Prescription Insurance—Frequently Asked Questions

Your prescription drug insurance frequently uses terms that can be confusing. Here's some help:

What is my copayment?
Your copaypayment is a fixed dollar amount that you pay for a prescription, generally ranging between $5 and $20. Your independent community pharmacy does not set the amount of your copayment or know it in advance. Your employer and health insurance provider do. The insurance provider (and you and your employer through the insurance premiums you both pay) makes up the difference between the copayment and the actual cost of the drug.

What is my deductible?
Your deductible is a specified amount of money (e.g., $200) that you must pay during a given time period (usually a year) before your health plan pays anything. You should know your deductible and to keep track of out-of-pocket expenses. The pharmacy has no way of knowing your deductible or when it has been met.

What is my coinsurance?
Your coinsurance is a specific percentage (usually 20 percent) of the cost of a prescription you are required to pay. Your health insurance pays the remainder. (See copayment.)

What is my formulary?
Your formulary is a list of drugs that your insurance provider, usually through a pharmacy benefit manager (PBM), prefers that you use. Drugs on the formulary may or may not be the medications that your physician believes are best. Manufacturers of "preferred" drugs often give your PBM a rebate if their medication is on the formulary's preferred list.

What is a non-formulary drug?
This is a drug that is not on the formulary. The drug may not be covered at all or may require a higher copayment or coinsurance percentage. The final cost depends on the member's benefit and is set by the insurance provider.

Can my formulary change?
Yes. Your PBM has the power to change the formulary. When a change to your formulary occurs, your PBM will generally notify you through the mail. Make sure that you have a copy of your formulary.

What is a prior authorization?
This means that your PBM will approve the medication for coverage only after certain conditions are met. Your doctor will need to contact your PBM and provide information on the medical reasons for prescribing the medication. It may take 24 to 48 hours to receive approval from your PBM before your pharmacy can fill your prescription.

Why are prior authorizations required on certain drugs?
The prior authorization process is used to determine medical necessity, ensure patient safety, promote preferred drugs, and to keep drug costs to your employer down.

What do you mean when you "process the billing of my prescription"?
The pharmacy must enter your prescription into its computer and then transmit a request to your PBM asking them to pay for the drug. Your PBM tells the pharmacy if you are eligible, what it will pay, and how much you must pay (see coinsurance, copayment, and deductible). The PBM also tells the pharmacy the quantity of medication the pharmacist is allowed to give you. Most PBMs refuse to let community pharmacies dispense more than a 30-day supply.

I'm going on vacation, and will need an extra supply of my medication. What should I do?
Some PBMs allow occasional "vacation overrides" while some do not. If you have a choice of insurance plans, this might be an important question to ask. If your PBM allows vacation overrides, you should call it in several days in advance. Always allow several days for the administration of vacation override requests.

Did I get brand or generic?
Most insurance requires that you fill the prescription with the generic, or encourages you by telling the pharmacy to charge a lower co-payment. The generic drug is the same medication as the brand product, but is not made by the original manufacturer and has a different appearance. Most pharmacies will ask you what you would like. If not asked, make sure that you tell your pharmacist if you would like the brand or the generic. □

Ask Your Family Pharmacist®