



North Central Indiana School Trust
Effective October 1, 2020

Plan 1 & Plan 2

	30 Day Supply Retail/Specialty*	90 Day Supply Mail
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).

	30 Day Supply Retail/Specialty*	90 Day Supply Mail
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).

	30 Day Supply Retail/Specialty*	90 Day Supply Mail
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%.

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



***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.

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

NG

**HOME DELIVERY
ORDER FORM**



1 Member information: Please verify or provide member information below.

Member ID: _____

Group: _____

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____.

New shipping address: _____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: _____

Evening phone: _____

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

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 _____

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to **Express Scripts**, and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order: _____

Payment options: e-check Payment enclosed Credit card Send bill

For credit card payments:

Visa MC Discover Amex Diners

Expiration date

_____/____/____/____
M M Y Y

Cardholder signature

Credit card number

_____/____/____/____/____/____

I authorize Express Scripts to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment (\$21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

FOLD HERE

FOLD HERE

