



# Town of Cary Employee Rx Plan



July 1, 2020

	1-31 Day Supply	90 Day Supply
	<u>Retail pharmacy</u>	<u>Mail Order or CVS</u>
Generic/Tier 1	\$ 0	\$ 0
Preferred Brand/Tier 2	\$ 25	\$ 50
Non-Preferred Brand/Tier 3	\$ 50	\$ 100
Specialty/Tier 4	\$ 0	N/A

- **Maximum Out of Pocket (MOOP): \$1,500 single/\$3,000 family:** The plan year MOOP applies to pharmacy. Each individual family member must meet the single MOOP unless the family MOOP has been met by any two or more covered family members. Once the MOOP is met, your covered prescriptions are paid at 100%. Generic dispense as written penalties do not apply to the MOOP.
- **Specialty Medications:** Specialty medications must be ordered through Caremark Specialty Pharmacy at 1-800-237-2767. Limited to a 30-day supply and may require prior authorization or step therapy. Step therapy categories are Autoimmune (Rheumatoid Arthritis), Multiple Sclerosis and Infertility.
- **Maintenance Medication Coverage:** The Prescription Drug Card Program will only cover maintenance medications through the Caremark Mail Order pharmacy or your local CVS pharmacy. Maintenance medications are those that treat an ongoing condition such as high blood pressure, diabetes or contraception. You can get up to two fills of maintenance medications from your local participating pharmacy. After that, the program will cover the medication **ONLY** if you order it from the Caremark Mail Order pharmacy or a local CVS pharmacy. You must use Caremark Mail Order or your local CVS pharmacy for maintenance medications **or you will be required to pay the full cost of the medication**
- **Generic Policy:** If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.
- **CCS Medical LivingConnected Diabetes Management Program:** Diabetic supplies are provided as part of the Prevention & Treatment Plan for diabetes and are provided to covered employees and their dependents at no cost to the employee (prescription copay is waived) when received from CCS Medical. These supplies include: cellular glucose meter, diabetic testing strips, control solution, lancets, lancing device (s) and alcohol pads. You can call 1-800-966-2046 to enroll in this voluntary program.

## DRUGS COVERED\*

- Legend Drugs (drugs that require a prescription)  
**Exceptions:** See Exclusion list below.
- Contraceptives
- Impotency Agents (quantity limit of 6 tablets per 30 days)
- Prescription Vitamins
- Anti-obesity/Appetite suppression medications
- Prescription and OTC smoking cessation (one 12-week program per calendar year) OTC requires prescription
- ADD/ADHD medications (prior authorization required ages 18 and older)
- Narcolepsy Medications (prior authorization required)
- Androgens (prior authorization required)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required)
- Topical Acne Agents (prior authorization required over age 34)
- Anabolic Steroids (prior authorization required)
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding \$500 per script will require prior authorization. (quantity limits may apply)
- Hypnotic Agents (quantity limit of 15 per month. More than the standard limit per month may be obtained if the member meets certain medical criteria and documentation is provided by the treating physician.)
- Migraine Medications (quantity limits apply)
- Infertility Medications (limited to \$5,000 per lifetime)
- Extended Release Controlled Substances (quantity limits apply)
- Gastrointestinal – Antiemetic (quantity limits apply)
- Influenza Agents (quantity limits apply)
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin, needles, syringes, lancets. Supplies covered at 100%.

## EXCLUSIONS\*

- Biologicals, Hemophilia factors, Vaccines, Intravenous drugs, Plasma, Blood Products and Immunization Agents
- Allergy Serums
- Cosmetic agents (Anti-wrinkle agents, Hair growth stimulants and removal products)
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Nutritional Supplements and OTC vitamins
- Therapeutic devices or appliances unless listed as a covered product
- Medication which is 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 institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.

\*This is not an inclusive list but is a representation of the most commonly used medications. Contact customer service for specific drug coverage information.

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Customer Service if you have specific drug questions or register at [www.caremark.com](http://www.caremark.com) to check drug costs and coverage.

For Prescription Drug Card Customer Service Call 1-800-334-8134