



PRESCRIPTION DRUG SCHEDULE OF BENEFITS

PLAN CODE: TVSBKAA

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 accrue correctly. The deductible, coinsurance, and copays will apply to the maximum out of pocket amounts. Dollar amounts paid by Physicians Plus (PPIC) will apply to the Policy Lifetime Maximum.

POLICY MAXIMUMS – The amount listed indicates what is paid by PHYSICIANS PLUS.

	Single Plan	Family Plan
• RX Policy Lifetime Maximum:	\$1,000,000	\$5,000,000
• RX Deductible:	N/A	N/A
• RX Coinsurance:	N/A	N/A
• RX Maximum Out of Pocket:	N/A	N/A
• Biopharmaceutical RX Maximum Out of Pocket:	N/A	N/A

COPAYS/COINSURANCE – The amount listed below indicate what the MEMBER is responsible to pay unless noted otherwise.

	Tier 1 <u>Generic</u>	Tier 2 <u>Brand</u>	Tier 3 <u>Non Formulary</u>
Formulary Legend Drugs:	\$10	PPIC pays \$50 – member pays balance	100%†
Formulary Contraceptives:	\$10	PPIC pays \$50 – member pays balance	100%†
Prior Authorized* (PA) Formulary Drugs:	\$10	PPIC pays \$50 – member pays balance	100%†
Formulary Insulin Products:	\$10	\$10	100%†
Disposable Diabetic Supplies (Swabs, syringes, strips, needles, lancets)	20%	20%	100%†
Biopharmaceutical Drugs⁺⁺:	\$10	PPIC pays \$50 – member pays balance	100%†

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 (not 120mg SR) \$0 Copay
- Opcon A eye drops \$0 Copay
- Pseudoephedrine (not 120mg SR) \$0 Copay
- Zaditor (ketotifen) \$0 Copay

BENEFIT MAXIMUMS & LIMITATIONS

Infertility Drugs 50% coinsurance up to \$1000 is the lifetime limit paid by Physicians Plus. Note: For Tier 2 medications Physicians Plus pays 50% coinsurance up to \$50 per prescription per month and member pays the balance. Coinsurance on this benefit does not apply to the RX policy maximum out of pocket.

*** Biopharmaceuticals⁺⁺** 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

* **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)
Nplate® (romiplostim)
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)
Promacta® (eltrombopag)
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)
Sandostatin® (Octreotide)
Serostim® (somatropin-rDNA)
Somatuline® (Lanreotide)
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.

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
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.

(NF) Indicates Non-Formulary (NF) as of 6/1/2009.

† The member is responsible for 100% of the cost of the drug after the Physicians Plus contracted pharmacy discount has been applied to any online pharmacy claim. All applicable exclusions and limitations apply as indicated in the Physicians Plus Medical Certificate of Coverage.