



**State System of Higher Education  
Prescription Drug Card Program\***  
*Effective January 1, 2008*

Benefits	Retail Pharmacy	Mail Service Pharmacy
<b>Deductible</b> <i>Per Calendar Year</i>		\$0
<b>Generic Prescription Drug</b>	\$0	\$0
<b>Brand Formulary Prescription Drug</b>	\$15 copayment	\$30 copayment
<b>Brand Non-Formulary Prescription Drug</b>	\$30 copayment	\$60 copayment
<b>Days Supply</b> <i>(per prescription)</i>	Up to 30-days	Up to 90-days
<b>Generic Substitution</b>	When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed.	
<b>Out of Pocket Maximum</b>	Not Applicable	
<b>Network Pharmacy</b>	Pharmacy Files Claim at Point-of-Sale	
<b>Non-Network Pharmacy</b>	Member Files Claim	
Prescription Drug Categories		
Contraceptives <i>(oral and injectable)</i>		Covered
Fertility Agents		Covered
Fluoride Products		Covered
Insulin and Diabetic Supplies		Covered
Smoking Deterrents <i>(prescription)</i>		Covered
Vitamins <i>(prescription)</i>		Covered
Weight Loss Drugs		Covered
Allergy Serum	Covered Under Medical Program	
Durable Medical Equipment	Covered Under Medical Program	
Prescription Hair Growth Products		Not Covered
Care Management Programs		
<b>Quantity Level Limits</b> <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
<b>Managed Prior Authorizations</b> <i>on select prescription drugs</i>	Applies only on select prescription drugs***	

*Customized*

*\* This program applies to all active employees and annuitants under the age of 65 retired on or after January 1, 2008*

*\*\*\* Prescription Drugs that require Prior Authorization: Anabolic Steroids/Androgens, Growth Hormones, Retin A, Viagra, Cialis, Levitra.*

**This exhibit provides only general information. More detailed information about benefits and eligibility are contained in the Plan Document. If there is a difference between this summary and the Plan Document, the Plan Document will govern.**



### ***Prescription Drug Program Exclusions***

Except as specifically provided in the contract or benefit booklet, you are not covered for the following services, supplies or charges when provided by a Pharmacy Provider.

1. Any amounts the member is required to pay directly to the Pharmacy Provider for each prescription order or refill order.
2. Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);
3. Any drug or medication which is otherwise excluded under the terms of the Agreement;
4. Allergy serums provided by a pharmacy provider;
5. Hair growth stimulants;
6. Food supplements provided by a pharmacy provider;
7. Immunizations and biologicals provided by a pharmacy provider;
8. Any drugs used to abort a pregnancy when provided by a pharmacy provider;
9. Any drugs prescribed for cosmetic purposes only;
10. Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;
11. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances);
12. Any drugs that can be purchased without a prescription order;
13. Any Prescription Drug which is Experimental/Investigational in nature as determined by Blue Shield in accordance with this Program.