



PRESCRIPTION DRUG SCHEDULE OF BENEFITS

PLAN CODE: TP081035

POLICY MAXIMUMS

	Single	Family
• RX Policy Lifetime Maximum:	N/A	N/A
• 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 contract year basis. Please present your member ID card at the pharmacy so discounts, deductible amounts, and maximum out of pocket amounts accrue correctly. The deductible, coinsurance, and copays will apply to the maximum out of pocket amounts. Dollar amounts paid by Physicians Plus will apply to the Policy Lifetime Maximum.

COPAYS/COINSURANCE

	Tier 1 <u>Generic</u>	Tier 2 <u>Brand</u>	Tier 3 <u>Non Formulary Not Excluded</u>
Formulary Legend Drugs:	\$10	30%+	50%
Formulary Contraceptives:	\$10	30%+	50%
Prior Authorized* (PA) Formulary Drugs:	\$10	30%+	
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%*	

+Maximum of \$200 per prescription for drugs on Tier 2.

FORMULARY OVER-THE-COUNTER DRUGS

• Chlorpheniramine	\$0 Copay
• Guaifenesin/Codeine Syrup	\$0 Copay
• Naphcon-A eye drops	\$0 Copay
• Nasalcrom Nasal Spray	\$0 Copay
• Niacin	\$0 Copay
• Opcon A eye drops	\$0 Copay
• Pseudoephedrine (not 120mg SR)	\$0 Copay
• Zaditor (ketotifen)	\$0 Copay

BENEFIT MAXIMUMS & LIMITATIONS

Infertility Drugs 50% up to \$1000 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 contract 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 list on our website at www.healthychoicesbigrewards.com

See next page for other BENEFIT MAXIMUMS & LIMITATIONS

* **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)
Copaxone® (glatiramer)
Enbrel® (etanercept)
Epogen® (epoetin alfa)
Forteo® (teriparatide)
Fragmin® (dalteparin)
Genotropin® (somatropin-rDNA)
Geref® (sermorelin)
Humatrope® (somatropin-rDNA)
Humira® (adalimumab)

Brand Name (Generic Name)
Infergen® (interferon alphacon-1)
Intron-A® (interferon alfa-2b)
Kineret® (anakinra)
Leukine® (sargramostim)
Lovenox® (enoxaparin)
Neulasta® (pegfilgrastim)
Neumega® (oprelvekin (interleukin-11; IL-11))
Neupogen® (filgrastim)
Norditropin® (somatropin-rDNA)
Nutropin® (somatropin-rDNA)
Nutropin AQ® (somatropin-rDNA)
Nutropin Depot® (somatropin-rDNA)
Omnitrope® (somatropin)
Pegasys® (interferon alfa-2a)
Peg-Intron® (interferon alfa-2b)

Brand Name (Generic Name)
Procrit® (epoetin alfa)
Protropin® (somatrem)
Pulmozyme® (dornase alfa)
Raptiva® (efalizumab)
Rebetron® (ribavirin and interferon Alfa-2b)
Rebif® (interferon beta-1a)
Regranex® (becaplermin)
Roferon-A® (interferon alfa-2a-rIFN-A; IFLrA)
Saizen® (somatropin-rDNA)
Serostim® (somatropin-rDNA)
Somavert® (pegvisomant)
Tev-Tropin® (somatropin-rDNA)

Maintenance Drug List: Several medications used for chronic illnesses are available from your pharmacy in a 90-day supply for 3 copayments (1 (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.

Imitrex Tablets	[9] tablets per copay, 2 copays per month
Imitrex Injection	[6] syringes per copay per month
Imitrex Spray	[6] spray devices per copay, 2 copays per month
Maxalt	[12] tablets per copay, 2 copays per month
Maxalt MLT	[12] tablets per copay, 2 copays per month
Amerge (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
Lovenox, Fragmin, Innohep*, Orgaran*, 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 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, a tier 2 copay/coinsurance applies. 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.

+ Maximum of \$200 per prescription per drug per month for drugs on Tier 2.

(NF) Indicates Non-Formulary (NF) as of 9/1/2008.