



**The Reta Trust
Pharmacy Schedule of Benefits for 3-Tier Formulary**

Summary of Benefits	Generic	Brand Formulary	Brand Non Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	\$10	\$20	\$30
Mail-Service Pharmacy Copayment (up to 3 Prescription Units or up to 90 days)	\$20	\$40	\$60

What is my Schedule of Benefits?

This *Schedule of Benefits* provides specific details about your Prescription Drug Benefit, as well as its exclusions and limitations.

How do I use my Prescription Drug Benefit?

Your Prescription Drug Benefit helps to cover the cost for some of the medications prescribed by a licensed Physician. Using your benefit is simple.

- Present your prescription and Prescription Solutions ID card at any Prescription Solutions Participating Pharmacy.
- Pay the Copayment for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

When I fill a prescription, how much medication do I receive?

- For a single Copayment, Members receive either one Prescription Unit or up to a 30-day supply of a drug.
- If you use the Prescription Solutions Mail Service Pharmacy program, you will receive three Prescription Units or up to a 90day supply of maintenance medications.

What else do I need to know?

- You should become familiar with Prescription Solutions’ prescription drug Formulary. Any medication not on the Formulary you will pay the higher non-formulary copayment. For more information on the Formulary, please visit www.prescriptionsolutions.com.
- It is possible to buy a brand-name drug in place of a generic equivalent, even though the generic drug is the only one listed on our Formulary. Your cost, however, will be higher (Non-Formulary copayment). For more information, please continue to “Medications Covered by Your Benefit” and read the description for Generic Drugs.

ADDITIONAL INFORMATION

Medications Covered by Your Benefit

The following medications are included in the Prescription Solutions managed Formulary and are available to your Physician.

- Federal Legend Drugs: Any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription.”
- State Restricted Drugs: Any medicinal substance that may be dispensed by prescription only according to state law.
- Generic Drugs: Comparable generic drugs may be substituted for brand-name drugs.

- For the purposes of determining coverage, the following items are considered prescription drug benefits: glucagon, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen[®], Ana-Kits[®] and Ana-Guard[®]).

Selective Preauthorization

Your covered services include certain medications that require the covered person go through a preauthorization or step therapy process. Preauthorization means that certain select medications will not be covered until one or more formulary alternatives or "first-line" drugs have been tried first.

Prescription Solutions reserves the right to preauthorize, institute step therapy and/or limit the quantity of any prescription to ensure that the following coverage criteria are met: (1) the prescription is for the treatment of a medical condition (2) there is sufficient evidence to draw conclusions about the effects of the prescription on the medical condition being treated and on the health outcome of the member (3) the expected beneficial effects of the prescription outweigh the expected harmful effects and (4) the prescription represents the most cost-effective method to treat the medical condition

The Appeals Process

Prescription Solutions contracts with a leading independent review organization (IRO) for the administration and determination of appeals. Your appeal will be reviewed and you will be notified in writing of the determination within 30 calendar days of Prescription Solutions receipt of the appeal. If your appeal is denied, your written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the pharmacy plan documents that exclude that coverage. If you are not satisfied with the outcome of the first appeal, you may request a second appeal.

Expedited Review Appeals Process

Appeals involving an imminent and serious threat to your health including, but no limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to the IRO's clinical review personnel. Expedited appeals will be reviewed and you will be notified of the determination within 72 hours from Prescription Solutions receipt of the appeal. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process.