OptumRx Co-Insurance Prescription Plan

Administered by OptumRx

Effective July 1, 2020

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PLAN DESCRIPTION

MARICOPA COUNTY PRESCRIPTION BENEFITPLAN

ADMINISTRATIVE INFORMATION

Plan Name:	Maricopa County Prescription Benefit Plan
Sponsor/Administrator:	Maricopa County Benefits Plan Administrator
Group Number:	512229
Type of Plan:	Self-Insured Prescription Benefit Plan Pharmacy
Benefit Manager:	OptumRx 1600 McConner Parkway Schaumburg, IL 60173
Funding Mechanism:	Self-Insured
Plan Year:	July 1 to June 30

ABOUT THIS DOCUMENT

- This Summary Plan Description (SPD) is intended to describe your prescription benefit plan.
- Every effort has been made to ensure the information contained in this SPD is accurate. If there is a discrepancy in the information, the plan sponsor will make the final determination.
- The plan sponsor reserves the right to amend or terminate any benefit described in this document at any time. Notices of changes will be communicated through Maricopa County's website.
- The plan and/or OptumRx has the right to deny benefits for any drug prescribed or dispensed in a manner that does not conform to normal medical or for pharmaceutical practices or that are received in a manner that does not conform to the plan design.
- When the words 'we,' 'us,' 'our,' and 'plan' are used in this document, they refer to Maricopa County. When the words 'you' and 'your' are used, they refer to Maricopa County employees and COBRA participants who are covered for medical benefits through the Cigna HMO and UnitedHealthcare PPO plans.
- The Maricopa County Employee Benefits and Wellness Division has two web sites for employee use. The address of the Internet site is www.maricopa.gov/benefits, and the Intranet site is located at mymc.maricopa.gov. Both of these web sites are collectively referred to as the 'Employee Benefits Home Page' in this document.

DESCRIPTION OF BENEFITS

This Plan description explains your prescription benefits, how you are able to access these benefits, and limitations and exclusions that apply. This document and the prescription benefit plan are effective July 1, 2020.

If you are a benefits-eligible active employee or COBRA beneficiary and enrolled in the County-sponsored Cigna HMO or UnitedHealthcare PPO medical plan, this prescription benefit plan applies to you.

If your medical coverage is through the UnitedHealthcare HDHP with H.S.A, your prescription benefit is available through the OptumRx HDHP Prescription Plan. If your medical coverage is through the Cigna HDHP with H.S.A., your prescription benefit is available through the Cigna HDHP Prescription Plan.

> **OptumRx Diabetes Program:** If you are covered under this plan and have diabetes, you will automatically be enrolled in the OptumRx Diabetes Program. This program consists of one-on-one counseling and certain diabetes testing supplies covered at no cost to the member. Contact the number on your OptumRx insurance card for additional information about the program.

Prescriptions may be filled at either a retail pharmacy or by mail order through OptumRx Home Delivery (refer to the 'Obtaining Prescription Benefits' section) with the exception of Specialty medications. (Refer to the 'Specialty Pharmacy Program' section for details.)

If you are eligible for and enrolled in coverage under this prescription benefit, the name of your prescription plan is the OptumRx Co-Insurance Prescription Plan (referred to in this document as the Co-Insurance Plan.

CO-INSURANCE PLAN

The Co-Insurance Plan is a multi-level plan in which a co-insurance amount (percentage of the cost of the medication) is the responsibility of the member based on the classification of the medication, unless the applicable maximum cap applies. This plan covers generic, preferred brand-name and non-preferred brand-name medications.

Excluded Medications

Some medication requires prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetic, erectile dysfunction, non-sedating oral antihistamines, some non-steroidal anti-inflammatory, and proton pump inhibitors for the treatment of GERD, are excluded.

Preventive Medications

Certain preventive medications are offered to plan participants at zero cost when utilizing in-network providers (a co-insurance will be charged on brand-name contraceptives). The list of medications may change to ensure compliance with ACA recommendations. Preventive medications include:

- Aspirin OTC
  - Prescription required
  - For prevention of preeclampsia during pregnancy, prevention of cardiovascular disease and for prevention of colon cancer

- Breast Cancer
  - Prescription required & Prior Authorization required
  - Member must be 35 or older, at increased risk for the first occurrence of breast cancer after risk assessment and counseling, and obtain prior authorization
  - If a member qualifies, they can receive these drugs at $0 cost share for up to five years, minus any time they have been taking them for prevention.
    - Raloxifene
    - Tamoxifen

- Bowel Prep Agents
  - Prescription required
  - Recommended age 50-75
  - Limited to 1 per year; Bisacodyl EC Tab, Magnesium Citrate Sol., PEG 3350 (generic Miralax), Generic Colyte 240/22.74 g, Generic Golytely 236/22.7 g and Generic Nulytely.
    - For PEG 3350 (generic Miralax) Only the OTC product may be covered at $0 cost-share.

- Folic Acid
  - Prescription required
  - Single ingredient and prenatal vitamins that contain 400mcg to 800mcg of folic acid
  - For women who are or may become pregnant; to prevent birth defects

- Fluoride chew tablets, drop (not toothpaste or rinses)
  - Prescription required
  - Single ingredient generic products only
  - Children age 0-5 years
  - For prevention of dental cavities if water source is deficient in fluoride

- Immunizations (as required by the Affordable Care Act)
  - Prescription required

- Birth Control Products
  - Generic products only (unless none is available)
  - Quantity Limits may apply

- Smoking cessation products
  - Generic and OTC products, with a prescription
  - Maximum daily dose quantity limits and step therapy may apply
  - Covered up to 180 days of treatment each year

- Statin Preventative Medications: Lovastatin, Atorvastatin and Simvastatin
  - Are age 40-75 <u>and</u> have one or more cardiovascular risk factors (high cholesterol, diabetes, hypertension or smoking) <u>and</u> a calculated 10-year risk of cardiovascular event of 10% or greater
  - Prior authorization required, Prescription required

Medication Coverage Tiers

- **Tier LC** covers Lower Cost generics
- **Tier One** covers generic medications
- **Tier Two** covers brand-name medications
- **Tier Three** covers non-preferred brand-name medications
- **Tiers Four, Five, and Six** cover Specialty medications

You will be charged the maximum co-insurance amount for a medication based on the medication's tier and total discounted cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic equivalent and the non-preferred brand-name medication. Refer to the 'Co-insurance Schedule of Costs' section for details.

The co-insurance or the maximum cost you pay for any covered medication counts towards your out-of-pocket maximum. This does not apply when you choose to purchase a non-preferred brand- name medication when a generic equivalent is available. In this case, the difference between the non-preferred brand-name and the generic equivalent will not count towards your out-of-pocket maximum. Refer to the 'Maximum Out-of-Pocket Limit' section for details.

Premium Formulary

The Premium Formulary includes a list of medications that have received FDA approval as safe and effective, and have been chosen by a committee of doctors and pharmacists to be included in the list. The Premium Formulary applies to the Co-Insurance plan and can help you and your doctor maximize your prescription benefit while minimizing overall prescription costs for you *and* Maricopa County.

The OptumRx Pharmacy and Therapeutics (P&T) committee evaluates clinical efficacy and safety of each drug and designates the drug into one of three categories:

- **Therapeutically Unique** – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile, prompting automatic addition to the Premium Formulary.
- **Therapeutically Equivalent** – Clinical effectiveness and safety profile are comparable to existing drugs.

- **Therapeutically Inferior** – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable, prompting automatic non-preferred status.

The P&T committee's evaluation is based solely on clinical criteria. Only after the P&T committee's clinical assessment is made are the economics of the drug considered. Products classified by the P&T committee as therapeutically equivalent are then further evaluated to determine which are most cost-effective for clients and members.

New FDA-approved drugs are automatically available to you and are initially classified as non-preferred, except those excluded under your benefit plan. Based on the P&T committee's decision, the new drug may later be classified as a preferred medication. Additions to the Premium Formulary may be made on a quarterly basis throughout the year, with deletions occurring annually and effective January 1st and July 1st of each year.

Certain drugs that are listed on the Premium Formulary posted on the OptumRx website at www.OptumRx.com may not be covered under the Maricopa County Prescription Benefit Plan. Refer to the 'Exclusions and Limitations' section for details. For example, infertility medication is excluded on the Maricopa County plan but is listed on the Premium Formulary. Additionally, some medication listed on the Premium Formulary may require prior authorization or may be a step-care medication. Please refer to the 'Prior Authorization' and 'Step Care' sections for details.

Because so many generic medications are available, only the most frequently used generics are listed on the Premium Formulary. However, all generics are covered unless specifically excluded.

Lower cost generic use tier LC for lowest out-of-pocket costs.

Generics (tier one) this tier may also include some brand-name drugs. Use tier 1 drugs instead of tier 2, to help reduce your out-of-pocket costs.

Preferred brand-name medications (tier two) (tier are listed on the Premium Formulary. Consists of mid-range cost, common brand-name drugs. Use tier 2 drugs instead of tier 3, to help reduce your out-of-pocket costs.

Non-preferred brand-name medications (tier 3) are mostly higher-cost brand drugs. Many tier 3 drugs have lower-cost options in tier 1 or 2. Ask your doctor if they could work for you.

Co-Insurance Schedule of Costs

- Retail Pharmacy 30-Day Supply
- Retail Pharmacy 84-90 Day Supply of Non-Maintenance Medication
- First two fills of Maintenance Medication
- First fill of Specialty Medication

Retail Pharmacy

LC Lower Cost Generics	Retail Pharmacy 30 day: $4 copay (day supply 1-30) Retail Pharmacy 90 day: $12 copay (day supply 84-90)
Tier One Generic Medications	You are responsible for 25% of the contracted cost.* The cost of each prescription medication will be no more than $18 (the maximum coinsurance) for a 30-day supply or no more than $54 for a three-month (84-90 days) supply.
Tier Two Preferred Brand Medications	You are responsible for 25% of the contracted cost.* The cost of each prescription medication will be no more than $80 for a 30-day supply or no more than $240 for a three-month (84-90 days) supply.
Tier Three Non-Preferred Brand Medications	You are responsible for 50% of the contracted cost.* The cost of each prescription medication will be no more than $200 for a 30-day supply or $600 for a three-month (84-90 days) supply. If you choose to fill a non-preferred brand name prescription medicatior not on the Premium Formulary that has a generic equivalent, you are responsible for 50% of the contracted cost* plus the difference betweer the cost of the generic medication and the non-preferred brand-name medication. The cost of each prescription medication will be no more than $200 for a 30-day supply or $600 for a three- month (84-90 days) supply plus the difference between the cost of the generic medication and the nor preferred brand-name medication.

** Cost is the contracted discounted price or the maximum allowable cost of the medication.*

Mail Service 84-90 Day Supply

LC Lower Cost Generics	Mail Order 90 day: $10 copay (day supply 84-90)
Tier One Generic Medications	You are responsible for 25% of the contracted cost.* The cost of a three-month (84-90 days) supply of each prescription medication will be no more than $42.
Tier Two Preferred Brand Medications	You are responsible for 25% of the contracted cost.* The cost of a three- month (84-90days) supply of each prescription medication will be no more than $160.
Tier Three Non-Preferred Brand Medications	You are responsible for 50% of the contracted cost.* The cost of a three-month (84- 90 days) supply of each prescription medication will be no more than $500. If you choose to fill a non-preferred brand name prescription medication no on the Premium Formulary that has a generic equivalent, you are responsible for 50% of the contracted cost* plus the difference between the cost of the generic medication and the non-preferred brand-name medication. The cost of each prescription medication will be no more than $500 for a three-month (84-90 days) supply, plus the difference between the cost of the generic medication and the non-preferred brand-name medication.

Specialty Prescription Medications

GS	
Specialty Generic Medications	Specialty prescription medication may only be purchased in 30-day quantities. You are responsible for 25% of the contracted cost.* The cost of each prescription medication will be no more than $150 (the maximum coinsurance) for a 30-day supply. Specialty prescription medication is not available at a retail pharmacy. All Specialty prescription medication is received through Home Delivery. Refer to the 'Specialty Pharmacy Program' section for details.
PS	
Specialty Preferred Brand Medications	Specialty medication may only be purchased in 30-day quantities. You are responsible for 30% of the contracted cost * The cost of each prescription medication will be no more than $175 for a 30-day supply. Specialty medication is not available at a retail pharmacy. All specialty prescription medication is received through Home Delivery. Refer to the 'Specialty Pharmacy Program' section for details.
NS	
Specialty Non-Preferred Brand Medications	Specialty medications may only be purchased in 30-day quantities. You are responsible for 50% of the contracted cost * The cost of each prescription medication will be no more than $325 for a 30-day supply. Specialty medication is not available at a retail pharmacy. All specialty prescription medication is received through Home Delivery. Refer to the 'Specialty Pharmacy Program' section for details.

** Cost is the contracted discounted price or the maximum allowable cost of the medication.*

OBTAINING PRESCRIPTION BENEFITS

You can obtain your prescriptions from three different sources. The three sources include:

1) Retail pharmacies in the OptumRx national pharmacy network for up to a 30-day supply of non-maintenance medication, the first two fills of a maintenance medication, or the first fill of specialty medication. Refer to the 'OptumRx Pharmacy Network' section for details.
2) A retail pharmacy within the OptumRx national pharmacy network which has the ability to process an 84-90 day supply of maintenance medication, and
3) OptumRx Home Delivery for an 84-90 day supply of maintenance or non-maintenance medication. (Refer to the 'Specialty Pharmacy Program' section for information regarding the centralized distribution of specialty medication).

Prescriptions filled at non-contracted pharmacies are not covered under your prescription benefit plan, except in emergency situations. Medication obtained in a 31-83 day quantity or 91 or more day quantity is not covered under your prescription benefit.

Federal law prohibits the return of dispensed prescription medication. It is advisable to check your medication before leaving the pharmacy counter to make sure you are charged correctly and that you received the correct medication and number of pills.

IDENTIFICATION CARDS

OptumRx issues Prescription ID cards to you for identification purposes only. The Prescription ID card is not proof of coverage or eligibility for services on a particular date of service. The Prescription ID card includes the name of the employee (Subscriber) and each covered dependent. Each covered dependent is identified by a person code. The pharmacist must enter the appropriate person code in order for a prescription to process.

You must show your ID card at the time you fill your prescription at a participating (network) pharmacy or provide the pharmacy with identifying information that can be verified with the OptumRx Member Services during regular business hours.

The computer system at the pharmacy will confirm your eligibility for benefits even if you do not have your Prescription ID card with you, as long as you provide the pharmacist with the following information:

- RxBIN 603286
- RxPCN 01410000
- RxGrp 512229
- Issuer (80840)
- Your name
- Your Employee ID Number

If you do not show your ID card or provide verifiable information, or if your enrollment information cannot otherwise be verified, you will be required to pay the full cost of the prescription.

You may request reimbursement for covered medication in covered quantities as described in the 'Member Reimbursement' section. When you submit a claim for reimbursement, you may pay more for the medication because the reimbursement amount will be based on the contracted cost, less the required co-insurance.

To be eligible for the covered prescription medication, you must be the employee or a covered dependent on whose behalf all applicable premiums have been paid, and all eligibility requirements have been met. Any person receiving a covered prescription medication who is not eligible, or through fraudulent information submitted to OptumRx, will be fully responsible to reimburse the cost of the covered prescription medication and any administrative costs to the Maricopa County Employee Benefits Trust Fund.

If you lose your ID card or need additional cards for covered dependents, call OptumRx Member Services at (866) 312-1597 and provide your name and Employee ID number. Two additional cards will be sent to your address on file with Maricopa County.

OptumRx NATIONAL RETAIL NETWORK

You can choose from more than 68,000 contracted pharmacies to purchase your non-maintenance medication. The list includes, but is not limited to, the pharmacy chains listed below. For additional participating pharmacies, visit www.OptumRx.com, download the OptumRx Mobile App, or call OptumRx Member Services at (866) 312-1597, 24-hours a day, seven days a week.

- Albertsons/Osco
- Bashas
- Cigna CMGs
- Costco
- CVS
- Fry's
- Kmart
- Safeway
- Sam's Club
- CVS Pharmacy at Target
- Walgreens
- Wal-Mart

SHORT-TERM MEDICATION NEEDS

UP TO A 30-DAY SUPPLY AT RETAIL PHARMACIES

The OptumRx retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or for your first two fills of maintenance medication. You can choose from thousands of participating network pharmacies nationwide, and you can obtain up to a 30-day supply at one time. Find the a convenient network pharmacy by visiting www.OptumRx.com, downloading the OptumRx Mobile App, or call OptumRx Member Services at (866) 312-1597. A small number of medications are limited by the manufacturer or the Federal Drug Administration to a 30- day or less supply, such as, but not limited to, Accutane (including generic equivalents) and Peg- Intron.

LONG-TERM MEDICATION NEEDS

THREE MONTH SUPPLY AT RETAIL PHARMACIES

When you need maintenance medications for chronic or long-term health conditions, you must purchase a 90-day supply. You may use any retail pharmacy which has the ability to process 84-9 90day supply medications. You may purchase a 90-day supply of your maintenance medication on your first fill, if you so choose. Your doctor must write your prescription for an 84-90 day supply.

THREE MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY

You can order prescriptions for maintenance medications or long-term health conditions by mail through OptumRx Home Delivery. Ordering through the mail is a safe and convenient way to receive your prescriptions and save money. You must use a specific order form when placing your first order to provide OptumRx Home Delivery with important health, allergy and plan identification information.

You can complete this enrollment online at www.OptumRx.com or print and mail the form.

You can have your prescriptions delivered to the location of your choice, such as your home address, your work location or even to a local contracted retail pharmacy.

OptumRx Home Delivery uses trusted shippers, such as USPS, UPS, and FedEx to deliver your prescriptions. Your package usually arrives within seven to 10 business days. Your order will include the filled medication container(s), instructions for refills and information about your medication.

To ensure that you don't run out of medication, remember to reorder by the refill date indicated on your refill slip or medication container, or when you have 14 days of medication left. Order refills quickly and easily online at OptumRx.com or through the OptumRx Mobile App.

PRESCRIPTION COSTS

MAXIMUM OUT-OF-POCKET LIMIT

The co-insurance paid towards covered drugs, including specialty medication, will be applied to your maximum out-of-pocket limit:

- Individual coverage: $1,500
- Family coverage: $3,000

The amount applied includes maximum amounts but does not include the difference between the cost of a non-preferred brand-name medication and its generic equivalent for the Co-insurance plan.

Once you and/or your covered dependents meet the out-of-pocket maximum, covered prescriptions are paid 100% by the plan for the remainder of the plan year. Any number of family members can contribute to the family out-of-pocket maximum.

The amount you pay for any *excluded drug* will not be included in calculating your annual out-of- pocket maximum. You are responsible for paying 100% of the contracted cost for any excluded drug.

Note: Diabetic supplies and medications obtained at a Cigna contracted pharmacy under your Cigna HMO medical insurance are not included in the calculation of your maximum out-of-pocket limit since the cost of these supplies and/or medications are covered under your medical plan instead of your prescription plan.

FINDING THE LOWEST COST FOR YOUR MEDICATION

The cost of your medication will vary based upon:

- Contacted discount rate
- Drug type
- The tier of the medication (lower cost generics, generic, preferred brand-name, non-preferred brand-name)
- Maximum allowable cost

Generally, you will pay less for your medication through OptumRx Home Delivery than at a retail pharmacy.

To find the best price for your medication, visit www.optumrx.com and sign in to your member portal. Once you provide information about each of your medications, you will be provided with cost estimates.

MEMBER REIMBURSEMENT

There may be times when you need to fill a covered prescription but are unable to have your claim processed through an OptumRx pharmacy. For example, this may occur when you are outside the service area, you have an emergency, or you are a new member whose enrollment has not been processed. In these situations, you are required to pay the full retail cost of the covered medication.

You may be able to be reimbursed for covered prescriptions you have paid for under the plan by following these steps:

1. Pay the pharmacist the full amount of your prescription. Keep your prescription receipt(s).
2. Obtain and complete a *Member Prescription Claim Reimbursement* form available on the Employee Benefits Home page.
3. Send your completed form and itemized receipts to the address on the form.

The reimbursement will be processed according to the plan's guidelines, coverage, limitations, and exclusions. If the request is approved, you should receive your reimbursement within four weeks. Reimbursement is calculated at the submitted/receipt amount for the medication, minus your co-insurance.

PRESCRIPTION COVERAGE, EXCLUSIONS AND LMITIATIONS

COVERED ITEMS

The following items are covered under the prescription benefit plan, unless specifically listed in the 'Exclusions and Limitations' section.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications and supplies such as blood glucose monitors, test strips, disposable insulin syringes, lancets (including automatic lancing devices), glucagon, prescribed oral agents for controlling blood sugar and any of the devices listed above that are needed due to being visually impaired or legally blind.

Note: Insulin pumps, insulin pump supplies, continuous glucose monitors, and continuous glucose monitor sensors are not available through your prescription benefit. Your medical insurance may provide these items through the durable medical equipment (DME) benefit.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization (approval before they will be covered). Types of prior authorizations include, but are not limited to:

- medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe,
- where an age limitation has been reached and/or exceeded, or
- where appropriate utilization must be determined.

OptumRx, in its capacity as the pharmacy benefit manager, administers the clinical prior authorization process on behalf of Maricopa County.

You, your pharmacist, or your doctor can initiate a Clinical Prior Authorization (CPA) request by calling 1-877-665-6609 Monday through Friday, 8 AM-8 PM, Central Standard Time (CST). The pharmacy *may* call after being prompted by a medication denial with a message stating, '*Prior authorization required; call 1-877-665-6609.* The pharmacy may also pass the information on to you and require you to request the prior authorization.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that Maricopa County participates in a CPA program for the particular drug category. The representative generates a drug-specific form and faxes it to the prescribing doctor. Once the Clinical Call Center receives the fax form from your doctor, a pharmacist reviews the information and approves or denies the request based on established protocols. Standard pre-service prior authorization requests may take up to 15 days from OptumRx's receipt of the completed form from the prescribing doctor, not including weekends and holidays.

If the prior authorization request is approved, the OptumRx Clinical Services Representative calls the person who initiated the request and enters an override into the OptumRx claims processing system for a limited period of time. The pharmacy will then process the prescription.

If the prior authorization request is denied, the OptumRx Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the reason for denial. The letter will include instructions for appealing the denial. For more information, see the 'Appeal Procedures' section.

Drug categories or medications that require prior authorization include, but are not limited to:

- Anabolic steroids (Anadrol-50)
- Antiemetics (Cesamet, Marinol)
- Anti-fungals (Sporanox, Onmel)
- Cardiovascular Disease
- Diabetes (Symlin, Afrezza)
- Weight Loss (Belviq, Contrave)
- Pain Management (Actiq)
- Topical Acne
- Topical Analgesic Agents (Diclofenac Solution)
- Viral Hepatitis (Specialty medication)
- Opthalmic Immunomodulators (Restasis, Xiidra)

The criteria for the CPA program are based on nationally recognized guidelines, FDA-approved indications, and accepted standards of practice. Each guideline has been reviewed and approved by OptumRx's P&T committee for appropriateness.

To confirm whether your medication requires prior authorization and/or to request a prior authorization, call OptumRx's Member Services at (866) 312-1597 Monday through Friday, 8 AM – 8 PM, CST. Please have the information listed below available when initiating your request for prior authorization:

- Name of Your Medication
- Prescribing Doctor Name
- Prescribing Doctor Phone Number
- Prescribing Doctor Fax Number, if available
- Member ID Number (from your OptumRx ID card)
- Maricopa County Group Number: 512229

STEP CARE/STEP THERAPY

A Step Therapy Program is an approach to medication therapy that requires you to first try a more cost-effective medication (typically a generic medication) that has proven effective for most people with your condition before you can receive coverage for a similar, more expensive, brand name medication. These are considered "steps" of therapy.

Drug categories or medications that require step therapy include, but are not limited to:

- Antidepressants (SSRI/SNRI)
- Blood pressure
- DDP-4 Inhibitors
- GLP-1 Inhibitors (Byetta,Victoza)
- Long-Acting Beta 2 Agonists and Combinations
- Sleep aids (Edluar, Belsomra)
- Triptans (Treximet)

AGE AND QUANTITY LIMITATIONS

Some medications are subject to age and quantity limits. Your claim will be denied at the time of purchase if these limitations are exceeded. Limitations are based on criteria developed with guidelines from various national medical agencies in conjunction with OptumRx clinical review process.

Age Limitations

Certain medications have an age limitation, including, but not limited to, the following health conditions:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Topical Acne

If your prescription is denied due to age limitations, but you and your doctor believe that it is medically necessary for you to take this medication to treat one of the above listed conditions, you may request prior authorization. Refer to the 'Prior Authorizations' section for details.

Quantity Limitations

A Quantity Limit Program supports the management of your prescription drug plan by confirming that prescribed quantities are consistent with clinical dosing guidelines and medical literature. This program was established to provide safe and appropriate use of certain medications. This includes, but, is but not limited to, the following health conditions and medications:

- Antiemetics
- Fentanyl Transdermal (prior authorization also applies)
- Insomnia
- Migraine
- Opioids (prior authorization also applies)

If your prescription is denied due to quantity limitations, and you and your doctor believe that it is medically necessary for you to take a larger quantity of this medication, you may request prior authorization. Refer to the 'Prior Authorizations' section for details.

OVERRIDE FOR LOST OR FORGOTTEN MEDICATIONS

If a medication has been lost or forgotten, you and/or your healthcare provider can submit a written request for review for a one-time replacement. The request should include the name of the employee or covered dependent, the name of the medication along with the quantity, and the reason for requesting the override. If the override request is for a narcotic, anti-depressant, or pain medication, a note from the prescribing doctor must also be faxed directly to the Maricopa County Employee Benefits and Wellness Division. Once received, the override request will be reviewed and either approved or denied.

SPECIALTY PHARMACY PROGRAM

Certain medications used for treating chronic or complex health conditions are handled through the OptumRx Specialty Pharmacy Program through Optum Specialty Pharmacy.

The Specialty Pharmacy Program assists you with monitoring your medication needs for complex conditions such as those listed below. It also provides support and patient education. It includes specific injectable drugs and other therapies requiring complex administration methods, or special storage, handling and delivery.

Medications covered through the Specialty Pharmacy Program may include, but are not limited to, the following conditions:

- Acromegaly
- Chronic Granulomatous Disease
- Cystic Fibrosis
- Deep vein thrombosis
- Gaucher disease
- Growth Hormone Deficiency
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Multiple Sclerosis
- Psoriasis
- Respiratory Syncytial Virus (RSV)
- Rheumatoid Arthritis
- Solid Organ Transplant
- Some Oncology-related conditions
- Viral Hepatitis

Your specialty medication is delivered to your home or doctor's office. Enroll in the Specialty Pharmacy Program by calling Optum Specialty Pharmacy at (855) 427-4682. A representative is available 24 hours a day, 7 days a week for emergency "on call" services.

Certain self-administered injectable medications can only be filled through the OptumRx Specialty Pharmacy Program and may not be covered if administered in your doctor's office. Examples of these injectable medications include, but are not limited to:

- Biologic Response Modifiers (i.e. Enbrel, Humira, Kineret)
- Growth Hormone (i.e. Genotropin, Humatrope, Norditropin, Nutropin, Saizen,)
- Multiple Sclerosis (i.e. Avonex, Betaseron, Copaxone, Rebif)
- Narcolepsy (i.e. Xyrem)
- Osteoporosis (i.e. Forteo)
- Parkinsons Disease (i.e. Apokyn)
- Pulmonary Hypertension (i.e. Revatio)
- Viral Hepatitis (i.e. Copegus, Intron A, Pegasys, Peg Intron, Rebetol, Ribapak Dosepack, Ribasphere, Ribatab)

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including, but not limited to, certain anti-fungals, hair loss treatments, those used for pigmenting/depigmenting and reducing wrinkles
- Fertility drugs (oral and injectable)
- Diabetic urine tests and alcohol swabs
- Nutritional/dietary supplements
- Over-the-counter medications and other over-the-counter items
- Prescription strength medication that is available over-the-counter in lower doses
- Certain injectable medication obtainable through and administered by a doctor in an office setting. If the medication is available to and administered through your doctor's office, it may be covered through your medical insurance plan
- Miscellaneous medical supplies
- Coverage of prescription drug products for an amount that exceeds the supply limit (either day supply, age or quantity limit)
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers compensation law or other similar laws
- Charges to administer or inject any drug
- Prescription drugs not deemed medically necessary
    - Charges for delivering any drugs except through the mail service. Express or overnight delivery costs are not covered
    - Experimental or investigational medications

- Prescription drugs purchased from an institutional pharmacy for use while you are an in-patient of that institution (hospital, skilled nursing facility or alternate facility), regardless of the level of care
- Prescription drugs furnished by the local, state or federal government
- A specialty medication prescription drug product (such as immunizations and allergy serum) which, due to its characteristics as determined by the plan administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an out-patient setting
- Replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill, without substantiating evidence and/or prescriber permission for controlled substances, anti-depressants, recurring requests, or other prescription drugs deemed unsafe.
- The difference between the cost of a non-preferred brand-name medication and its generic equivalent
- Maintenance medication purchased in a 30-day quantity after two 30-dayfills
- Botulinum Toxin
- Medications for erectile dysfunction
- Oral non-sedating antihistamines
- Medical marijuana
- Proton pump inhibitors for the treatment of gastro esophageal reflux disorder (GERD)
- Continuous glucose monitors and continuous glucose monitor supplies

Notes:

- Reimbursement for prescription drugs purchased at full retail cost is limited to the contracted cost, less co-insurance or copay. Refer to the 'Member Reimbursement' section.
- Maricopa County does not coordinate benefits (as a secondary payer) with other prescription benefit plans.
- Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your medical insurance according to Arizona state statute.

OTHER PROGRAMS

DRUG UTILIZATION ALERTS AT TIME OF PURCHASE

Drug Utilization Review (DUR) is an effective tool used by OptumRx in monitoring your medication use to assure that it is appropriate, safe and effective. When you fill a medication, the OptumRx DUR program monitors your claim submissions across all pharmacies and prescribing doctors, compares each claim with your active prescriptions and notifies the pharmacist if any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) guidelines and monitors every prescription for numerous conditions. The pharmacist may decide not to dispense medication based on the DUR alert received at the point of service. Examples of some of the DUR alerts are listed below.

Drug/Drug Interaction

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more medications at the same time. The possible results of the interaction could include an increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these interactions occur, the OptumRx claim system advises the dispensing pharmacist that the drug about to be dispensed may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgment to intervene, if necessary, to prevent the patient from being harmed.

Overutilization/Overuse

The submission of prescription drug claims across all contracted pharmacies is monitored. When a prescription claim request is received, OptumRx reviews the patient's medication profile, searching for a previous prescription for the same medication or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim if the request for the medication is being submitted sooner than the plan recognizes as appropriate.

Therapeutic Duplication Monitoring

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed medication may duplicate the therapeutic effects of another medication already prescribed for the patient. This duplication can occur even when the two medications are prescribed for different medical conditions.

When a duplication of therapy is detected, OptumRx transmits this information to the dispensing pharmacist, including the name of the medication that is duplicating the therapy, for further evaluation and intervention.

RETROSPECTIVE DRUG UTILIZATION REVIEW

OptumRx reviews all prescriptions after they are purchased to assist your health care providers in their effort to ensure safe and appropriate use of medications for you. As part of this program, OptumRx pharmacists may confidentially analyze your medication history in order to determine appropriateness of therapy. The prescribing doctor may be provided with the most recent educational materials based on nationally accepted therapy guidelines to assist in this determination. You may also receive a call from a clinically trained pharmacist who will provide targeted, one-on-one counseling about your medications and how to help you take them appropriately.

SAFE EFFECTIVE COMPOUND UTILIZATION REVIEW and EVALUATION (SECURE)

As defined by the Food and Drug Administration (FDA), "compounding is a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient."

Compound drugs may be necessary for certain patients when other available products are not an option. However, because of safety concerns and rising costs, select compound drugs and ingredients used for making compounds may no longer be covered under the plan or may require prior authorization. Compound prescriptions will be processed in accordance with SECURE program criteria.

TERMINATION OF BENEFITS

Coverage ends the last day of the month in which benefits ineligibility occurs. You are responsible for immediately notifying the Employee Benefits Division when a dependent no longer meets the eligibility requirements for coverage. Prescription and administrative costs paid or incurred on behalf of an ineligible dependent become your responsibility.

When any of the following happen, we will provide you written notice that coverage has ended and the effective date of such termination.

- **Fraud, Misrepresentation or False Material Information:** You provided false information related to another person's eligibility or status as a dependent.
- **Improper Use of ID Card:** You permitted an uncovered person to use your ID card to obtain services under this plan.
- **Failure to Pay:** You failed to pay the required premium for coverage.

RIGHT OF RECOVERY

If the amount of payment for prescription claims paid by Maricopa County was more than should have been paid on your behalf, the County may recover the excess from you.

PROBLEM RESOLUTION

Complaint Procedure

If you are dissatisfied with the service received under this prescription benefit plan, you are encouraged to contact the **OptumRx Member Services Division, 24 hours a day, seven days a week, at (866) 312-1597.** Frequently, your concern can be resolved with a telephone call to a Member Services Representative.

If OptumRx Member Services cannot resolve your concern, you may file a complaint with the Employee Benefits and Wellness Division either telephonically by calling (602) 506-1010,
or in writing.
Examples of concerns for which you may file a complaint include, but are not limited to, quality of service received, payment amount of a claim, plan design, or the Premium Formulary content.

For issues that involve an adverse benefit determination (denial), you may file an appeal as explained below.

Appeals Procedure

If you have an adverse benefit determination (denial) for a clinical prior authorization, specialty prior authorization, step care therapy program, direct member reimbursement, formulary exception or coinsurance override request, you may have it re-considered through OptumRx's clinical appeal review program. The appeal process involves a full review of your claim for benefit coverage and of the adverse benefit determination. The program provides up to two levels of appeals. Appeal reviews will be conducted internally by OptumRx pharmacists (first level) or externally by an independent review organization (second level).

In the case of a denial, you will be sent a denial notice informing you of the benefit denial, your rights set forth by the Patient Protection and Affordable Care Act (PPACA) appeal regulations, and the information necessary for you to initiate the clinical appeal review process.

The clinical appeal review process is initiated upon submittal of a written request appealing the denial. Such request can include additional information you believe requires further consideration. You may file an appeal, in writing, to:

OptumRx c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Fax: 877-239-4565

Following the submission of an appeal, all pertinent medical/prescription information will be objectively and thoroughly reviewed by clinicians. After the review, clients are provided a recommendation to either overturn or uphold the denial. Upon an appeal determination, you will be informed of the decision in writing.

An independent review organization will conduct the appeal analysis for level-two appeals. An independent doctor expert will review the case and make a recommendation. This recommendation to either uphold or overturn the denial will be sent to you and the Maricopa County Employee Benefits Division.

IMPORTANT PHONE NUMBERS

	Phone Number	Hours	Who should call	Reasons to call (including but not limited to)
OptumRx Member Services	866- 312-1597 Toll free	24 hours a day, 7 days a week	• Members • Dependents • Pharmacies • Maricopa County Employee Benefits personnel	• Eligibility • Prescription will not process • Find out if a drug is covered • Find out if drug is on the Premium Formulary • Find out your co-insurance amount • File an appeal • Reimbursement for prescriptions for which you paid
OptumRx Clinical Center	877-665-6609 Toll free	Monday – Friday, 8 AM–8 PM (Central Standard Time)	• Members • Dependents • Pharmacies • Doctors • Maricopa County Employee Benefits personnel	• Initiate a clinical prior authorization (CPA)review • Check status of a CPA review • Check to see if prior authorization is required fora drug *(See 'PRIOR AUTHORIZATIONS' section for details.)*
Optum Specialty Pharmacy	855-427-4682 Toll free www.optumrx.com	Monday – Friday, 8:30 AM–5 PM (Eastern Standard Time)	• Members • Dependents • Doctors	• Obtain a specialty medication • Check on status of a specialty drug (See '*SPECIALTY PHARMACYPROGRAM'* section for details.)
OptumRx Home Delivery	888-637-512 Toll free	24 hours a day, 7 days a week	• Members • Dependents	• Enroll in home delivery for prescription drugs • Check on status of a prescription • Order a prescription refill • Order status detail • Check account balance
Maricopa County Employee Benefits and Wellness Division	602-506-1010	Monday – Friday, 8 AM–5 PM (Mountain Standard Time)	• Maricopa County employees and Dependents	• Eligibility

Get help and manage your prescriptions 24/7 online!

Visit www.OptumRx.com or download the OptumRx Mobile App for iPhone or Android.

- Enroll in OptumRx Home Delivery
- Order Home Delivery Refills
- Check medication cost
- Find a nearby pharmacy
- View your prescription history
- Get an electronic Pharmacy ID card