PRESCRIPTION DRUG SUMMARY OF BENEFITS
PLAN CODE: TM081003

Physicians Plus

POLICY MAXIMUMS

	Single	Family
• RX Deductible:	N/A	N/A
• RX Coinsurance:	N/A	N/A
• RX Maximum Out of Pocket:	$2,000	N/A
• Biopharmaceutical RX Maximum Out of Pocket:	N/A	N/A

All benefits are calculated on a per member per calendar year basis. Please present your member ID card at the pharmacy so discounts, deductible amounts, and maximum out of pocket amounts are calculated correctly. The deductible, coinsurance, and copays will apply to the maximum out of pocket amounts.

COPAYS/COINSURANCE

	Tier 1 Generic	Tier 2 Brand	Tier 3 Non Formulary Not Excluded
Formulary Legend Drugs:	$10	$25	50%
Formulary Contraceptives:	$10	$25	50%
Prior Authorized* (PA) Formulary:	$10	$25	
Formulary Insulin Products:	$10	$10	50%
Disposable Diabetic Supplies (Swabs, syringes, strips, needles, lancets)	20%	20%	50%
***Biopharmaceutical Drugs**[++]**:** (Maximum of $100 per prescription per month)	10%*	10%*	Excluded

OVER THE COUNTER (OTC) DRUGS & OTHER $0 COPAY MEDICATIONS

Medication	Copay	Medication	Copay
• Chlorpheniramine	$0	• Naphcon-A eye drops	$0
• Fluoride Supplements	$0 (Age 6 mo.– 6 yrs)	• Nasalcrom Nasal Spray	$0
• Folic Acid	$0 (Women under 42)	• Niacin (not 120mg SR)	$0
• Prenatal Vitamins	$0 (Women under 42)	• Opcon A eye drops	$0
• Guaifenesin/Codeine Syrup	$0	• Pseudoephedrine (not 120mg SR)	$0
• Iron Supplements	$0 (Age 6-12 months)	• Zaditor (ketotifen)	$0

BENEFIT MAXIMUMS & LIMITATIONS

Infertility Drugs	50% coinsurance up to $1,000 is the lifetime limit paid by Physicians Plus. Coinsurance on this benefit does not apply to the RX policy maximum out of pocket.
* Biopharmaceuticals[++]	Member pays, 10% up to $100 per prescription/per drug per month up to the RX policy maximum out of pocket per member per calendar year. All biopharmaceuticals require prior authorization. Page 2 of this document includes the current Biopharmaceutical drug list; this list is subject to change without notice, please find the most up to date information on our website at www.pplusic.com

*** BIOPHARMACEUTICAL DRUG LIST** – All biopharmaceuticals require prior authorization.

Brand Name (Generic Name)

Actimmune® (interferon gamma-1b)
Apokyn® (apomorphine)
Aranesp® (darbepoetin alfa)
Arixtra® (fondaparinux)
Avonex® (interferon beta-1a)
Betaseron® (interferon beta-1b)
Cimzia® (certolizumab Pegol)
Copaxone® (glatiramer)
Enbrel® (etanercept)
Epogen® (epoetin alfa)
Extavia® (interferon beta-1b)
Forteo® (teriparatide)
Fragmin® (dalteparin)
Genotropin® (somatropin-rDNA)
Gilenya™ (fingolimod)
Humatrope® (somatropin-rDNA)
Humira® (adalimumab)
Infergen® (interferon alphacon-1)

Brand Name (Generic Name)

Incivek™ (telapravir)
Increlex® (mecasermin-rDNA)
Intron-A® (interferon alfa-2b)
Kineret® (anakinra)
Kuvan® (sapropterin)
Leukine® (sargramostim)
Lovenox® (enoxaparin)
Neulasta® (pegfilgrastim)
Neumega® (oprelvekin(interleukin-11; IL-11))
Neupogen® (filgrastim)
Norditropin® (somatropin-rDNA)
Nplate® (romiplostim)
Nutropin® (somatropin-rDNA)
Nutropin AQ® (somatropin-rDNA)
Nutropin Depot® (somatropin-rDNA)
Omnitrope® (somatropin)
Pegasys® (interferon alfa-2a)

Brand Name (Generic Name)

Peg-Intron® (interferon alfa-2b)
Procrit® (epoetin alfa)
Promacta® (eltrombopag)
Pulmozyme® (dornase alfa)
Rebif® (interferon beta-1a)
Regranex® (becaplermin)
Saizen® (somatropin-rDNA)
Sandostatin® (octreotide)
Sandostatin LAR® (octreotide)
Serostim® (somatropin-rDNA)
Simponi™ (golimumab)
Somatuline® (lanreotide)
Somavert® (pegvisomant)
Stelara™ (ustekinumab)
Sylatron™ (peginterferon alfa-2b)
Tev-Tropin® (somatropin-rDNA)
Tyvaso® (treprostinil)
Ventavis® (iloprost)
Victrelis™ (telapravir)

Maintenance Drug List: Several medications used for chronic illnesses are available from your pharmacy in a 90-day supply for three copayments (one copay per 30 day supply). A list of these drugs can be obtained from our website at www.pplusic.com or by contacting the Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015.

Quantity Limitations: The following medications have specific quantity limitations.

Medication	Limitation
Sumatriptan Tablets (Imitrex)	[9] tablets per copay, 2 copays per month
Sumatriptan Injection (Imitrex)	[6] syringes per copay per month
Sumatriptan Spray (Imitrex)	[6] spray devices per copay, 2 copays per month
Samsca (PA)	[10] day supply per copay
Relpax (NF)*	[12] tablets per copay, 2 copays per month
Naratriptan (NF)*	[9] tablets per copay, 2 copays per month
Axert (NF)*	[6] tablets per copay, 2 copays per month
Zomig Nasal Spray (NF)*	[6] spray devices per copay, 2 copays per month
Zomig (NF)*	[6] tablets per copay, 2 copays per month
DDAVP	[2] spray bottles per copay
Ear & Eye Drops	[30] day supply or 2 containers per copay, whichever is less
Glucagon Kit	[1] (one) kit per copay
Pulmicort Inhaler	[1] (one) inhaler per copay
Other Inhalers	[2] inhalers or one month supply, whichever is less
Enoxaparin, Fragmin, Arixtra*	[14] day supply per copay
Regranex (PA)	[1] (one) copay per 15 gram tube
Vitamin A Derivatives (Retin-A)	Not covered for members over age [35] years

***Prior Authorization** (PA) is required for some medications and ALL Biopharmaceuticals. Formulary status is subject to change, see our website at www.pplusic.com, GO-TO Rx Manager or contact Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015 for a current formulary and/or list of drugs requiring prior authorization.

If a PA is approved, the appropriate tier level copay/coinsurance will apply. If the PA is denied or not obtained, the member will be responsible for payment at the tier 3 level of benefits or payment in full.

(NF) Indicates Non-Formulary (NF) as of 9/20/2011.