# OPTION E
# Prescription Drug Summary

## How To Use The Prescription Drug Card

Choose a pharmacy from the ODS Pharmacy Network Participating Pharmacy Directory or the ODS website at *www.odsalaska.com*

Present your ODS Pharmacy Network card to the pharmacist at any ODS Pharmacy Network pharmacy. You will pay the copayment (per prescription), at the time of purchase. **Unless your doctor requires the use of a brand name drug, your prescription will be filled with a generic when available and permissible by Alaska law.** If you or your doctor requests a brand name drug when a generic drug is available, you are required to pay the copayment plus the difference in cost between the brand name drug and its generic equivalent. (The following drugs may be filled with the brand name without the added cost to you: Coumadin, Dilantin, Lanoxin, Levothyroxine branded products, Norpace CR, Premarin, Procanbid, Quinaglute, Quinidex, Tegretol, Tegretol XR and Theodur. )

| Drug Type | Prescription Drug Card Plan | Mail Order Drug Plan |
|---|---|---|
| Generic | $15 Copay or 50%* | $30 Copay or 50%* |
| Brand Name | $15 Copay or 50%* | $30 Copay or 50%* |

*Whichever is greater; subject to $5,000 Annual Maximum

## Covered Drug Supply

* A 34-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 must bear the legend "Caution - - federal law prohibits dispensing without prescription."
* Insulin, insulin syringes, insulin needles, glucose tablets, blood glucose test tape, and ketone test strips for urinalysis (separate copays are applied to a supply of insulin and to each diabetic supply item).
* Contraceptive drugs and devices used for medical reasons and birth control but only if they cannot legally be dispensed without a prescription.
* OTC - Over-the-counter drug products may be covered by your plan. Pleaes refer to member handbook.
* Self-injectable medications are available through ODS.

**If you go to a Non-Participating Pharmacy:**

* Obtain a claim form from ODS and take it to your pharmacy to be completed.
* Pay your bill in full.
* Forms are available at **www.odsalaska.com**
* Mail the completed form to:

ODS Pharmacy
PO Box 40168
Portland, Oregon 97240-0168

* You will be reimbursed at the ODS Pharmacy contracted rate minus your copayment, or the maximum plan allowance minus your copayment, whichever is less.

**Claims questions should be addressed to:**

ODS Pharmacy
PO Box 40168
Portland, Oregon 97240-0168
1-888-361-1610

## Mail Order Pharmacy

You also have the option of obtaining prescriptions for covered drugs and medicines through the Mail Order Pharmacy. If you or your doctor request a brand name drug when a generic drug is available, you are required to pay the copayment plus the difference in cost between the brand name drug and its generic equivalent. (The following drugs may be filled with the brand name without the added cost to you: Coumadin, Dilantin, Lanoxin, Levothyroxine branded products, Norpace CR, Premarin, Procanbid, Quinaglute, Quinidex, Tegretol, Tegretol XR and Theodur.)

Each prescription is limited to a 90-day supply.

Mail Order Pharmacy forms are available from your employer. Of you have questions about the Mail Order Pharmacy, call (toll free) **1-800-635-3070**. Forms are available at **www.odsalaska.com**

**Visit our website at www.odsalaska.com**

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

Insurance products provided by ODS Health Plan, Inc.

Subject to approval of the health benefit plans by the Alaska insurance division

## PRIOR AUTHORIZATION

* Certain prescription drugs and/or quantities of prescription drugs may require prior authorization by ODS. www.odsalaska.com

## LIMITATIONS

* Retin-A: Covered for anyone under the age of 26. Age of 26 or older must have a letter of medical necessity from the doctor. Not covered for cosmetic purposes.
* Prescriptions over $500: Will require authorization from ODS.
* Newly FDA approved drugs are subject to review by ODS and may require additional coverage parameters, requirements, or limits established by ODS.
* Compounded prescriptions will be paid as brand drugs. If over $50, requires prior authorization.

## EXCLUSIONS

No Prescription Drug Expense Benefit will be paid for any charge excluded by the General Limitations or General Exclusions sections of the program or for:

* Devices; including, but not limited to: therapeutic devices and appliances; hypodermic needles and syringes (but this does not exclude hypodermic needles and syringes for use with insulin). For contraceptive devices, see Covered Drug Supply.
* Charge for administration or injection of a drug or medicine.
* Drugs that are, in our judgement, experimental or investigational or that are labeled: "Caution - - limited by federal law to investigational use". (Also excluded are drugs such as progesterone suppositories, which may be approved for some health conditions when they are prescribed for another experimental purpose.)
* Hair growth legend drugs.
* Drugs or medicine that are to be taken by or administered to a covered person in whole or in part while the covered person is a patient in a hospital, sanitarium, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution.
* Refills or quantities of medications that are in excess of the number prescribed by the physician or the number established by the Plan or that are dispensed more than one year after the order of the physician.
* Biological sera, blood, blood products, or immunization agents other than allergy sera.
* A drug or medicine to treat an addiction to or dependence on a drug or chemical (e.g., Nicorette).
* Medication that by law must bear the legend "Caution - Federal law prohibits dispensing without prescription" if a dosage form of equal or greater strength of the medication is available without a prescription under federal law.
* Drugs prescribed or used for cosmetic purposes.
* Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission.
* Drugs or devices prescribed or used to treat sexual dysfunction.
* Drugs prescribed to treat a medical condition that is not covered under this Plan.
* Drugs prescribed for purposes other than treating disease.
* Drugs prescribed for preventive purposes, unless such preventive services are specifically covered by this Plan.

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