



**Flagler County Public Schools
Effective September 1, 2016**

PPO Choice Standard Plan

	1-31 Day <u>Supply Retail</u>	90 Day Supply <u>Retail / Mail</u>
Generic Medications	\$ 10	\$ 25
Preferred Medications	\$ 45	\$ 112.50
Non-Preferred Medications	\$ 80	\$ 200

Maximum Out of Pocket (MOOP): \$6,350 single / \$12,700 family

The plan year MOOP applies to pharmacy and medical. Each individual family member must meet the single Maximum Out of Pocket (MOOP) unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

PPO Choice Premium Plan

	1-31 Day <u>Supply Retail</u>	90 Day Supply <u>Retail / Mail</u>
Generic Medications	\$ 10	\$ 25
Preferred Brand Medications	\$ 30	\$ 75
Non-Preferred Brand Medications	\$ 50	\$ 125

Maximum Out of Pocket (MOOP): \$ 2,500 single / \$5,000 family

The plan year MOOP applies to pharmacy and medical. Each individual family member must meet the single Maximum Out of Pocket (MOOP) unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

HSA Choice Plan

Deductible: \$ 3,000 single / \$6,000 family

The plan year deductible applies to pharmacy and medical. Each individual family member must meet the single deductible unless the family deductible has been met by any two or more covered family members. Once met, your covered prescriptions are subject to the below copays. The deductible applies to the MOOP.

	1-31 Day <u>Supply Retail</u>	90 Day Supply <u>Retail / Mail</u>
Generic Medications	\$ 10 (after Deductible)	\$ 25 (after Deductible)
Preferred Brand Medications	\$ 30 (after Deductible)	\$ 75 (after Deductible)
Non-Preferred Brand Medications	\$ 50 (after Deductible)	\$ 125 (after Deductible)

Maximum Out of Pocket (MOOP): \$ 4,000 single / \$8,000 family

The plan year MOOP applies to pharmacy and medical. Each individual family member must meet the single MOOP unless the family MOOP has been met by any two or more covered family members. The deductible applies to the MOOP. Once met, your covered prescriptions are paid at 100%.

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.

DRUGS COVERED*

- Legend Drugs (drugs that require a prescription) **Exceptions:** See Exclusion list below.
- Compounded medications of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding \$250 per script will require prior authorization and are subject to the non-preferred copay. Limit of \$5,000 per policy year maximum.
- Contraceptives: Oral, Transdermal, Intravaginal, Implants/IUD and Injectable; extended cycle products are subject to the mail copays for a 90 day supply

DRUGS COVERED* (continued)

- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets
- Prenatal and Single Entity Vitamins
- ADD/ADHD (prior authorization required age 19 and older)
- Topical Acne Agents (prior authorization required over age 34)
- Narcolepsy Medications (prior authorization required)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required)
- Androgens (prior authorization required)
- Migraine Medications (quantity limits apply)
- Impotency Medications (quantity limits apply)
- Hypnotics/Sleep Aids
- Extended Release Controlled Substances-Opioid Analgesics (quantity limits apply)
- Influenza Agents (quantity limits apply)
- Gastrointestinal – Antiemetics
- Prescription and OTC smoking cessation (two 12 week programs per plan year) OTC requires prescription

EXCLUSIONS*

- Biological, blood products, serums, immunoglobulin, and Non-ACA immunization agents
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants and removal products)
- Compounded medications that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Topical Analgesic Pain Patches
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Infertility Medications
- Anabolic Steroids
- Nutritional Supplements
- Anti-obesity/Appetite suppression
- Formulary Exclusion Lists
- Over the counter (OTC) medications unless mentioned above
- 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 Member Services 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 Member Services if you have specific drug questions or register at www.caremark.com to check drug costs and coverage.