Glossary of Terms

(Terms are listed in Alphabetical Order)

Access
Access refers to the availability and location of pharmacies that participate in the network that serves your pharmacy benefit plan.

Acute Drugs
Medications that are taken for a short period of time, usually requiring a supply less than 30 days (i.e., antibiotics).

Age Specifications
Coverage for certain drugs may be restricted based on your age (i.e., age<21 for Retin-A).

Appeal
In the event that a prior authorization or medical exception request is denied, the process by which you or your physician may ask your plan sponsor to review the request further.

Benefit Limit
A predetermined amount of pharmacy benefit expenses that your plan sponsor will cover before you must pay for your medications at 100%. In most cases, the plan sponsor paid amount is tracked and, once your benefit limit is met, you are responsible for a 100% copayment amount.

Cardholder
The primary person maintaining the pharmacy benefit coverage and, as such, is issued the pharmacy benefit card in their name. Also referred to as a covered individual or member.

Cardholder Number
A unique number that appears on a pharmacy benefit card that identifies the cardholder. Also referred to as an identification number.

Centers for Medicare and Medicaid Services (CMS)
The federal agency responsible for administering Medicare and for overseeing the states' administration of Medicaid.

Compliance
The degree to which you follow recommended treatment guidelines as specified by your physician.

Copayment
A fixed-dollar amount or a percentage of the total drug cost (also known as coinsurance), set by your plan sponsor, that you must pay each time you obtain a covered medication. Sometimes a copayment can also be a combination of a fixed dollar amount and a percentage of the total drug cost.

Cost Sharing
A provision of the pharmacy benefit that requires you to pay some portion of the cost of the product or service. Examples of cost-sharing include copayments and deductibles.

Deductible
A predetermined amount that you must pay for your medications before your pharmacy benefit coverage begins. In most cases, your paid amount is tracked and, once the deductible is met, you are responsible for your copayment amount only.

Dependent Coverage
Dependents of the primary cardholder who are eligible for pharmacy benefit coverage. The plan sponsor determines the eligibility rules for covering dependents.

Exclusions
The plan sponsor determines pharmacy benefit coverage, and may exclude specific drug classes, individual medications, pharmacy-related services or medical devises from that coverage.

Formulary
A formulary is a list of drugs designated for coverage both from a therapeutic and an economic standpoint through your pharmacy benefit plan. The drugs on the formulary have been reviewed by a Pharmacy and Therapeutics (P&T) committee, and found to be appropriate for formulary inclusion on the basis of safety, efficacy, approved indications, ease of use, potential for adverse effects, and cost effectiveness.

Formulary/Preferred Product
There may be more than one drug within a therapeutic category to treat your condition. Therefore, your plan sponsor designates selected drugs as formulary/preferred because of their overall ability to meet your therapeutic needs at a lower cost. If appropriate, ask your physician to consider prescribing a formulary/preferred drug as highlighted on Drug Price Check.

Gender Specifications
Coverage for certain drugs may be restricted based on your gender (i.e., You must be male to receive Viagra).

Generic
A product that is therapeutically equivalent (contains the same active ingredient(s), is the same strength and the same dosage form) to a brand name drug, is referred to by its chemical name, and is generally made available when patent protection on the brand name drug expires.

Generic Dispensing Rule
If a generic dispensing rule applies to your pharmacy benefit and a multi-source brand name drug is dispensed, you may be required to pay the applicable copayment amount plus the difference in cost between the generic product and the multi-source brand name drug. Please refer to your pharmacy benefit materials for further clarification.

Generic Substitution
Generic substitution is a pharmacy action whereby a generic product is dispensed rather than a prescribed multi-source brand name drug.

Group Number
An assigned number that identifies a specific group under a plan sponsor. This number is listed on the pharmacy benefit card.

Maintenance Drug
Any medication that requires more than a short-term supply. Most maintenance drugs are used on a continuous basis for long-term conditions, such as asthma, diabetes, and high blood pressure.

Maximum Out-of-Pocket Expenses
A predetermined amount that you must pay for your medications before your plan sponsor will cover your pharmacy benefit expenses at 100%. In most cases, your paid amount is tracked and, once your maximum out-of-pocket expenses are met, you are responsible for a $0 copayment amount.

Medicaid
A nationwide, state administered health insurance program that provides medical benefits for eligible low-income persons. The federal and state governments share the programs' costs.

Medical Exception
The process by which your physician may request additional quantities of a medication or coverage of a drug excluded from the formulary if he/she deems it medically necessary.

Medically Necessary
A treatment that is appropriate and consistent with the physician's diagnosis and, in accordance with accepted standards of medical practice, that could not have been omitted without adversely affecting the patient's condition or the quality of medical care provided.

Medicare
A nationwide, federally administered health insurance program that covers the costs of hospitalization, medical care, and other services for eligible persons. Medicare has two parts: 1) Part A covers inpatient services and pays for medications administered in hospitals, but not drugs dispensed in outpatient settings. 2) Part B covers outpatient services.

Multi-source Brand
A brand name drug that is marketed or sold by two or more manufacturers or labelers, is no longer protected under patent exclusivity, and has a therapeutically equivalent generic available.

Network
A defined group of pharmacies that have agreed, typically through contractual arrangements, to provide pharmacy-related products and services covered by your pharmacy benefit plan for a

defined reimbursement formula.

Non-formulary/Non-preferred Product
There may be more than one drug within a therapeutic category to treat your condition. Therefore, your plan sponsor designates selected drugs as non-formulary/non-preferred because the relative cost of the drug is higher than others in the therapeutic category without demonstrating additional beneficial value.

Over-the Counter (OTC)
A pharmacy product that is available without a prescription.

Pharmacy and Therapeutics (P&T) Committee
A group of healthcare professionals, comprised of pharmacists from the community and physicians from varying specialties, that serves as an advisory panel to a pharmacy benefit manager and/or a plan sponsor regarding the safe and effective use of prescription medications. A major function of such a committee is to develop and manage a formulary.

Pharmacy Benefit Manager (PBM)
An organization that provides pharmacy-related products, programs and services designed to help maximize drug effectiveness and contain drug expenditures by influencing the behaviors of prescribing physicians, dispensing pharmacists, and utilizing members.

Pharmacy Benefit Plan
A pharmacy benefit plan refers to coverage of specific pharmacy-related products and services as determined by a plan sponsor under an insurance policy or prepayment plan.

Plan Sponsor
A general term used to indicate the party responsible for the payment of healthcare-related products and services expenses. Also referred to as a payer.

Prior Authorization
A process that evaluates a drug's prescribed use against a predetermined set of criteria to determine whether your plan sponsor will cover the medication. In most cases, if your physician does not submit a prior authorization prior to you presenting the prescription at the pharmacy, the claim will be denied at the point of service.

Quantity Limitation
A quantity limitation refers to the maximum days' supply or quantity of medication that you can obtain at one time under your prescription benefit plan (i.e., up to a 30-day supply or 100 unit dose, whichever is less/more). Sometimes general therapeutic categories, specific drug classes or individual medications may have additional quantity limitation restrictions.

Single-source Brand
A drug that is marketed or sold by one manufacturer or labeler, is referred to by its trade name, and is protected under patent exclusivity.

Specialty Medications
Your pharmacy benefit may include coverage for certain products that are referred to as specialty medications. These specialty medications are prescribed to treat certain conditions, such as anemia, cancer, cystic fibrosis, growth hormone deficiency, hepatitis C, multiple sclerosis, and respiratory syncytial virus. Most specialty medications are injectable or require special shipping and handling, such as refrigeration. As a result, distribution of specialty medications and additional related services are arranged by a specialty provider.

Step Therapy
An automated process that defines how and when a particular drug can be dispensed based on your drug history. Step therapy usually requires the use of one or more prerequisite drugs prior to the use of another drug.

Therapeutic Substitution
The practice of dispensing one drug for another for economic purposes when both drugs produce the same therapeutic effects.

Tier
A tier usually represents the copayment level that applies to a certain formulary status and medication type (i.e., Tier 1: formulary/preferred generic, Tier 2: formulary/preferred brand, or Tier 3: non-formulary/non-preferred brand).

Still have questions? Call Cigna Pharmacy at
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