



High Deductible Health Plan (HDHP) Prescription Form

Participant: Use this form to submit prescription drug claims when you or your dependents have coverage under the High Deductible Health Plan (HDHP). Claims will not be applied toward your deductible/coinsurance unless you submit them.

MUST MEMBER SUBMIT PRESCRIPTIONS	
Participant Information	Name on MUST ID card: _____
	MUST ID Number: _____
Prescriptions were purchased for:	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse (Provide name: _____) <input type="checkbox"/> My dependent (Provide name: _____)
Expenses Submitted in the Amount of:	\$ _____

Instructions:

1. Fill out the section above to provide information about your prescription coverage. (If submitting pharmacy receipts for more than one dependent child, attach a separate sheet for each.)
2. Attach pharmacy receipts for each purchase. The receipts must include:
 - ▶ The name of the drug
 - ▶ Whether the drug is "generic" or "brand"
 - ▶ The full retail cost, *and* the cost to you after your discount
3. Mail all documents to:

MUST Claims Administration
 PO Box 3777
 Missoula, MT 59806-3777

Below is a review of pharmacy benefits as stated in the HDHP Schedule of Medical Benefits.

DISCOUNT PHARMACY CARD BENEFIT

Retail Pharmacy

Prescriptions may be purchased at a discounted rate from network pharmacies. Prescription drugs must be paid for at the point of purchase then submitted to the Medical Plan for reimbursement by the Plan. The Annual Deductible applies, then charges will be subject to the following co-payments until satisfaction of the Out-of-Pocket Maximum:

All Prescription Drugs.....20%

The Plan will reimburse the contract cost of the prescription drug, less the applicable Co-payment per Prescription. Contract cost is the PBM's (Pharmacy Benefit Manager) discounted cost of the prescription drug. Reimbursement will not exceed the contract cost.

Mail Order Pharmacy

Co-payment per Prescription

All Prescription Drugs.....20%