CITY OF DEL RIO

RETAIL AND MAIL ORDER PRESCRIPTION DRUG BENEFIT

Effective Date: October 1, 2020

This benefit schedule is made a part of the Plan for the purchase of retail and mail order prescription drugs. All charges for outpatient prescription drugs are covered under this benefit and are not considered eligible expenses unless purchased through this program.

Definitions

Brand Name Drugs	Drugs produced and marketed exclusively by a particular manufacturer. The drug name is usually registered as a trademark and will cost the highest copay.
Generic Drugs	Drugs not protected by a trademark and will cost the lowest copay.
Legend Drugs	Those drugs which cannot be purchased without a prescription from a physician and bear the legend: Caution -- Federal law prohibits dispensing without a prescription.

Network Retail Pharmacy Copays

Generic Drugs---------- $5 (up to a thirty (30) day supply)
Generic Drugs---------- $10 (for a thirty-one to ninety (31-90) day supply)
Brand Drugs ---------- $50 (up to a thirty (30) day supply)
Brand Drugs ---------- $100 (for a thirty-one to ninety (31-90) day supply)

Mail Order Copays

Generic Drugs---------- $40 per prescription (up to a ninety (90) day supply)
Brand Drugs ---------- $100 per prescription (up to a ninety (90) day supply)

For Mail Order services, contact Navitus at (855) 673-6504.

Maximum Allowable Cost

If a brand drug is dispensed and a generic alternate drug exists, the Covered Person pays the difference between the brand name and generic price in addition to the appropriate copayment for the brand name. *The cost difference between the brand name and generic price does not apply to any individual deductibles or out of pocket amounts*. The differential applies to all prescriptions purchase through this program when a generic alternate is available.

SpecialtyRx/Biotech Drugs

The Plan offers an injectable drug benefit called the SpecialtyRx/Biotech drug program. This benefit is accessed through Lumicera Health Services. The member pays a $100 copay per thirty (30) day supply. This same copay will also apply for biosimilar prescriptions. This service provides the Plan and Covered Individual a convenient and cost-effective way to order injectable drugs and supplies through the Lumicera Health Services drug program. Contact Lumicera at (855) 847-3554 to access these medications.

Clinical Pre-Authorization

For Pre-Authorization contact Navitus at (855) 673-6504 **(Doctor/Prescription Prescribers)**. Your doctor will be asked a series of questions and will then be immediately approved or denied. Once Pre-authorization has been established, the covered individual can contact Lumicera Health Services at (855) 847-3554 to access these medications.

For Pre-Authorization of **Oral Chemotherapy/Oncology-related** SpecialtyRx/Biotech drugs, contact Navitus at (855) 673-6504 **(Doctors/Prescription Prescribers)**.

Pre-Authorization will be required on the following prescriptions:

General

These medications may be reimbursed following satisfaction of clinical criteria as determined by prior authorization review.

- Narcolepsy Medications including *Xyrem® (for individuals seventeen (17) years of age or older)*
- Acne Medications*:* only required for Tretinoin all dosage forms (e.g. Retin-A, Differin, Tazorac) *(for individuals twenty-six (26) years of age or older)*
- Compounds which cost $200 or greater

Major Biotech Prescription Categories (including but not limited to)

- Blood Cell Deficiency
- Crohn's Disease
- Cystic Fibrosis
- Osteoarthritis
- Pulmonary Arterial Hypertension
- Rheumatoid Arthritis
- Hemophilia
- HIV/Immune Deficiency Medications
- Multiple Sclerosis
- Oncology Oral
- Psoriasis
- Renal Disease
- Hepatitis C
- Others

Diabetes

These medications may be reimbursed following satisfaction of clinical criteria as determined by prior authorization review.

- Bydureon®
- Byetta®
- Jentadueto®
- Juvisync®
- Kazano®
- Kombiglyze®
- Oseni®
- Symlin®

Lipid-Lowering Agents (Statins)

- Crestor® (Prior authorization required for 40 mg strength only.)

Note: All clinical programs are subject to change without notice to accommodate new drug entries to the marketplace and adjustments in established medical and pharmacy practice guidelines.

Over the Counter Benefit

This Plan covers these non-prescription drugs for a $0.00 copay, when purchased at the pharmacy counter with a physician's prescription: Non-Sedating Antihistamines (i.e., Claritin and Alavert); Smoking Deterrents (i.e.: Chantix, Nicorette, Nicotine Patch or Lozenges); Stomach and Ulcer (i.e., Prevacid and Prilosec); Aspirin; Folic Acid; Iron Deficiency Supplements; Fluoride Chemoprevention Supplements; and Vitamin D supplementation to prevent falls in community-dwelling adults age sixty-five (65) years and older who are at an increased risk for falls. This also includes store brand and generic versions of these products.

Prescription Identification Cards

Each covered employee will be issued a Prescription ID card from TML Health. You must present your ID card to the pharmacist at the time of purchase.

If a covered person does not have the Prescription ID card at the time of purchase these steps must be followed:

1. Pay for the entire cost of the prescription;
2. Obtain and complete a direct prescription drug claim form. These are available on the Navitus website or from TML Health; and
3. Send the drug claim form with the prescription receipt directly to Navitus. Navitus will pay the appropriate amount, less the copayment and Maximum Allowable Cost differential (if applicable), directly to the Covered Persons usually within thirty (30) days.

Drugs Covered Under This Benefit	Drugs Not Covered Under This Benefit
1. Legend Drugs; 2. Insulin and insulin delivery devices; 3. Disposable insulin needles/syringes and physician prescribed needles/syringes; 4. Blood glucose testing devices (monitors are limited to one (1) per calendar year), lancets and blood/urine testing agents; 5. Tretinoin all dosage forms (e.g., Retin-A, Differin) for individuals through the age of twenty-five (25) years; Prior Authorization is required for ages twenty-six (26) and older; 6. Glucose Elevating Agents (prescription only); 7. Compound medication of which at least one ingredient is a legend drug; however, the plan will require Prior Authorization to OptumRx for compounds costing $200 or more. For Prior Authorization, please have your doctor call OptumRx at (800) 711-4555; 8. Any other drug which under the applicable State Law may only be dispensed upon the written prescription of a physician or other lawful prescriber; 9. Oral legend contraceptives (generic at no cost share), implantable contraceptives (e.g., Nexplanon), and Emergency Contraceptives (at no cost share); 10. Contraceptive devices (e.g., IUD, diaphragm) at no cost share; 11. Depo Provera and other injectable contraceptives at no cost share; 12. Female Condoms, spermicides, cervical caps, hormone patch, transdermal and intravaginal contraceptives (e.g., Nuvaring), and sponges (all at no cost share); 13. Central Nervous Stimulants (e.g., Adderal, Ritalin, Dexidrine, etc.); 14. Prenatal Vitamins (prescription only); 15. Pediatric Vitamins (prescription only); 16. Prescription Fluoride; 17. Vitamins, Minerals and Nutrient Supplements (prescription only); 18. Dietary formulas when necessary for the treatment of PKU; 19. Growth Hormones; 20. Immunizations; and 21. Emergency Allergic Reaction kits (i.e.: EpiPen and Bee Sting Kits - limit four (4) per calendar year).	1. Alcohol swabs; 2. Vitamins or formulas not listed as covered; 3. Biological sera blood or blood plasma; 4. Anabolic Steroids (oral and injectable); 5. Anorexiants and Anti-obesity medications; 6. Male pattern baldness medications; hair growth stimulants; 7. Insulin pumps and supplies (e.g., tubing, electrical wiring, etc.); 8. Cosmetic agents including anti-wrinkle and skin depigmenting agents; 9. Vitamins individually or in combination that do not require a prescription; 10. Non-injectable Calcium Supplements; 11. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use; 12. Charges for the administration or injection of any drug; 13. Drugs labeled “Caution - limited by Federal Law to investigational use” or experimental drugs even though a charge is made to the individual; 14. Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar premises which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals; 15. Fertility medications; 16. Sexual Stimulants (e.g., Viagra); 17. Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one year from the physician’s original order; 18. Prescription which an eligible person is entitled to receive without charges from any Workers’ Compensation Laws; 19. Topical non-narcotic pain medications (e.g., Sinelee, Flector, Solaraze, etc.); 20. Prescription Acid Reflux medications; 21. Over the counter medications (unless listed as covered); and 22. Non-legend drugs other than those listed as covered.