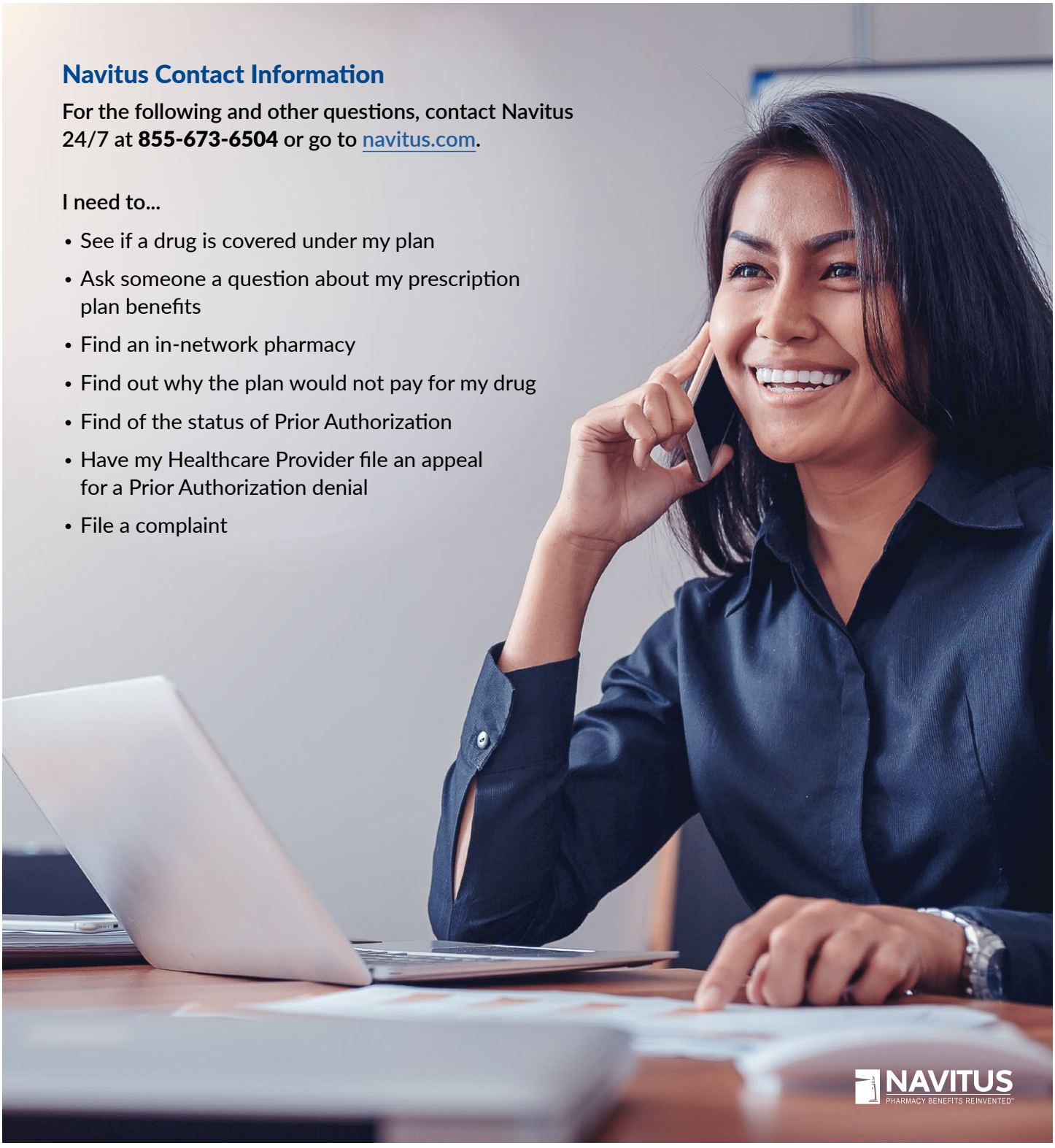
2022-2023

Prescription Plan Book

TML Health Benefits Pool

Table of Contents

Helpful Resources



Navitus Contact Information

For the following and other questions, contact Navitus 24/7 at 855-673-6504 or go to navitus.com.

I need to...

- See if a drug is covered under my plan
- Ask someone a question about my prescription plan benefits
- Find an in-network pharmacy
- Find out why the plan would not pay for my drug
- Find of the status of Prior Authorization
- Have my Healthcare Provider file an appeal for a Prior Authorization denial
- File a complaint

Definitions

CLINICAL PRIOR AUTHORIZATIONS

Certain drugs require Prior Authorizations. Clinical Prior Authorizations are based on evidence-based clinical criteria and nationally recognized peer-reviewed information. They may apply to an individual drug or a drug class on the formulary, including some preferred and non-preferred drugs.

COST SHARE DRUGS

Certain drugs are classified as non-preferred (Cost Share) drugs as there is no clinical evidence to show that they perform any better than therapeutic doses of less costly alternative drugs. The Plan will impose a higher Cost Share copay for these drugs.

DISEASE MANAGEMENT MAINTENANCE DRUGS

Certain generic drugs used to treat hypertention, high cholesterol and diabetes that are available at a $0 copay for up to a 90 day supply.

HIGH DEDUCTIBLE HEALTH PLAN WELLNESS LIST DRUGS

If you are enrolled in the High Deductible Health Plan, certain wellness drugs (for prevention, rather than treatment) are only subject to prescription copays. Non-Wellness drugs are subject to the In-Network deductible. Once the In-Network deductible is met, prescription copays will apply.

Refer to your Summary of Benefits & Coverage (SBC) to determine which Plan design applies.

LEGEND DRUG

A legend drug is a drug approved by the U.S. Food and Drug Administration that can be dispensed to the public only with a prescription from a medical doctor or other licensed practitioner.

LESSER OF BENEFIT

If the actual cost of the drug is less than the applicable copay, you will only pay the actual cost of the drug.

MANDATORY GENERIC PLAN (DAW1&2)

Refer to the prescription drug section of your Summary of Benefits & Coverage (SBC) to determine if you have a mandatory generic plan.

If a brand name drug is dispensed and a generic alternative drug exists, you will pay the difference between the brand name and generic price plus the appropriate copay for the brand name. The cost difference between the brand name and generic price does not apply to any individual deductibles or out-of-pocket amounts. The differential applies to all prescriptions purchased through this program when a generic alternative is available.

NON-MANDATORY GENERIC PLAN (Non-DAW)

Refer to the prescription drug section of your Summary of Benefits & Coverage (SBC) to determine if you have a non-mandatory generic plan.

If a brand name drug is dispensed and a generic alternative drug exists, you will pay the appropriate copay.

SPECIALTY DRUGS

Specialty drugs are typically medications requiring special storage, handling, administration, and patient monitoring, or are taken for complex or rare patient conditions. Specialty drugs are sometimes biotechnology medications. Most specialty medications are limited to no more than a 30-day supply of the medication per prescription fill and require clinical prior authorization.

STEP THERAPY

Step Therapy is required on certain drugs. Step Therapy means trying less expensive options before “stepping up” to drugs that cost more. Step therapy ensures that medically sound and cost-effective medications are prescribed appropriately.

Your Copay/Financial Responsibility

High Deductible Health Plan Copay Structure

When you are enrolled in a High Deductible Health Plan, prescription copays apply to certain wellness drugs (for prevention, rather than treatment). All other drugs are subject to the In-Network deductible, which means that you will pay 100% of the cost of the drug until the In-Network deductible is met. Once the In-Network deductible is met, prescription copays will apply until you have satisfied the out-of-pocket maximum. Refer to your medical Summary of Benefits and Coverage (SBC) for prescription copay information.

PPO and HMO Copay Structures

Refer to your medical Summary of Benefits and Coverage, (SBC) for prescription copay information.

Affordable Care Act Benefits

In accordance with the Affordable Care Act (ACA), the Plan provides coverage of the following preventive medication categories without imposing a copay, coinsurance, or deductible. Coverage of these medications, including over the counter (OTC) medications, requires a prescription from a licensed healthcare provider. Not all medications are covered in full under the following categories:

Medication	Coverage Guidelines	Age Guidelines
Breast Cancer Prevention		
tamoxifen	20 mg daily for up to 5 years	Women age 35 and older
anastrazole	1 mg daily for up to 5 years	Postmenopausal women
exemestane	25 mg daily for up to 5 years	Postmenopausal women
raloxifene (Evista equiv)	60 mg daily for up to 5 years	Postmenopausal women
Cardiovascular Disease Primary Prevention – Preventative Statins		
atorvastatin	10-20 mg (moderate-intensity regimen)	Adults aged 40-75 years
lovastatin	20 mg (low-intensity); 40 mg (moderate)	Adults aged 40-75 years
pravastatin	10-20 mg (low); 40-80 mg (moderate)	Adults aged 40-75 years
rosuvastatin	5-10 mg once daily (moderate). QLs apply	Adults aged 40-75 years
simvastatin	10 mg (low); 20-40 mg (moderate)	Adults aged 40-75 years
Colorectal Cancer Screening		
Bowel Prep: Peg 3350/ electrolytes trilyte	Limited to 2 fills/calendar year	Covered for screening for colorectal cancer in adults between the ages of 50 and 75
Heart Attack Prevention		
Aspirin	Prescribed when potential benefit (due to reduced heart attacks) outweighs the potential harm (due to an increase in GI hemorrhage); also covered for pregnant women at high risk for preeclampsia	Men ages 45-79 years; Women ages 55-79 years; Pregnant women at high risk for preeclampsia
HIV pre-exposure prophylaxis (PrEP) – HIV prevention		
DESCOVY TAB	PrEP is prescribed with effective antiretroviral therapy for HIV-negative people at high risk of acquiring HIV infection	None
TRUVADA TAB		
emtricitabine/tenofovir disoproxil fum		

Medication	Coverage Guidelines	Age Guidelines
Smoking Cessation		
buproprion (Zyban equivalent)	Provides tobacco cessation intervention to those adults that use tobacco products. Includes FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications); QL applies – six month supply per plan year	18 years and older
Nicotrol Nasal Spray		
Nicotrol Inhaler		
Nicotine kits		
Nicotine Replacement Patch		
Nicotine Gum		
Nicotine Replacement Lozenge		
Chantix		
Vitamins and Minerals		
Fluoride	Prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride (toothpastes and rinses do not apply)	Fluoride covered for children of both sexes: ages 0 months to five years
Folic Acid	Prescribed to women planning or capable of pregnancy as a daily supplement containing 0.4 to 0.8 mg (400 to 800 ug) of folic acid.	None
Iron	Prescribed to children aged 6 to 12 months who are at increased risk of iron deficiency anemia	Covered for children of both sexes: ages 0 months to 1 year
Vitamin D 400unit & 1000unit	Covered for men and women 65 years or older who are at increased risk for falls	Adults aged 65 years or older who are at increased risk for falls

Women's Preventive Health Services

Benefit	Medical Plan You Pay	Prescription Plan You Pay
Aspirin, low-dose 81 mg/d as preventive medication after twelve (12) weeks of gestation in women who are at high risk for preeclampsia	N/A	$0
Contraceptive management, including patient education and counseling	$0	N/A
Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges	N/A	$0
Diaphragm (cervical) instruction and fitting fee	$0	N/A
Emergency contraceptives	N/A	$0
Female condoms	N/A	$0
Female surgical sterilization	$0	N/A
Folic Acid supplements for women who may become pregnant	N/A	$0
Implant device	$0	$0
Injectable administration fee	$0	N/A

Benefit	Medical Plan You Pay	Prescription Plan You Pay
Injectable contraceptives	$0	$0
Insertion and/or removal of contraceptive devices	$0	N/A
IUD device	$0	$0
Medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects: Tamoxifen or Raloxifene	N/A	$0
Oral contraceptives, generic	N/A	$0
Over the Counter (OTC) contraceptives (contraceptive films, foams, gels)	N/A	$0
Permanent Implantable Contraceptive Coil and hysterosalpingography services related to the fitting	$0	N/A
Urine pregnancy test, Urinalysis, Sonogram to detect placement of device	$0	N/A

Please note: Not all medication/devices/products are covered by the Plan. Please refer to the formulary to see the list of eligible drugs and devices.

Medication Refill Restrictions

Refills of medications are not covered until at least a percentage of the previous fill has been used (based on the days' supply on the last fill of the medication).

Prescriptions filled at retail pharmacies
Refill not covered until 75% of days' supply of previous fill has passed
Opioids not covered until 90% of days' supply of previous fill has passed
Prescriptions filled at Mail Service Pharmacy
Refill not covered until 70% of days' supply of previous fill has passed
Opioids not covered until 80% of days' supply of previous fill has passed

Clinical Programs

TML Health reserves the right to modify and/or amend all clinical programs: clinical prior authorization, step therapy, cost share drugs, and quantity limits without notice to accommodate new drug entries to the marketplace and in response to adjustments in established medical and pharmacy practice guidelines.

This is a representative list as of the time of printing. Always check your formulary at navitus.com for the most current information.

Clinical Prior Authorization

If a Clinical Prior Authorization is required, please have your healthcare provider call the Member Services number on your ID card to request one. Your healthcare provider will be asked a series of questions and the request will either be approved or denied. A Prior Authorization is active for no more than one year.

Certain drugs in the following categories typically require Prior Authorizations. Some of these drug categories include, but are not limited to, the following:

- Acne Medications
- Analgesics/Anti-inflammatory/Pain Agents
- Antifungals
- Congestive Heart Failure
- Gastrointestinal Medications
- Gout Medications
- Lipid Reducers
- Migraine Medications
- Narcolepsy Medications
- Specialty/Biotech Medications
- Topical Anesthetics

Drugs requiring Prior Authorization are listed in the Navitus formulary.

Step Therapy

If Step Therapy is required, your pharmacist and/or healthcare provider will need to answer a series of questions to determine if the requirements are met, or if you will need to step down to a different drug.

Drugs requiring Step Therapy are listed in the Navitus formulary.

ADHD

Must try appropriate equivalent of at least two generic IR or ER formulations (for release formulation prescribed) for a period of 30 days each, before receiving the following medications.

Adzenys	Mydayis
Cotempla XR	Quillichew
Daytrana	Quillivant
Dyanavel XR	

Asthma

Required for members less than 40 years of age who have not demonstrated adherence to an inhaled corticosteroid (ICS) (at least 90 days of therapy in the past 120 days).

Category A

Inhaled corticosteroid (ICS) – Member must demonstrate adherence to an inhaled steroid and/or satisfy specific clinical criteria prior to obtaining a Category B medication.

Category B

(Only after demonstrated compliance and/or failure with a Category A medication).

Advair®	Perforomist®
Breo Ellipta®	Serevent®
Brovana®	Symbicort®
Dulera®	Wixela Inhub®
Fluticasone-salmeterol inhaler	

Diabetes

Member must try and fail Metformin 2,000 mg per day before receiving one of the following medications:

Treatment plan adherence is required for authorization to be approved.

Bydureon	Jentadueto XR
Byetta	Ozempic
Farxiga	Rybelsus
Glyxambi	Synjardy
Janumet	Synjardy XR
Janumet XR	Trulicity
Januvia	Victoza
Jardiance	Xigduo XR
Jentadueto	Xultophy

Depression

Member must try and fail MAX DOSE OF ANY TWO (2) generics for at least 6 weeks per.

Fetzima	Saphris sublingual
Fetzima Titration Pack	Trintellix
Fluoxamine ER	Viibryd

Cost Share Drugs

Certain drugs are classified as non-preferred as there is no clinical evidence to show that they perform any better than therapeutic doses of less costly alternative drugs. The Plan will impose the highest copay for these drugs.

Drugs on the Cost Share list are found in the Navitus formulary.

Quantity Limits

Quantity Limits are set on certain drugs and are intended to promote safe, appropriate use of medications, enhance patient safety, and discourage misuse, waste, and abuse.

Overuse of medications can lead to poor health outcomes and may unnecessarily drive up the cost of healthcare.

Quantity limits are based on generally accepted pharmaceutical guidelines, FDA labeling, efficient dosing regimens and dosing recommendations.

The following types of quantity limits are in place:

- Dose Efficiency – Limits coverage of medications to a specific number of doses per day based upon common prescribing practices and FDA labeling. Examples include one dose per day for drugs that are approved for once-daily dosing, two doses per day of drugs that are dosed twice daily.
- Maximum Daily Dose – Coverage is provided up to a specific limit per day, such as a number of milligrams. A message is sent to the pharmacy if a prescription exceeds the highest allowed dose.
- Quantity Limits Over Time – Limits coverage of prescriptions to a specific number of units in a defined period of time. Examples include one course of therapy in a year.
- Quantity Limits Per Fill – A member may obtain a specific amount of medication each time the prescription is filled.

Drugs with Quantity Limits are found in the Navitus formulary.

New Drugs to Market

All newly approved drugs on the market will initially not be covered, pending further review by an independent group of physicians and pharmacists to assess drugs based on their therapeutic value, side effects, and cost compared to similar medications.

Disease Management Maintenance

Certain generic medications used to treat the chronic conditions of diabetes, high blood pressure, and high cholesterol are covered under this program. As such members can receive up to a 90 day supply of these drugs for $0.

Diabetes – Generic Copay

glimepiride	glyburide/metformin
glipizide	metformin
glipizide ER	metformin ER (generic Glucophage XR only)
glyburide	pioglitazone

High Blood Pressure – Generic Copay

amlodipine	furosemide
atenolol	hydrochlorothiazide (hctz)
benazepril	lisinopril
benazepril/hctz	lisinopril/hctz
carvedilol	metoprolol
clonidine	propranolol
diltiazem ER	verapamil
doxazosin	verapamil ER/SR

Specialty Drugs

Oral Oncology Split Fill Program

Forty-nine percent of patients discontinue their oncology drug therapy within ninety days due to incompatibility with their medication. To allow you time to adjust to your medication and avoid waste, the mandatory oral oncology split fill program enables twice-monthly prescription refills at 50% copay for the first 6 fills.

Steps Necessary for Specialty Drugs

If a Clinical Prior Authorization is required, please have your healthcare provider call the Member Services number on the ID card to request one. Your healthcare provider will be asked a series of questions and the request will either be approved or denied.

Coverage for eligible injectable and non-injectable biotech and/or biosimilar prescriptions that are available through the Prescription Drug Plan but are purchased from medical providers will be paid per the Medical Benefit Plan.

Prescription Drug Plan non-injectables purchased outside of the pharmacy benefit manager will not be an eligible benefit under the Medical Benefit Plan.

Specialty Drugs are listed in the Navitus formulary.

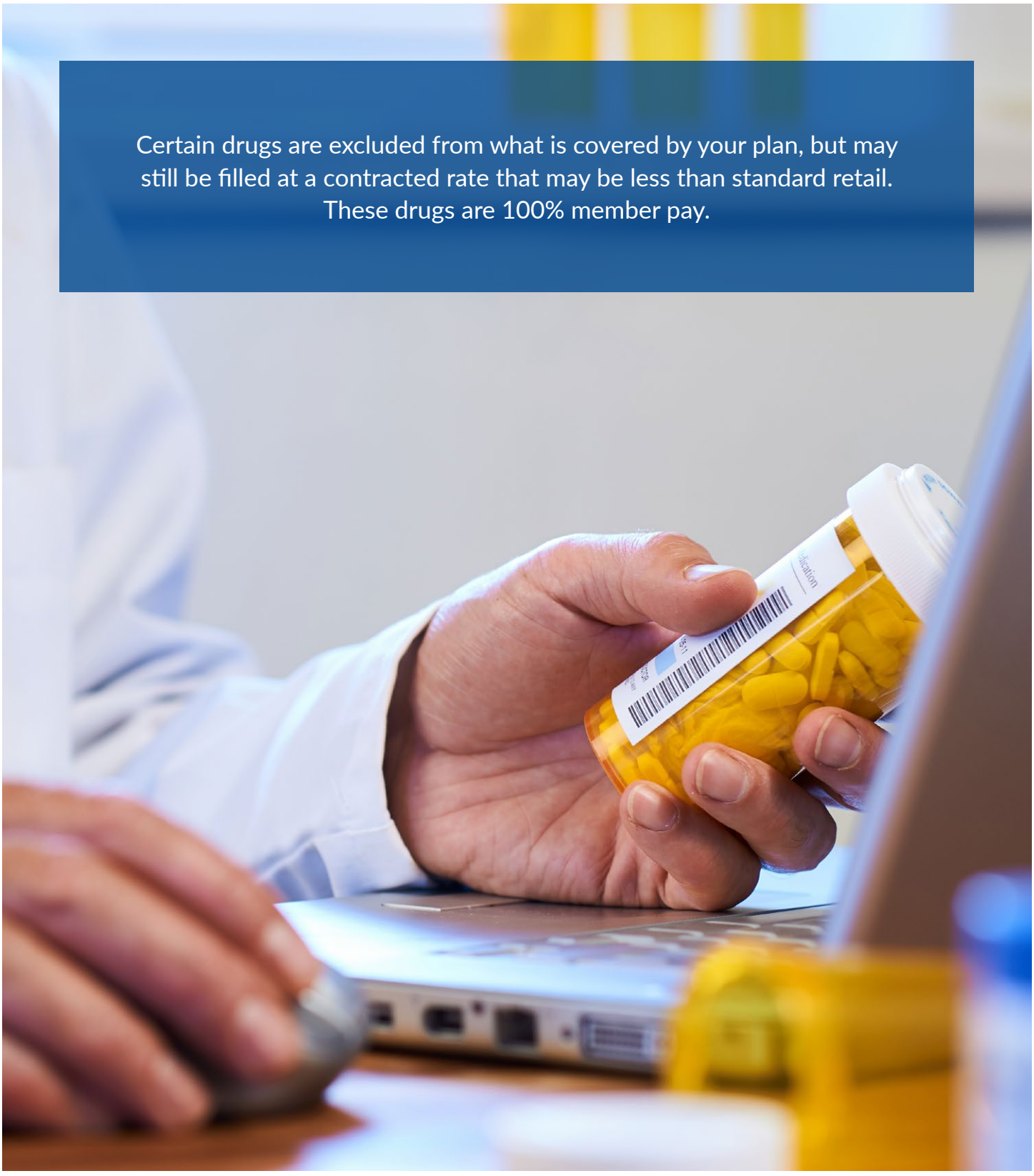
Please note: Not all specialty drugs are eligible for coverage under the prescription drug plan. Non-specialty alternatives may be a recommended first-line therapy to treat your condition. Please consult your physician for further information.

Copay Max

Copay Max Plus is a copay assistance program offered for more than 350 high cost Specialty Drugs. The program maximizes copay assistance available through drug manufacturers to save both the member and the plan money. Copays for these drugs will be the amount determined by the manufacturer copay assistance program, often $0.00.

Members taking drugs covered under Copay Max Plus will receive information about the enrollment into the copay assistance programs from their pharmacy.

Excluded Drugs



Certain drugs are excluded from what is covered by your plan, but may still be filled at a contracted rate that may be less than standard retail. These drugs are 100% member pay.

Lower Cost Drug Alternatives

If you are looking for a lower cost alternative for a cost share or excluded drug you may wish to refer to the table below when consulting with your healthcare provider. This is not a complete list and is subject to change as new drugs are added to the market.

Please note: Drugs starting with an uppercase letter or that have the ® symbol are brand name drugs. Drugs starting with a lowercase letter are generic drugs.

Analgesics/Anti-Inflammatory/Pain Agents	
Instead of:	Covered Alternatives:
• Duragesic® • Lazanda® • Subsys®	• fentanyl patch (except 37.5 mcg, 62.5 mcg, 87.5 mcg) • fentanyl lozenge • fentanyl citrate lollipop
Instead of:	Covered Alternatives:
• Anaprox® • Arthrotec® • Celebrex® • Celecoxib • Daypro® • diclofenac/misoprostol • Feldene® • Fenoprofen® • Fenortho® • indomethacin ER • Ketoprofen® • Ketoprofen ER® • Meclofen Sod® • mefenamic acid • Mobic® • Nalfon® • Naprelan CR® • naproxen sodium 550mg • naproxen CR • oxaprozin • piroxicam • Ponstel® • Tivorbex® • Vivlodex® • Zipsor® • Zorvolex®	• diclofenac • ibuprofen • meloxicam • naproxen
Instead of:	Covered Alternatives:
• Allzital® • Bupap® • butalbital/acetaminophen • butalbital/acetaminophen/caffeine • Esgic® tablet • Fioricet® • Fiorinal® • phrenilin cap forte • Tencon® • Vanatol LQ® Solution	• naproxen • ibuprofen • sumatriptan • rizatriptan
Instead of:	Covered Alternatives:
• Conzip® • tramadol ER • Ultracet® • Ultram® • Ultram ER®	• Tramadol (except 100 mg • tramadol/acetaminophen
Antibiotics/Anti-Infective Agents	
Instead of:	Covered Alternatives:
• Acticlate® • Adoxa® • Amoxicillin® (brand only) • Coremino • Doryx® • doxycycline monohydrate capsules (except 50 and 100mg) • doxycycline monohydrate tablets 150mg • doxycycline hyclate • doxycycline hyclate DR • Minocin® • minocycline tablets • minocycline ER • Minolira® • monodoxyne NL • morgidox • Moxatag® • Nuzyra® • Okebo • Oracea® • Seysara® • Solodyn® • soloxide DR • Targadox® • Vibramycin® • Xepi® cream • Ximino ER®	• amoxicillin • doxycycline monohydrate capsules 50 mg • mupirocin ointment

Anticonvulsants	
Instead of:	Covered Alternatives:
• Sympazan® oral film	• clobazam tablet

Antidepressants/Fibromyalgia	
Instead of:	Covered Alternatives:
• Aplenzin® • Brisdelle® • branded Bupropion ER • Forfivo XL® • Paroxetine® 7.5mg capsule • trazodone tablet 300mg • Trintellix®	• citalopram • duloxetine (EC cap other than 40 mg) • escitalopram • fluoxetine (other than 60 mg) • paroxetine • sertraline • trazodone (other than 300mg) • venlafaxine • venlafaxine ER (capsules only) • Viibryd (Tier 3) • Fetzima (Tier 3)

Antihypertensive Agents (High Blood Pressure)	
Instead of:	Covered Alternatives:
• amlodipine/Olmesartan • amlodipine/olmesartan/HCTZ • amlodipine/valsartan • amlodipine/valsartan/HCTZ • Atacand® • Atacand HCT® • Avalide® • Avapro® • Azor® • Benicar® • Benicar HCT® • Coreg CR® • Cozaar® • Diovan® • Diovan HCT® • Edarbi® • Edarbyclor® • Eprosartan® • Exforge® • Hyzaar® • Inderal LA • Inderal XL • InnoPran XL® • Micardis® • Micardis HCT® • Olmesartan • olmesartan HCTZ • Tekturna® • Tekturna HCT® • telmisartan/amlodipine • Tribenzor® • Twynsta®	• any generic ACE Inhibitor • losartan • losartan/HCTZ • irbesartan • irbesartan/HCTZ • telmisartan • valsartan • valsartan/HCTZ • carvedilol (immediate release) • propranolol IR/ER (for Inderal LA/XL, InnoPran XL • propranolol HCTZ • nadolol • pindolol • propranolol • propranolol ER • timolol • acebutolol • atenolol • betaxolol • bisoprolol • metoprolol ER tab • metoprolol (except 37.5mg and 75mg) • atenolol/chlorthalidone • bisoprolol/hydrochlorothiazide • metoprolol/hydrochlorothiazide • nadolol/bendroflumethiazide

Central Nervous System: Sedative Hypnotics	
Instead of:	Covered Alternatives:
• Ambien® • Ambien CR® • Belsomra® • Edluar® • Intermezzo® • Lunesta® • Rozerem® • Silenor® • Sonata® • zolpidem ER • zolpidem sublingual • Zolpimist®	• doxepin capsules • eszopiclone • zaleplon • zolpidem immediate release

Lipid-Lowering Agents – Statins (High Cholesterol)	
Instead of:	Covered Alternatives:
• Altoprev® • amlodipine/atorvastatin combination • Caduet® • Crestor® • ezetimibe-simvastatin • Flolipid® • Fluvastatin • fluvastatin ER • Lescol® • Lescol XL® • Lipitor® • Livalo® • Mevacor® • Pravachol® • Vytorin® • Zetia® • Zocor® • Zypitamig®	• atorvastatin • lovastatin • pravastatin • rosuvastatin • simvastatin

Migraine Headaches	
Instead of:	Covered Alternatives:
• Almotriptan • Amerge® • Axert® • Frova® • Frovatriptan • Eletriptan • Imitrex® (brand) • Imitrex® Spray • Maxalt® • Maxalt-MLT® • Naratriptan • Onzetra XSAI® • Relpax® • sumatriptan spray • sumatriptan/naproxen • Sumavel® • Treximet® • Zembrace • Zolmitriptan • Zomig® • Zomig® nasal spray • Zomig ZMT®	• rizatriptan • sumatriptan
Osteoporosis Drugs	
Instead of:	Covered Alternatives:
• Actonel® • Alendronate® (brand) • Atelvia® • Binosto® • Boniva® • Fosamax® • Fosamax-D® • Ibandronate • risedronate	• alendronate
Overactive Bladder Drugs	
Instead of:	Covered Alternatives:
• Darifenacin • Detrol® • Detrol LA® • Ditropan XL® • Enablex® • Gelnique® • Myrbetriq® • oxybutynin ER® • Oxytrol® patches	• generic: oxybutynin immediate release
• Solifenacin • Tolterodine • tolterodine ER • Toviaz® • trospium CL • trospium CL ER • Vesicare®	• generic: oxybutynin immediate release
Skeletal Muscle Relaxants	
Instead of:	Covered Alternatives:
• Amrix® • carisoprodol 250mg tablet • Chlorzoxazone® • cyclobenzaprine ER • Fexmid® • Lorzone® • Metaxall • Metaxalone • Parafon Forte® • Robaxin® • Skelaxin • Soma® • Tabradol® • tizanidine (capsules only) • Zanaflex®	• carisoprodol (except 250mg tablet) • cyclobenzaprine (except 7.5 mg tablet) • methocarbamol • tizanidine tablets

Excluded Drugs

Drugs Covered Under This Benefit

1. Legend drugs;
2. Insulin or oral diabetic drugs;
3. Disposable insulin needles/syringes and physician prescribed needles/syringes/ supplies;
4. Disposable blood/urine/glucose/acetone testing agents (e.g. Acetest Tablets, Clinitest Tablets, Glucometer (one per calendar year), Lancets, Diastix Strips, Tes-Tape and Chemstrips);
5. Diabetic supplies purchased with a prescription for insulin or oral diabetic medication. The plan will allow needles, syringes, lancets, and testing strips at no charge if ordered within 30 days of a prescription for insulin or oral diabetic medication;
6. Compound medication of which at least one ingredient is a legend drug to maximum $200.00 per prescription payment;
7. Any other drug which under the applicable State Law may only be dispensed upon the written prescription of a physician or other lawful prescriber;
8. Contraceptives: Oral, Brand Extended cycle (mail order only), Generic Extended cycle (In-Network at 90 days copay), Transdermal patches, Contraceptive devices, Levonorgestrel (Norplant), Prescription Strength Only;
9. Depo-Provera;
10. Prescribed smoking cessation medications containing nicotine or any other smoking cessation aids, all dosage forms;
11. Growth hormones (requires a prior authorization);
12. Extended Release anti-depressive agents: Wellbutrin XL, Effexor XR; and
13. Extended Release migraine prophylactic agents: Depakote ER.

Drugs Not Covered under this Benefit

Plan exclusions apply to both the brand and generic version of the medication unless otherwise noted.

1. Non-legend drugs other than those listed above.
2. Non-FDA approved medications.
3. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use.
4. Charges for the administration or injection of any drug.
5. Drugs labeled “Caution - limited by Federal Law to investigational use”; experimental, investigational or unproven services or drugs; drugs used for experimental indications and/or dosage regimens.
6. Drugs prescribed, dispensed, or intended for use while an individual is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar premises which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
7. Coverage for prescription drug products for the amount dispensed (days’ supply or quantity limits) that exceed the supply limit.
8. Any prescription refilled more than the number of times specified by the physician or any refill dispensed after one year from the physician’s original order.
9. Prescription which an eligible individual is entitled to receive without charges from any Workers’ Compensation Laws or which is prescribed for an injury or illness which is excluded from any medical coverage which is provided in conjunction with this prescription plan.
10. Prescription drug products dispensed outside of the United States, except as required for emergency treatment.

11. Prescription drug products furnished by the local, state, or federal government.
12. Prescribed prenatal vitamins are not covered under the prescription plan. Claims for prescribed prenatal vitamins with a pregnancy diagnosis may be submitted to us for payment consideration under the medical benefit.
13. Immunization agents, biological sera, blood, or blood plasma.
14. Dietary supplements, vitamins or formulas, vitamins individually, or in combination.
15. Nutritional Supplements (i.e. Deplin®, Metanx®).
16. Fertility medications.
17. Any drug or product dispensed for the purposes of appetite suppression or weight loss; including FDA approved prescriptions for weight loss and/or appetite suppression.
18. All non-injectable testosterone (including pellet and buccal formulations), Brand injectable testosterone is also excluded.
19. Agents used for cosmetic purposes.
20. Male pattern baldness medications; hair growth stimulants.
21. Lifestyle convenience prescriptions (i.e. erectile dysfunction prescriptions, topical and buccal testosterone products).
22. All nasal steroids (e.g. Beconase® AQ, Nasonex®, QNASL®, etc.).
23. All non-sedating/low-sedating antihistamines (e.g. Claritin®, Clarinex®, desloratadine, levocetirizine, Zyrtec®, etc.).
24. All proton pump inhibitors (e.g. Dexilant®, Nexium®, Prilosec®, Protonix, etc.) and H2 Antagonists (e.g. Pepcid®, Tagamet®, Zantac®, etc.).
25. All topical non-narcotic pain medications (e.g. Sinelee®, Flector®, Solaraze®, etc.).
26. Certain acne medications including, but not limited to: Absorica®, all benzoyl peroxide, Altreno®, Cleocin-T® gel, Clindagel®, Clindamycin® gel, Duac® gel, Fabior®, Refissa®, Renova®, tretinoin emulsion cream, Retin-A®, and Riax®.
27. Certain analgesic/anti-inflammatory/ pain agents including, but not limited to: Acetaminophen/Caffeine/ Dihydrocodone®, Apadaz®, Aspirin/ Caffeine/Dihydrocodone®, Arymo® ER, Belbuca®, benzhy/acetaminophen, Bunavail®, Dsuvia®, Embeda®, Exalgo®, hydromorphone ER (generic Exalgo only), Hysingla® ER, Kadian® CR/ ER, Levorphanol®, Morphabond® ER, morphine sulphate ER capsules (generic Kadian only), Nalocet®, Nucynta®, Nucynta® ER, Opana® ER, Oxaydo®, oxymorphone, Oxymorphone® ER, Roxybond®, Sprix spray®, Suboxone®, bupren/naloxone (generic Suboxone®), Synalgos- DC®, Trezix®, Xtampza® ER, Zohydro® ER, and Zubsolv®.
28. Certain combination analgesic and gastric reflux/ stomach ulcer medications including, but not limited to: Duexis®, Vimovo® and Yosprala®.
29. Certain antibiotics including, but not limited to: Impavido®, Furadantin® suspension, and its generic if over 7 years old.
30. Certain anticonvulsants including, but not limited to: Briviact®, Keppra® XR; Lamictal®, Lamictal XR®, levetiracetam ER, Qudexy XR®, roweepra XR, Topiramate® ER, and Trokendi XR.
31. Certain antidiabetic medications including, but not limited to: Glumetza®, metformin ER (certain 1000 mg and certain 500 mg strengths), Fortamet® Symlin®; Invokana®, Invokamet®, and Invokamet® XR.
32. Certain antiemetics including, but not limited to: Akynzeo®, Bonjesta®, Cinvanti®, Diclegis®, Emend® (suspension and tripack), Emend® for injection, Sustol®, and Varubi®.

33. Certain antifungals including, but not limited to: Cresemba®, Extina® Aer 2%, Jublia®, Kerydin®, Luliconazole®, Luzu®, Naftin®, Onmel®, Tolsura®, Vytone®, and Xolegel®.
34. Certain antipsychotics including, but not limited to: Abilify® Myci (only), Aristada®, Nuplazid®, and Rexulti®.
35. Certain cholesterol/triglyceride-lowering agents including, but not limited to: Lovaza®, Niaspan®, niacin ER, niacor, Flolipid® suspension, and all Fenofibrates (e.g. Antara®, Lipofen®, Fenoglide®, Tricor®, etc.).
36. Certain COPD medications including, but not limited to: Daliresp®, Lonhala Magn®, Trelegy®, and Yupelri®.
37. Certain gastrointestinal agents including, but not limited to: Motegrity®, Mytesi®, Relistor®, Symproic®, Viberzi®, and Xermelo®.
38. Certain gout agents including, but not limited to: Duzallo® and Zurampic®.
39. Certain ophthalmic agents including, but not limited to: Acular®, Acuvail®, Altrex®, Azopt®, Bromfenac®, Bromsite®, Flubiprofen®, Ilevro®, Inveltys®, Lotemax®, Nevanac®, Prolenssa®, Rhopressa®, and Vyzulta®, Xelpros®, Zylet®.
40. Certain topical steroids including, but not limited to: Enstilar®, Bryhali®, Impoyz®, Trianex®, Triderm®, Ultravate®, all brands with generics available, all gels, aerosols, sprays, shampoos, tapes, and lotions.
41. Most convenience Kits and Paks including, but not limited to: Flanax Pain Kit Relief, Morgidox Kit, Naproxen Comfort Kit, Nutridox Kit, etc.
42. Zolgensma injectable for the treatment of spinal muscular atrophy.

Please note: This is not a complete list of covered and non-covered drugs. This list is subject to change as new drugs are added to the market or for cost containment purposes. For a complete and current list of covered drugs, please log into your Member Portal at navitus.com or the Navitus App and click the Formulary link.

High Deductible Health Plan Wellness Drugs

When you are enrolled in a High Deductible Health Plan, certain wellness drugs are subject to prescription copays. Non-Wellness drugs are subject to the In-Network deductible. Once the In-Network deductible is met, prescription copays will apply.

In addition to a healthy lifestyle, preventive medications can help you avoid many illnesses and conditions. Preventive medications are defined as those prescribed to prevent the occurrence of a chronic disease or condition for those individuals with risk factors, or to prevent the recurrence of a disease or condition. Some examples of such medications are for high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, and heart disease.

High Deductible Health Plan Wellness drugs can be found in the Navitus formulary and are also available on the High Deductible Health Plan Wellness list. Both of these lists are available on the TML Health website at tmlhealthbenefits.org.

Prescription Drug Formulary

The most effective way to control costs is through the use of generic drugs and a drug formulary. As such, drugs that are not categorized as Specialty Drugs, Cost Share Drugs, or Excluded Drugs are assigned to a certain tier, as described below.

You can find information on what drugs are covered by your plan by logging into the Navitus Member Portal, at navitus.com, or the Navitus App.

Drug Tier	Includes
Tier 1	Lower cost generics and some brand name drugs. Use Tier 1 drugs for the lowest out-of-pocket costs.
Tier 2	Mid-range cost preferred brand-name drugs and higher cost generic drugs. Use Tier 2 drugs instead of Tier 3 to help reduce your out-of-pocket costs.
Tier 3	Highest-cost non-preferred drugs. Some low-cost brands may be included. Many Tier 3 drugs have lower cost options in Tier 1 or 2. Ask your doctor if they could work for you.
Tier 4	Specialty Drugs – Check the formulary to find covered Specialty Drugs (subject to the Specialty copay).
Tier 5	Cost Share Drugs – Check the formulary to find covered drugs (subject to the Cost Share copay).

Other Pharmacy Resources

Mobile App

Download the Navitus App to access your benefits, locate a nearby pharmacy, view and manage your medications, and more. Download the Navitus App from the App Store or the Google Play Store.

Navitus Member Portal

Starting on your effective date, you can go online to find information specific to your plan. To register your account, visit navitus.com and click "Portal Login", then "Member Portal", then "Click here for new registrations."

Mail Order Service

All mail order prescriptions must be sent to Costco Pharmacy. Register online at pharmacy.costco.com. Please allow 10 to 14 calendar days from the day you submit your order to receive your medication(s). You do not need to be a Costco member to use Costco Pharmacy.

"From day one, our focus has never been on profit, but the service and lives of our members."

Jay Stokes, *TML Health Board Member*

TML Health Benefits Pool

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