

## **Outpatient Prescription Drug Card Benefit**

A list of "Participating Pharmacies" or information regarding the "Mail Order Pharmacy" can be obtained on request from your Company.

When you are being treated for an Illness or Accident, your Physician may prescribe certain drugs or medicine as part of your treatment. Your coverage includes benefits for drugs, and this section explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

### **Covered Services**

The drugs for which benefits are available under this section are:

1. Drugs that require, by Federal law, a written prescription;
2. Injectable insulin, including syringes and needles purchased by prescription, and diabetic supplies;
3. All forms of contraceptives.

Benefits for these drugs will then be provided when:

1. You have been given a written prescription for them by your Physician; and
2. You purchase the drugs from a Participating Pharmacy.

Not all drugs are covered by this Plan. Those not covered include, but are not limited to, fertility agents, growth hormones, and Rogaine. In addition, benefits will not be provided for any refills if the prescription is more than one year old.

The Plan will cover each of the available options for prescription contraception to the same extent, and on the same terms, that it covers other drugs, devices and other Outpatient services.

### **Benefit Payment for Prescription Drugs**

Short Term - Acute Drugs:

When you obtain drugs from a Participating Pharmacy, there is a Copay amount of \$6.00 for generic drugs, \$12.00 for preferred brand name drugs, and \$27 for non-preferred brand name drugs for each prescription. Benefits will be provided for the remaining eligible charge. One prescription means up to a 34-consecutive-day supply of a drug.

Long Term - Maintenance Drugs - Mail Order:

When you obtain drugs from the Mail Order Pharmacy, there is a Copay amount of \$12.00 for generic drugs, \$24.00 for preferred brand name drugs and \$54.00 for non-preferred brand name drugs for each prescription. Benefits will be provided for the remaining eligible charge. Maintenance drug prescription means up to a 90-consecutive-day supply of a drug.

The plan includes a unique feature to help individuals with diabetes effectively manage their illness: you may obtain a 90-consecutive-day supply of your diabetes-related supplies and medications as a "bundle" instead of as single items. For example, test strips, insulin, alcohol swabs, lancets, needles, and syringes may be combined and require just one copay as a generic drug—regardless of the brand prescribed. This applies to prescriptions filled at both retail and mail service pharmacies.

Note: Benefits for Outpatient prescription drugs covered under this Outpatient Prescription Drug Card Benefit will not be provided under any other section of this Plan.

*The Quality Forum's Workplace-Focused Diabetes Project Team would like to thank Patricia Grunewald and Dave Smith for sharing this document and generously offering to have it included as an example for others.*

## Preferred Provider Benefit (PPO)

A listing of the preferred providers will be provided from your Company office. The Plan provides access to the PPO as an alternative to other providers. However, the Company in no way recommends or endorses these or any other provider. It is the responsibility of the patient or Family to determine the ability of any provider to render care or treatment.

All PPO benefits payable by the Plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned at your option. Payments made in accordance with an Assignment of Benefits are made in good faith and release the Plan's obligation to the extent of the payment.

### Standard Major Medical Benefits

#### Calendar Year Deductible

|                        |       |
|------------------------|-------|
| Per Covered Person     | \$250 |
| Per Family (aggregate) | \$750 |

#### Coinsurance by Plan

80% after satisfying the Deductible

#### Coinsurance Limit

**The Coinsurance limit includes the Deductible.**

|                        |         |
|------------------------|---------|
| Per Covered Person     | \$1,250 |
| Per Family (aggregate) | \$2,500 |

After your 20% Coinsurance equals these amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.

Note: Coinsurance for non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, office visit Copays, drug card Copays and other Copays, do not qualify under the Coinsurance limit provision.

#### Covered Services

|   |                             |
|---|-----------------------------|
| Ambulance Services  | 80%<br>after Deductible     |
| Chiropractic Services   | 100%<br>after \$25.00 Copay |
| Colonoscopies<br>(Routine and Diagnostic)                       | 80%<br>after Deductible     |
| Diagnostic X-Ray & Lab - Outpatient                             | 80%<br>after Deductible     |
| Durable Medical Equipment                                       | 80%<br>after Deductible     |
| Emergency Care<br>(Copay is waived if admitted within 24 hours) | 100%<br>after \$75.00 Copay |
| Home Health Care<br>(Limited to 100 visits per Calendar Year)   | 80%<br>after Deductible     |
| Hospice Care  | 80%<br>after Deductible     |
| Hospital Services - Inpatient/Outpatient Services               | 80%<br>after Deductible     |
| Orthotics (Casted)  | 80%<br>after Deductible     |

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|  |                             |
|--|-----------------------------|
| Physician Office Visit<br>(includes all office services, including office surgery and related services)  | 100%<br>after \$25.00 Copay |
| Physician Services – Other   | 80%<br>after Deductible     |
| Pre-Admission Testing  | 80%<br>after Deductible     |
| Routine Cancer Screening   |                             |
| • Routine annual pap smear and gynecological exam;   | 100%<br>after \$25.00 Copay |
| • Routine annual prostate exam, including the PSA test;  | 100%<br>after \$25.00 Copay |
| • Routine mammograms.  | 100%<br>no Deductible       |
| Routine Well Adult Care Age 5 and Over<br>Coverage includes routine physical exams, related x-ray and lab charges,<br>and immunizations with a maximum benefit of \$500 per person per<br>Calendar Year. | 100%<br>after \$50.00 Copay |
| Routine Well Child Care to the Age of 5<br>Coverage includes routine physical exams, related x-ray and lab<br>charges, and immunizations.  | 100%<br>after \$25.00 Copay |
| Skilled Nursing Facility   | 80%<br>after Deductible     |
| Surgery (other than office surgery)  | 80%<br>after Deductible     |
| Therapy – Occupational   | 80%<br>after Deductible     |
| Therapy – Physical   | 80%<br>after Deductible     |
| Therapy – Speech   | 80%<br>after Deductible     |
| Treatment of Mental Health/Substance Abuse   |                             |
| • Outpatient Care<br>(limited to 20 visits per Calendar Year)  | 100%<br>after \$25.00 Copay |
| • Inpatient Care/Intensive Outpatient Treatment<br>(limited to 30 days per Calendar Year)  | 80%<br>after Deductible     |

**Lifetime Maximum for Treatment of Substance Abuse:**

All treatment for Substance Abuse is limited to a combined maximum benefit of \$10,000 while covered under this Plan.

**Maximum Lifetime Benefit:**

\$1,000,000 per Covered Person for Major Medical Benefits, which includes a maximum benefit of \$10,000 for all care or treatment of Substance Abuse.

**Important Notation:**

Wherever the word “Lifetime” appears in this Summary Plan Description in reference to benefit maximums and limitations, it is understood to mean “while covered under this Plan.” Under no circumstances does “Lifetime” mean “during the lifetime of the Covered Person.”

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