Mercer Rx Plan

Patient First Prescription Drug Program

Prescription Co-Pays

Pharmacies, Participating Retail
There is not an additional deductible for prescription drugs.

Maximum Days Supply per Co-pay
30 Days, 60 Days, 90 Days - retail pharmacy

Co-payment or the Greater of 20% per Prescription:

RETAIL PHARMACY

Day Supply	30	60	90
Generic Drugs:	$15 or 20%	$30 or 20%	$45/20%
Brand Name Drugs (No Generic Available)	$25 or 20%	$50 or 20%	$75 or 20%
Brand Name (By Preference)	$50 or 20%	$100 or 20%	$150 or 20%

Total costs not to exceed $150 for any 30-day supply

If the actual cost of the Prescription Drug is less than the co-pay, the Covered Person will be responsible only for the actual cost.

Prescription Mail Order Program
The mail service prescription drug program is an extension of the prescription drug benefit that allows you to receive a 90-day supply of medications at the costs of 60 days. Some medications, however, may not be available through the mail order program. In the event that your prescription may not be dispensed through mail order, retail co-pays will apply.

Maximum Days Supply per Co-pay
90 Days - mail order

Co-Payment per Prescription:

Mail Order

90 day supply available through mail order for two co-pays

Day Supply	90
Generic Drugs:	$30
Brand Name Drugs (No Generic Available)	$50
Brand Name (By Preference)	$100
Covered Percentage After Co-Payment	100%

If the actual cost of the Prescription Drug is less than the co-pay, the Covered Person will be responsible only for the actual cost. NO “Coordination of Benefits” will apply for Prescription Drug Coverage whether retail or mail order.

Benefits are payable when a Covered Person incurs eligible drug expenses which are in excess of the co-payment amount, per prescription or refill. No reimbursement will be made if a Covered Person chooses to have prescriptions filled at a pharmacy that does not participate in the Patient First system. The covered person must show the Patient First ID card in order to obtain the appropriate co-pay.

PARTICIPATING PHARMACIES:

Use the Patient First card at any participating pharmacy.

Each Covered Person will be responsible for the required co-payment at the time of purchase. The remainder of the transaction will be handled between Patient First and the pharmacy.

The Covered Person is expected to show the Patient First card to the member pharmacy when paying for the prescription. However, if the Covered Person does not have the card with them at the time of purchase, the Covered Person must:

1. Pay the full charge for the prescription;

2. Obtain a paid receipt which includes prescription information, not just a cash register receipt; and

3. Complete a Direct Reimbursement Claim Form (available from the Benefits Office or CAS) with the pharmacist's help, attach the receipt and send both directly to the address indicated on the claim form.

NO reimbursement will be made if a prescription is filled at a pharmacy that does not participate in the Patient First Pharmacy Network.

Prescription Drug Coverage

The following list contains categories of Prescription drugs, which are covered or excluded from the Plan

C = Covered / N = Not Covered

A.D.D. / Narcolepsy

C	Amphetamines (e.g. Adderall)
N	Dextroamphetamine (e.g. Dexedrine)
C	Dextroamphetamine (e.g. Dexedrine) / through age 16
N	Methylphenidate (e.g. Ritalin)
C	Methylphenidate (e.g. Ritalin) / through age 16

Anabolic Steroid

N	Therapeutic classification (e.g. Winstrol, Durabolin)

Anorectics

N	Therapeutic classification (e.g. Desoxyn, Fastin, Ionamin)

Appetite Suppressants

N	Any drug used for the purpose of weight loss.

Birth Control (Contraceptives)

C	Oral dosage forms (e.g. Ortho Novum, Demulen)
C	Non-oral dosage forms (e.g. IUD, Diaphram)
C	Injectable dosage forms (e.g. Depo Provera)
N	Levonorgestrel (Norplant) 5 year implant

Controlled Substances

C	Class 2
C	Class 3
C	Class 4
C	Class 5

Cosmetic Medication

C	Accutane (for acne)
N	Anti-wrinkle agents (e.g. Renova)
N	Retin-A
C	Retin-A for acne through age 25
N	Pigmenting/depigmenting Agents (e.g. Solaquin Forte)

DESI Drugs

C	All legend drugs which would otherwise be covered.

Diabetic Supplies (requires prescription from physician)

C	Insulin
C	Disposable Insulin Needles/Syringes (for insulin only)
C	Blood/Urine testing agents (strips)
C	Alcohol swabs
C	Blood Glucose testing monitors

C Glucose Tablets
C Glucagons
C Lancets
C Lancet Devices
C Non-Insulin Needles Syringes (for administering prescribed medications)
C Insulin and needles/syringe under one co-pay
C Insulin, needles/syringes, and test strips under one co-pay

See also Educational Services/Diabetes.

Experimental or Investigational Drugs
This is NOT a covered Expense under your Plan.
Drugs labeled "Caution - limited by federal law to investigational use," or Experimental drugs, even though a charge is made to the Covered Person.

Facility Administered Medication
These medications are not covered under the Prescription Drug Coverage. However, they may be covered under Hospital Services.
Medication which is to be taken by or administered to a Covered Person, 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. See also Hospital Services.

Fluoride Supplements
N Tablet forms
N Oral rinses
N Topical dental preparations

HIV / AIDS Medications
Pre-notification through CAS recommended.
C Therapeutic classifications (e.g. Hivid, Epivir, Videx, Zervit)

Imitrex (Motion Sickness)
C Oral dosage forms
C Injectable dosage forms

Infertility Medications
N Oral dosage forms (e.g. Clomid, Serophene)
N Injectable dosage forms (e.g. Metrodin, Pergonal)

Interferon
Pre-notification through CAS recommended.
C Therapeutic classification (e.g. Betaseron, Intron-A)

Miscellaneous Prescriptions
N Anti-Wrinkle Agents (e.g. Renoval)
N Blood and Blood Plasma (see hospital services)
C Growth Hormones (e.g. Humatropin, Genotropin) to age 18. Pre-notification through CAS is recommended.
N Growth Hormones (e.g. Humatropin, Genotropin)
N Immunization Agents (e.g. Hepatitis, Chicken Pox). See Routine Physical Exam.

N Levonorgestrel (Norplant) see Birth Control
N Minoxidil (Rogaine-for the loss of hair)

Non-Legend Drugs
N Over the counter medications

Nutritional Supplements
N Non-legend vitamins (over the counter)
C Legend vitamins (Rx required).
C Pediatric multi-vitamins with fluoride (Rx required)
C Prenatal vitamins
N Diet supplements (e.g. Calcium)
N Hernatinics (e.g. Folic Acid, Chromogen, Iron Supp.)
N Minerals (e.g. Phoslo, Potaba)

Prescriptions, Workers' Compensation Related
This is NOT a covered Expense under This Plan.
Prescriptions that a Covered Person is entitled to receive without charge from any Workers' Compensation Laws.

Smoking Deterrents
N Gum (e.g. Nicorett)
N Patches (e.g. Habitrol, Nicoderm)

Therapeutic Devices
This is NOT a covered Expense under This Plan.
Therapeutic devices or appliances, including needles, syringes (except as specified), support garments and other non-medicinal substances, regardless of intended use.