



Benefit Summary
Outpatient Prescription Drug
 Sedgwick County Pharmacy Plan
 Effective Date: 1/1/19

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myuhc.com® or calling Customer Care at the telephone number on the back of your ID card

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network

Individual Deductible No Annual Deductible
 Family Deductible No Annual Deductible

Out-of-Pocket Drug Maximum – Network and Non-Network

Individual Out-of-Pocket Maximum \$4,400 Out-of-Pocket Drug Maximum
 Family Out-of-Pocket Maximum \$8,800 Out-of-Pocket Drug Maximum

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	Non-Network	Network
Tier 1	\$15.00	\$15.00	\$37.50
Tier 2	\$30.00	\$30.00	\$75.00
Tier 3	\$55.00	\$55.00	\$137.50

* Only certain Prescription Drugs are available through mail order; please visit www.myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information.

- Diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, lancets and devices, ketone test strips and tablets) will be dispensed, up to a 90 day supply.
- Formulary meter and supplies = \$ 0 copay
- Formulary Insulin Vials = \$0 copay
- Generic Oral Anti-Diabetic Medications = \$0 copay
- Oral Anti-Cancer medications if these have an equivalent intravenous or injectable = \$0 Copay

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Other Important Information about your Outpatient Prescription Drug Benefits

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the **Sedgwick County** have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that **Sedgwick County** determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.

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- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.
 - A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
 - Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.