FACT SHEET #5 - Summary
Prescription Medication Benefits

This fact sheet is intended to help Navigators answer specific questions that people with disabilities might ask about prescription medication benefits when they are considering buying health insurance through the Marketplace

Q1. What do I need to know about prescription drug coverage as I evaluate plans I am considering purchasing?

A. Health plans must offer either at least one drug in every treatment category, or the same number of drugs in each category as the plan your state has selected as a guide, or benchmark for determining EHBs, which ever is greater. If the benchmark plan does not include a specific category or class of drug, then plans must offer at least one drug in that category or class.

Q2. How can I find out what medications are covered by the health plans I am considering?

A. Once you have selected a plan, click on "List of Covered Drugs," which appears at the top of the window summarizing deductibles, annual out-of-pocket expenses, and required co-payments and coinsurances. You should be able to navigate to a list of drugs that plan covers. The list will be organized in various ways depending on the plan.

Q3. What is a tiered pharmacy benefit structure and how does it apply to drugs I take?

A. It is likely that the medications that appear on the list of covered drugs for plans you are considering will be organized in "tiers" from lowest to highest copayments. Typically, you will pay the least out of pocket for drugs that are listed in Tier 1 and the costs will typically increase as you go up tiers.

Q4. How can I tell if the health plans I am considering require preauthorization for the drugs I need?

A. If the medication you require is included on the list of covered drugs, you might see the letters "PA" next to the medication that is of interest to you. These letters stand for "Prior Approval." If they appear by your needed drug, then that plan requires preauthorization before the prescription can be filled.

Q5. How can I tell if I will be required to try a generic or other drug before the plan will cover a brand-name drug prescribed for me?

A. On the list of drugs the plan covers, look for the letters "ST" (Step Therapy) next to the drug you need. If ST appears, then that plan requires you try a generic drug before it will approve the medication.

Q6. I frequently travel out-of-state to visit my family and require refills for several months. Will the plans I am considering provide these refills?

A. Most covered prescriptions have a "day supply" limit, typically a 30-day supply when the prescription is filled at a retail pharmacy and a 90-day supply when the prescription is filled by a mail-order service. Plans refer to these limits as "Quantity Per Dispensing (QPD)" limits or "Quantity Limits (QL)". If the letters, QDP or QL, appear on the list of covered drugs next to the drugs you need to take, then you will know that plan limits how frequently you can get certain medications refilled.

Q7. I take a specialty drug related to my disability. It must be hand formulated by a specialty pharmacy. Will the plan I am considering cover that specialty drug?

A. Although coverage for specialty drugs will vary by plan, covered specialty drugs are often included in Tier 4 of the list of covered drugs. Plans might impose limitations on these types of drugs such as requiring you buy these drugs at a network specialty pharmacy or limit the drug to a specific day-supply, for example, a 30-day supply.

Q8. I have a mental health disability and require a specific brand-name medication. My previous health plan required that I take a generic drug first, even though my doctor said I needed the brand-name medication. Can Marketplace plans do the same thing?

A. Plans cannot use treatment limitations, such as "step therapy" requirements, for mental health pharmacy benefits that are more limiting than are permitted for treatment of other illnesses and conditions, so plans might approve the brand-name drug without requiring that you take the generic version to prove it is ineffective or causes a negative reaction, but they likely will require preauthorization.

Q9. I have difficulty getting to the pharmacy, so my neighborhood pharmacy delivers my prescriptions to my home. Can I go to my regular pharmacy to get my medications?

A. Health plans contract with certain pharmacies, called "in-network pharmacies." In order to learn what pharmacies various plans use, you must call those plans or visit their websites to find out whether your regular pharmacy is included.

Q10. I need a prescription medication that the plans I am considering do not cover. Is there anything I can do to get these medications covered?

A. Plans participating in the Marketplace must have procedures in place to ensure that individuals receive clinically appropriate medications not covered by the plan. Once you have selected a plan and become a member, you have the right to follow your plan's pharmacy exceptions process.