

## Northwestern Medical Center Effective January 1, 2022

### HSA Plan

#### **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 subject to the copays below. Generic Dispense as Written policy [does not] apply to the Deductible. The Deductible [does] apply to the Maximum Out of Pocket (MOOP).

	<u>30 Day Supply NMC &amp; Affiliated Pharmacies</u>	<u>90 Day Supply NMC &amp; Affiliated Pharmacies</u>	<u>30 Day Supply All Other Retail Pharmacies</u>	<u>90 Day Supply All Other Retail*/Mail Pharmacies</u>
Tier 1 - Generic Drugs	\$5	\$15	\$10	\$30
Tier 2 - Preferred Brand Name Drugs	\$20	\$60	\$40	\$120
Tier 3 - Non-Preferred Brand Name Drugs	\$20	\$60	\$50	\$150
**Specialty	N/A	N/A	30%	N/A

#### **Maximum Out of Pocket (MOOP): \$5,000 Individual/\$10,000 Family**

The calendar year MOOP applies to pharmacy and medical claims. 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%. Generic Dispense as Written policy does not apply to the MOOP.

**Affiliated Pharmacies:** Rite Aid – St. Albans, Rite Aid – Milton, Rite Aid – Enosburg, Walmart – St. Albans, Kinney Drugs – St. Albans, and Kinney Drugs – Milton, Walgreens-Essex Junction, Walgreens-Colchester, Walgreens-Winooski, NOTCH-Swanton, NOTCH-Richford

**\*Limited pharmacy network:** Over 58,000 retail pharmacies. Contact RxBenefits Member Services if you would like to inquire about a specific pharmacy.

**\*\*Specialty Medications:** Specialty medications are limited to 30 day supply and are subject to the coinsurance above. Specialty medications must be ordered from Accredo Specialty Pharmacy at 1-800-803-2523. Specialty medications may be subject to prior authorization, step therapy, and quantity limits.

**High Dollar Claim Review:** Medication costs exceeding \$1,000 per 30 day supply and \$3,000 per 90 day supply require prior authorization.

**Low Clinical Value:** Certain formulary exclusions including medications which have low clinical value may apply. Contact Member Services at 1-800-334-8134 for additional information.

**Step Therapy Program:** Your plan has certain medications that are subject to step therapy. You could be asked to try one of the first or second level options before a brand medication is covered by the plan.

**Dispense as Written (DAW) 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 DAW Policy does not apply if your doctor requires a brand name medication.

**DRUGS COVERED\*\*\***

Drugs covered may be subject to Utilization Management which may include prior authorization and/or quantity limits. Please contact Member Services if you have specific drug questions or register at [express-scripts.com](http://express-scripts.com) to check coverage.

- ADD/ADHD Medications
- Androgens
- 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.
- Contraceptives: Oral, transdermal, intravaginal, implantable devices, injectable, diaphragms, IUD's and extended cycle products
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips for testing, Disposable insulin needles/syringes and lancets
- Growth Hormones
- Gastrointestinal-Antiemetics
- Hypnotics
- Impotency Medications
- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below
- Migraine medications
- Narcolepsy Medications
- Nutritional Supplements (Rx Only)
- Pain/Narcotics
- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription
- Topical Acne Medications

**EXCLUSIONS\*\*\***

- Anti-obesity/Appetite Suppression medications
- Biologicals, 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
- Formulary Exclusion List
- Infertility Medications
- OTC Products unless noted above
- Topical Analgesic Pain Patches
- 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.

**\*\*\*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 [Express-Scripts.com](http://Express-Scripts.com) to check drug costs and coverage.