out-of-Pocket Drug Maximum: No Out-of-Pocket Drug Maximum

Prescription Drugs Not Covered

The Prescription Drug Program will not provide benefits for any of the drugs or supplies listed in this section, regardless of the prescription of a Physician. The list includes, but is not limited to the following specifically excluded drugs:

- All infertility drugs.
- Drugs for cosmetic uses, except as stated above.
- Photo-aged skin products (example: Renova).
- Hair growth agents (example: Propecia, Vaniqa).
- Depigmentation products.
- Contraceptive implants (example: Norplant), diaphragms, IUDs, and emergency (example: Plan B, Preven).
- Impotence injectables or Yohimbine
- Drugs used for weight loss or appetite suppression.
- Serums, toxoids and/or vaccines.
- Allergens.
- Brand Name Smoking Cessation products (example: Zyban, Chantix).
- Over-the-counter (OTC) drugs and drugs with OTC equivalents, except insulin and covered diabetic supplies.
- Medical Foods.
- Durable Medical Equipment, Peak Flow Meters, Ostomy supplies.
- Non-FDA approved drugs, dosages or indications/uses.
- Experimental/investigational drugs.
- Therapeutic devices or appliances, support garments and other non-medical substances.
- Drugs intended for use in a physician's office or another setting other than home use.
- Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
- Diagnostic testing/imaging.

This Summary Plan Description is intended only to highlight your Pharmacy Benefits and should not be relied upon to determine coverage. Your plan may not cover all your outpatient prescription drug expenses. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description will prevail.