



**How To Use The Prescription Drug Card**

Choose a pharmacy from the ODS Pharmacy Network Participating Pharmacy Directory or the ODS website at [www.odscompanies.com](http://www.odscompanies.com).

Present your ODS Pharmacy Network card to the pharmacist at any ODS Pharmacy Network pharmacy. Both generic and brand name medications are covered benefits. Regardless of the reason or medical necessity, if you request a brand name drug or your physician prescribes a brand name drug when a generic equivalent is available, you will be responsible for the brand co-pay plus the difference in cost between the generic and the brand name drug. (The following is a partial list of drugs that may be filled with the brand name without any additional cost to you other than the co-payment: 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	\$10.00 Co-pay	\$20.00 Co-pay
Preferred Brand*	\$40.00 Co-pay	\$80.00 Co-pay
Non-Preferred Brand**	\$60.00 Co-pay	\$120.00 Co-pay

\* **Preferred Brand** means brand drugs that have been reviewed by ODS and found to be clinically effective at favorable costs. These drugs carry a preferred brand co-payment. **Attached you will find a list of preferred brand prescriptions.** This list is subject to change and will periodically be updated by ODS. If you should have any questions or concerns regarding the list, please do not hesitate to contact the ODS Pharmacy Customer Service at (503) 243-3960 or (toll free) 1-888-361-1610.

\*\* **Non-Preferred Brand** means brand drugs that have been reviewed by ODS and found to not have a significant therapeutic advantage over preferred brands, but which usually cost more. Drugs that are usually not recommended as first line therapy and have alternative treatment modalities are also considered non-preferred brand drugs.

**For self injectable prescription drugs** that must be purchased through a participating Specialty Pharmacy Provider, the member will pay 25% of covered expense.

**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 co-pays are applied to a supply of insulin and to each diabetic supply item).
- \* Contraceptive drugs and devices used for medical reasons and birth control are covered but only if they are legally dispensed with a prescription.

**Mail Order Pharmacy**

You also have the option of obtaining prescriptions for covered drugs and supplies through the Mail Order Pharmacy. Each prescription is limited to a 90-day supply.

Mail Order Pharmacy forms are available from your employer. Forms available at [www.odscompanies.com](http://www.odscompanies.com).

**Please see the reverse side of the prescription drug benefit summary for information regarding reimbursement for prescriptions if you go to a Non-Participating Pharmacy, prior authorizations, limitations, and exclusions.**

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

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

**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 available at [www.odscompanies.com](http://www.odscompanies.com).
- \* Mail the completed form to:

ODS Pharmacy Network  
PO Box 40168  
Portland, Oregon 97240-0168

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

**Claims questions should be addressed to:**

ODS Pharmacy Network  
PO Box 40168  
Portland, Oregon 97240-0168  
(503) 243-3960 or 1-888-361-1610

**PRIOR AUTHORIZATION**

- \* Certain prescription drugs and/or quantities of prescription drugs may require prior authorization by ODS. [www.odscompanies.com](http://www.odscompanies.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 with net cost 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.
- \* Charges for administration or injection of a drug or medicine.
- \* Drugs that are, in our judgment, 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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