

# Prescription Drug Coverage



HIAC-h13

Many managed care plans offer prescription drug coverage. Every plan is different and provides different amounts of coverage, but plans manage pharmacy benefits in some common ways. To receive the most benefits from your plan, you must understand what prescription drug benefits you have and how the plan works.

## **How do I know if my plan covers prescription drugs?**

Prescription drugs may be covered under your medical plan or a separate prescription plan, or you may have no prescription coverage at all. If prescription coverage is offered under your medical plan, a section in your benefit plan contract (also called *evidence of coverage*, *certificate of coverage*, or *summary plan description*) will outline prescription drugs and pharmacy services. If drug coverage is offered under a separate prescription plan, then you should have a separate prescription benefit contract.

If you have any questions about whether you have prescription benefits, ask your employer's human resources office or call your medical plan's customer service representative.

## **If I have a prescription plan, will all drugs be covered?**

All benefit plans are different, and the prescription coverage you have is based on your specific plan. Most managed care plans do not offer complete coverage for all drugs. Your plan most likely has different levels of coverage for different drugs. Some drugs may not be covered at all. (Your contract may call these *exclusions*.) Also, you may pay less for drugs that you purchase at a pharmacy that participates in your plan's network.

## **How much will I have to pay for covered prescription drugs?**

Most plans require that members make a copayment when they pick up their prescription. A copayment is the amount you pay to the pharmacy that fills your prescription. It can be a flat amount (for example, \$5

for each prescription) or a percentage of the total cost of the drugs (for example, 20 percent of the cost of the prescription).

Carefully read your benefit plan contract to find out the amount and type of coverage you have. It is important that you understand your benefits before you go to the pharmacy, so you can make sure you receive the correct amount of coverage.

## **My plan states that I have a different amount of coverage for drugs that are on their "formulary" than for drugs that are not. What does this mean?**

A formulary is a list of drugs and supplies that your plan covers. Every plan has its own formulary, and plans use their formularies in different ways. Under some plans, patients have a lower copayment for drugs that are on the formulary and a higher copayment for drugs that are not (sometimes called an *open formulary*). Under other plans, drugs that are not on the formulary are not covered at all (sometimes called a *closed formulary*).

## **How can I find out if a particular drug is on the formulary?**

Some plans will provide their entire formulary to members when they sign up. Other plans give the formulary only on request. Some plans post the formulary on the Internet at the plan's Web site. You can always find out whether a particular drug is on the formulary by calling your plan's customer service representative.

## **What happens if my child's doctor says that the only drug my child can use is one that is not on the formulary?**

Under some plans you may be able to obtain an exception to the formulary and receive coverage for a nonformulary drug if your child's doctor asks your plan to cover it. Your plan should have a special request process that you and your doctor need to follow to obtain an exception to the formulary. The

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exception process must be in writing and must be given to you when you ask for it.

Under Minnesota law, members of fully insured HMO plans have certain rights when it comes to drugs that are not on the formulary. (Self-insured plans are governed by the federal ERISA law rather than state law.) Minnesota law says that the HMO must *promptly* approve an exception to the formulary when:

- (1) the formulary drug causes an adverse reaction
- (2) the formulary drug is contraindicated
- (3) the doctor who prescribed the drug shows that the drug must be dispensed as prescribed for maximum medical benefit to the patient

If the HMO grants the exception to the formulary, it may charge a copayment, but no more than the approved flat-fee copayment or 25 percent of the cost of the prescription.

Contact your plan's customer representative to find out what to do if your child needs a drug that is not on the formulary.

**My plan says that I have to pay more for brand name drugs than for generic drugs. What is the difference between the two?**

Generic drugs have the same active ingredients in the same amounts as the matching brand name drugs but usually cost less. The FDA considers approved generic drugs to be as effective as their matching brand name drugs. Many plans want patients to use generic drugs and provide more coverage for them than for brand name drugs. If you want a brand name drug, you may have to pay a greater share of the cost. Not all brands have generic equivalents.

**My plan provides more coverage for a generic drug than a brand name drug unless my doctor writes "dispense as written" or DAW on my prescription. What does this mean?**

By writing "dispense as written" or "DAW" on your prescription, your doctor is telling the pharmacist that you *must* receive the exact brand name drug the doctor prescribed. If your doctor does not write "dispense as written" or "DAW," the pharmacist may give you the matching generic drug instead of the brand name drug.

**What is a pharmacy network?**

Managed care plans create pharmacy networks by contracting with specific pharmacies to serve the plan's members at more favorable prices for the managed care plan. The pharmacies that contract with the plan are part of the network and may be called a *network pharmacy* or a *participating pharmacy*. Pharmacies that do not contract with the plan may be called *non-network*, *out-of-network*, or *nonparticipating* pharmacies.

**What is the difference to me if I use a network pharmacy instead of a non-network pharmacy?**

Using a network pharmacy usually provides better benefits than using a non-network pharmacy. You may have a higher copayment at non-network pharmacies. In addition, network pharmacies are usually connected to your plan's computer system; they can quickly check whether your drug is on the formulary and submit your claim for coverage for you. If you use a non-network pharmacy, you may have to pay the pharmacy the entire price of the prescription first and then submit a claim to your plan for reimbursement.

**How can I find out what pharmacies are in my plan's network?**

Most plans have a provider directory that lists the pharmacies in the network. Plans generally furnish the provider directory when members sign up. You can always call your plan's customer service representative to find out whether a particular pharmacy is a network pharmacy.

**My plan covers some drugs only if I obtain "prior authorization" before I fill the prescription. What does this mean?**

Some plans require that you or your child's doctor call to ask for coverage before you have certain drugs dispensed. This is often called prior authorization or precertification. Your plan contract outlines the drugs that require prior authorization and explains the procedure you must follow to obtain prior authorization. Most often, these are very expensive drugs or drugs that may be effective only for certain diseases. If you obtain the drug before asking for precertification you may not receive coverage at all.

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