



**Rx \$2 / \$10 / \$40 / \$60**  
**Prescription Drug Summary**

**How To Use The Prescription Drug Card**

To ensure the highest level of benefits please select an ODS in-network pharmacy. We can help you find an in-network pharmacy, please visit us online at [www.odsalaska.com](http://www.odsalaska.com) or call ODS Pharmacy Customer Service. Your ODS member identification card (ID) will provide the in-network pharmacy with the information necessary to process your claim and allow you to access your Rx benefits at the point of service. Please remember to present your ODS ID card to ensure your pharmacy has the most current benefit detail loaded in their system.

Drug Type	Retail 30-day supply	Mail-Order 90-day supply	Specialty 30-day supply
<b>Essential Benefit Annual Maximum (Medical &amp; Rx)</b>	<b>\$2,000,000</b>		
Value	\$2.00 copay	\$6.00 copay	N/A
Select Generic	\$10.00 copay	\$30.00 copay	N/A
Preferred	\$40.00 copay	\$120.00 copay	N/A
Brand	\$60.00 copay	\$180.00 copay	N/A
Preferred Specialty	N/A	N/A	\$180.00 copay
Specialty	N/A	N/A	30% coinsurance (\$6,000 OOP Max)
Orphan	N/A	N/A	

**Value** medications include commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value medications is available on myODS.

**Select Generic** drugs have been determined by physicians and pharmacists to be therapeutically equivalent to the brand name alternative. Select generics also represent the most cost effective option within their therapeutic category. Generic drugs must contain the same active ingredients as their brand name counterpart and be identical in strength, dosage form and route of administration. Therapeutic equivalency of generic medications is determined by the FDA approval process, the physicians at the point of prescribing, and the pharmacist at the point of dispensing according to State Pharmacy Laws. This category may include certain brand medications that have been identified as favorable from a clinical and cost effective perspective.

**Preferred** or preferred specialty drugs have been reviewed by ODS and found to be clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes, from a clinical perspective, than other more cost effective generics may be included in this tier. The preferred drug list shows which drugs are considered preferred, and can be accessed online at [www.odscompanies.com](http://www.odscompanies.com), through your myODS account. This list is subject to change and will periodically be updated. If you should have any questions regarding the list, please do not hesitate to contact pharmacy customer service.

**Brand** name drugs are sold under a trademark and protected name. These products are considered exclusive and can only be produced and sold by the manufacturer holding the patent. Brand medications that are not designated as preferred have been reviewed by ODS and do not have significant therapeutic advantage over their preferred alternative(s). These products are usually not recommended as first line therapy and different methods of treatment exist.

**Specialty** drugs are often used to treat complex chronic health conditions. Specialty treatments often require special handling techniques, careful administration and a unique ordering process. Specialty drugs must be prior authorized and medically necessary. Specialty medications that are not designated as preferred have been reviewed by ODS and do not have significant therapeutic advantage over their preferred alternative(s). These products are usually not recommended as first line therapy and different methods of treatment exist.

**Orphan** drugs are considered specialty medications that have been developed to treat a rare medical condition. The Food and Drug Administration (FDA) closely regulates medications with orphan drug status and supports the research and development of these products. Orphan drugs must be prior authorized and medically necessary.

\* **Generic Substitution:** Both generic and brand name medications are covered. If a member requests, or the treating physician prescribes, a brand name drug when a generic equivalent is available, the member will be responsible for the brand copay or coinsurance plus the difference in cost between the generic and brand name drug.

**Covered Drug Supply**

- Diabetes related supplies such as insulin syringes, needles, glucose tablets and blood glucose test strips.
- Compounded medications containing at least one covered drug as an ingredient.
- Select federal legend prescription prenatal vitamins.
- Select contraceptive drugs and devices used for medical reasons and for birth control, but only if they are legend medications or cannot legally be dispensed without a prescription.
- Select immunizations and related administration fees are covered at 100% at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines). Covered immunizations will be limited to those that are recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention for children and adults. Immunizations for the sole purpose of travel or to prevent illness which may be caused by your work environment are not covered.

**Retail Prescription Benefit**

- A 30-day supply of a drug or medicine that is medically necessary for the treatment of an illness or injury, that cannot legally be dispensed without a prescription, and that by law it must bear the legend "Caution - federal law prohibits dispensing without prescription."

At times, you may be required to submit a claim form and applicable receipts for reimbursement. For example, if you fill your prescription at an out-of-network pharmacy that does not access ODS' claims payment system through MedImpact, you will need to submit a receipt. **The claim procedure is simple.**

**1. Complete the prescription drug claim form.** Forms can be found online at [www.odsalaska.com](http://www.odsalaska.com), through your myODS account.

**2. Submit claim forms to:**

ODS  
Attn: Pharmacy  
P.O. Box 40168  
Portland, OR 97240-0168

**3. ODS will process the claim request and send reimbursement to you in the form of a check.** All reimbursement is based on contracted in-network rates. If you fill your prescription at an out-of-network pharmacy, your reimbursement may be less than if you had filled your prescription at an in-network pharmacy.

**Mail Order Pharmacy Benefit**

- Members have the option of obtaining prescriptions for covered drugs and medicines through an exclusive mail order pharmacy.
- Each mail order prescription is limited to a 90-day supply per prescription. Prescriptions purchased through the mail order drug program are subject to the ODS generic substitution policy.
- A mail order pharmacy form can be obtained on myODS or by contacting ODS' Pharmacy Customer Service Department.

### Specialty Pharmacy Benefit

- Specialty prescriptions are limited to a 30-day supply maximum per prescription. Some specialty prescriptions may have shorter day supply coverage limits. In addition, these drugs require prior authorization.
- Members prescribed specialty medications (including orphan drugs) have access to enhanced clinical services and an exclusive specialty pharmacy provider. Specialty medications must be purchased through an exclusive specialty pharmacy provider to be a covered benefit. **If a member does not purchase these drugs at the exclusive specialty pharmacy provider, the drug expense will not be covered.**

### Prior Authorization

Certain prescription drugs and/or quantities of prescription drugs may require a prior authorization. Prior authorization programs are not intended to create barriers or limit access to medications. Requiring prior authorization supports cost effectiveness, promotes proper use of medications and ensures the safety of all members. Prior authorizations may be required for a variety of reasons, including the examples are listed below.

- **Utilization Control** - medications may have limited use, be prone to overuse or prescribed in quantities outside the recommended FDA indications.
- **Cost Effectiveness**- There may be therapeutically equivalent medications that are less expensive.
- **Prescribing Guidelines**- Medications may require diagnostic testing to ensure safety and effectiveness of the treatment.
- **Benefit Coverage**- Medications may be prescribed for conditions that are excluded under the plan.

A list of medications that require a prior authorization can be found online at [www.odsalaska.com](http://www.odsalaska.com), through your myODS account or by contacting ODS' Pharmacy Customer Service Department.

### Limitations

To ensure appropriate access to medications, the following limitations apply:

- Retail prescriptions with net cost over \$1,000 for a 30-day supply will require authorization.
- Mail-order and specialty prescriptions with a net cost over \$3,000 will require authorization.
- Compounded medications with a net cost over \$150 for a 30-day supply will require authorization.
- New FDA approved drugs are subject to review and may require additional coverage requirements or limits established by the plan.
- Select specialty medications may be limited to a 15-day supply for drugs that have been determined to have a high discontinuation rate following the first 2 weeks of therapy.
- Immunization agents for travel (other than allergy sera) are not covered.
- Access to covered prescription drugs for the treatment of tobacco use disorder is limited to members participating in a tobacco cessation program that follows the United States Public Health Service guidelines.

### Exclusions

The following services, procedures and conditions are not covered by the Plan, even if otherwise medically necessary or if recommended, referred, or provided by a physician, provider or pharmacy. In addition, any direct complication or consequence that arises from these exclusions will not be covered.

- **Blood and Blood Products.**
- **Charges Over the Maximum Plan Allowance.** Any charge in excess of the maximum plan allowance for a drug.
- **Cosmetic.** Drugs prescribed or used for cosmetic purposes.
- **Devices.** Devices, including, but not limited to therapeutic devices and appliances, hypodermic needles and syringes are not covered. (However, hypodermic needles and syringes for use with covered specialty medications and insulin will be a covered benefit). For contraceptive devices, see Covered Drug Supply.
- **Drug Administration.** A charge for administration or injection of a drug or medicine is not covered, except when administered for selected medications at retail pharmacies.
- **Drugs Covered Under Another Benefit.** A drug that is covered under another plan benefit (i.e. home health, medical, etc.).
- **Excess Quantities.** Prescription refills or quantities of medications that are in excess of the number prescribed by the physician or the number established by the Plan.
- **Experimental or Investigational Drugs.**
- **Gender Reassignment.** Drugs prescribed (such as hormone supplements) to support gender reassignment.
- **Hair Growth Drugs.**
- **Infertility Drugs.**
- **Institutional Drugs or Medicine.** Drugs or medications that are to be taken by or administered to a member in whole or in part while the member is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution.
- **Non-Covered Condition.** A drug prescribed for purposes other than to treat a covered medical condition.
- **Nutritional Supplements and Medical Foods** are not covered, unless determined to be medically necessary.
- **Off-label Usage.** Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission, are not covered. ODS may evaluate individual requests for coverage.
- **Over the Counter (OTC) Drugs** and prescription medications for which there is an OTC equivalent or alternative.
- **Pill Splitting.** Drugs dispensed in higher dosages, which must be split to attain the correct dosage are not covered unless medically necessary.
- **Repackaged Medications.**
- **Replacement Medications and/or Supplies.** A replacement supply for reasons including but not limited to; lost, stolen, destroyed or damaged medications are not covered.
- **Sexual Disorders.** Drugs or devices prescribed or used to treat sexual dysfunction.
- **Treatment Not Medically Necessary.**
- **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a physician are not covered.
- **Vitamins and Minerals.** The Plan does not cover over-the-counter (OTC) vitamins and minerals.
- **Weight Loss Drugs.**
- **Vitamins and Minerals.** The Plan does not cover over-the-counter (OTC) vitamins and minerals. Prescribed federal legend vitamins and mine are covered.
- **Weight Loss Drugs.**

*This is a benefit summary only. For a complete description please refer to your member handbook.*

Visit our website at [www.odsalaska.com](http://www.odsalaska.com)