Prescription Drug Benefit Description

Herein called "Description"

Prescription Drug Program For State of Kansas Employees Health Plan

This booklet describes the Prescription Drug benefits available through the State of Kansas program. The prescription drug program is underwritten by the State of Kansas and administered by Caremark. The State of Kansas reserves the right to change or terminate the program at any time or to change the company that administers the program.

The Caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. Caremark is not the insurer of this Program and does not assume any financial risk or obligation with respect to claims.

Contact Information

For answers to any questions regarding
Your prescription claims payment contact:

Caremark
P.O. Box 52136
Phoenix, Az 85072-2136
1-800-294-6324
http://www2.caremark.com/kse/

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Oral Anti-Cancer Medication Rider

Preferred Drug List effective 1/1/11

Section 1 Definitions

Allowed Charge – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Plan.

Brand Name – Typically, this means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. For purposes of pricing, drug classification (e.g., brand vs. generic) will be established by a nationally recognized drug pricing and classification source.

Compound Medication – a medication mixed for a specific patient and not available commercially. To be eligible for reimbursement a Compound Medication must contain at least one Legend Drug that has been assigned a national drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

Coinsurance – is a sharing mechanism of the cost of health care and is expressed as a percentage of the Allowed Charge that will be paid by You and the balance paid by the Plan.

Copayment – a specified amount that You are required to pay for each quantity or supply of prescription medication that is purchased.

Copayment/Coinsurance Maximum – the maximum combined total for a Member on the Coinsurance and Copayments for Generic, Preferred and Special Case Medications. Coinsurance for Non Preferred Drug does not accumulate toward the Copayment/Coinsurance Maximum.

Discount Medications – are medications not covered by the plan but for which the Plan has a negotiated discount with network pharmacies. These items include medications with primary indications for use of: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent non prescription product is available Over-The-Counter - example: non sedating antihistamines; Drug Efficacy Study Implementation (DESI-5) medications – older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies.

Drug Override – a feature that allows Members who meet specific criteria outlined in the Plan to receive Non Preferred Drugs at the Preferred Drug Coinsurance level.

Experimental, Investigational, Educational or Unproven Services – medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding coverage) to be: (1) not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or (5) for the primary purpose of providing training in the activities of daily living, instruction in scholastic skills such as reading or writing, or preparation for an occupation or treatment for learning disabilities.

Generic – Typically, this means a medication chemically equivalent to a Brand Name drug on which the patent has expired. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally-recognized drug pricing and classification source.

Injectable Drug List –Injectable medications includes drugs that are intended to be self-administered by the Member and/or a family member as well as some that may need to be administered by medical professional. The

cost to inject these drugs is not covered under this Plan. Coverage is limited to those medications that have been designated by the Plan. This list is subject to periodic review and modification.

Legend Drug – medications or vitamins that by law require a physician's prescription in order to purchase them.

Maximum Allowable Cost List (MAC List) – a list of specific multi-source Brand Name and Generic drug products that the maximum allowable costs have been established on the amount reimbursed to pharmacies.

Maximum Allowable Quantity List – some medications are limited in the amount allowed per fill. Limiting factors are FDA approval indications for (MAQ) as well as manufacture package size and standard units of therapy. The list is subject to periodic review and modification.

Medically Necessary – Prescription Drug Products which are determined by the Plan to be medically appropriate and: (1) dispensed pursuant to a Prescription Order or Refill; (2) necessary to meet the basic health needs of the Member; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies; and (4) commonly and customarily recognized as appropriate for treatment of the illness, injury, sickness or mental illness. The fact that a provider prescribed a Prescription Drug Product or the fact that it may be the only treatment for a particular illness, injury, sickness or mental illness does not mean that it is Medically Necessary. The fact that a medication may be medically necessary or appropriate does not mean that is a covered service.

Member – an individual eligible for benefits under the Plan as determined by the Plan Sponsor.

Network Pharmacy – a pharmacy that has entered into an agreement with Caremark to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates.

Non Network Pharmacy – a pharmacy that has not entered into an agreement with Caremark to provide Prescription Drug Products to Members or agreed to accept the Caremark reimbursement rates.

Non Preferred Drug – Any drug not listed on the Preferred Drug List or the Special Case Medication List of the Plan are considered Non Preferred.

Over-The-Counter (OTC) – are drugs you can buy without a prescription from a health care provider. The U.S. Food and Drug Administration ("FDA") determines whether medicines are prescription or nonprescription. Nonprescription or OTC drugs are medicines the FDA decides are safe and effective for use without a prescription.

Performance Drug List – encourages members to use lower cost generics before using non preferred brand products. Before a prescription for a non preferred drug in one (1) of three (3) specific classes of prescription drugs can be processed, the member must have tried one of the generic alternatives available. The three classes of prescription drugs include: cholesterol lowering statin medications (HMG's - 3-hydroxy-3-methyl-glutaryl), long-lasting reduction of gastric [stomach] acid production (PPIs - proton pump inhibitors), and high blood pressure medications (ARB's - Angiotensin II Receptor Blockers).

Pharmacy – a licensed provider authorized to prepare and dispense drugs and medicines. A Pharmacy must have a National Association of Boards of Pharmacy identification number (NABP number).

Plan – The benefits defined herein and administered on behalf of the State of Kansas by Caremark.

Plan Sponsor – State of Kansas

Preferred Drug List – a list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modification. The Preferred Drug List is available at: **http://www2.caremark.com/kse/**.

Preferred Drug– a drug listed on the Preferred Drug List.

Prescription Drug Product – a medication, product or device registered with and approved by the U.S. Food and Drug Administration ("FDA") as safe and effective when used under a health care provider's care and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under the plan, this definition includes insulin and diabetic supplies: insulin syringes with needles, alcohol swabs, blood testing strips-glucose, urine testing strips-glucose, ketone testing strips and tablets, lancets and lancet devices.

Prescription Order or Refill – the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization – the process of obtaining pre-approval of coverage for certain Prescription Drug Products, prior to their dispensing, and using guidelines approved by the Plan Sponsor. The Plan retains the final discretionary authority regarding coverage. The list of medications requiring prior authorizations is subject to periodic review and modification.

Special Case Medication – a group of high cost medications used for the treatment of catastrophic conditions. The list of Special Case Medications is designated by the plan and is subject to periodic review and modification.

Specialty Drugs - Utilized by a small percentage of the population with rather complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Specialty drugs may require specialized delivery and are administered as injectable, inhaled, oral or infusion therapies. The major conditions these drugs treat include, but are not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth deficiency. Coverage under the drug plan is limited to medications that have been designated by the plan as Specialty Drugs and are either self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the Caremark Specialty Mail Order Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

Standard Unit of Therapy –Up to a thirty (30) consecutive day supply of Prescription Drug Product, unless adjusted based on the drug manufacture's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

Tobacco Control – a program that encourages members to discontinuance using tobacco products and reduces the risk of disease, disability, and death related to tobacco use.

You or Your – refers to the Member.

Section 2 Benefit Provisions

Coverage for Outpatient Prescription Drug Products

The plan provides coverage for Prescription Drug Products, if all of these conditions are met:

(1) You are an eligible Member in the Plan; and
(2) it is Medically Necessary;
(3) it is obtained through a Network Retail, Network Home Delivery or a Non Network Retail Pharmacy;
(4) Specialty Drugs for self administration or self injection must be obtained from the Caremark Specialty Pharmacy;
(5) the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines.

Standard Prescription Drug Benefits

Coverage Level	Prescription Drug Product	Member Responsibility
Tier One	**Generic Drugs**	**20% Coinsurance**
Tier Two	**Preferred Drugs**	**35% Coinsurance**
Tier Three	**Special Case Medications**	**Maximum of $75 per standard unit of therapy**
Coinsurance/Copayment Maximum	**Tiers One, Tier Two and Tier Three Only**	**$2580 per person per year**
Tier Four	**Non Preferred and Compound Medications**	**60% Coinsurance**
Tier Five	**Discount Medications**	**100% Coinsurance**

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance or Copayment. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Network Pharmacy, the Member's payment shall not exceed the Allowed Charge when You present Your identification card to the pharmacy as required. When a Non Network Pharmacy is used, You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment. Benefits for services received from a Retail Non Network Pharmacy will be paid to the primary insured. To be eligible for coverage under the Plan, Specialty Pharmacy products that are self-administered or self injected must be purchased from the Caremark Specialty pharmacy. You can not assign benefits under this program to any other person or entity.

Information on the Performance Drug List, Preferred Drug List, Special Case List, Injectable Drug List or Specialty Drug List is available at: **http://www2.caremark.com/kse/** or **www. sehbp.org**

Generic Prescription Drug Products:

Your Coinsurance is 20% of the Allowed Charge.

Preferred Brand Name Prescription Drug Products:

For eligible Preferred Brand Name Drugs, Your Coinsurance is 35% of the Allowed Charge. The Preferred Drug List is subject to periodic review and modification.

Special Case Medications:

Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed a maximum of $75 per standard unit of therapy. For quantities less than a thirty (30) day supply, Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed $75.

Non Preferred Brand Name Drug Products:
Eligible Non Preferred Brand Name Drug Products (those not included on the Preferred Drug List) Your Coinsurance is 60% of the Allowed Charge.

Compound Medications:
The Coinsurance will be 60% of the Allowed Charge of the Compounded Medication. Caremark's mail order pharmacy is a contracting compounding pharmacy. To be eligible for reimbursement a Compound Medication must contain at least one Legend Drug that has been assigned a national drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

Specialty Drug:
Specialty drugs are medication that have been designated by the Plan and are self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the Caremark Specialty Pharmacy. The list of Specialty Drugs medications is available at: **http://www2.caremark.com/kse/** or **www. sehbp.org** and is subject to periodic review and modification. Coinsurance will be determined based on the Preferred Drug or Non Preferred Drug status of the medication; however most Specialty Drugs will also be on the Special Case List due to their high cost.

Discount Medications:
You will be responsible for 100% of the Allowed Charge. The Allowed Charge is the Caremark contracted reimbursement rate, and provides members with a discount off the retail price of the medication.

Prescription drug products that are only eligible for a discount include the following: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent non prescription product is available Over-The-Counter - example: non sedating antihistamines; Drug Efficacy Study Implementation (DESI-5) medications – older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies.

Chronic Care Benefit

Prescription Drugs for:	Prescription Drug Product	Member Responsibility Per 30 Day Supply
Diabetes	**Generic Drug**	**10% to a maximum of $10**
	Preferred Brand Drug	**20% to a maximum of $20**
Asthma	**Generic Drug**	**10% to a maximum of $10**
	Preferred Brands Drug	**20% to a maximum of $20**

Chronic Care Benefit
The chronic care benefit is designed to support self management of asthma and diabetes. Regularly taking Your medication along with monitoring peak flows and blood sugar levels are critical to the self management of asthma and diabetes. To promote adherence to medication therapy, the coinsurance has been reduced on prescription drug products primarily used for the treatment of asthma and diabetes as indicated above. The Plan retains the final discretionary authority on what constitutes an asthma or diabetic prescription drug product. This list is subject to periodic review and modification.

Copayment/Coinsurance Maximum
The total Copayment/Coinsurance Maximum per year for Generic, Preferred or Special Case Medication is $2,580 per person. Only Non Preferred Drugs being purchased with a Drug Override, accumulate toward the Copayment/Coinsurance Maximum. Purchases of Generic, Preferred, Special Medications and drugs purchase with a Drug Override in excess of the Member's Copayment/Coinsurance Maximum will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Oral Anti Cancer medication –Refer to the separate rider attached to this benefit description.

Performance Drug List

The Preferred Drug List (PDL) provides You a number of Generic and Preferred Brand Name Drug options to lower cholesterol, reduce stomach acid and treat high blood pressure. We encourage You to take the PDL with You to Your medical appointments so that you can discuss your prescription therapy options with Your physician. Using Generic drugs will save You and the Plan money.

Under the Performance Drug List, members are encouraged to use Generic and Preferred Brand Name drugs when appropriate. . Non Preferred Brand Name Drugs in the following three classes are covered by the Plan, if You have a history of having tried at least one (1) Generic option in the same class. The three (3) class of drugs are: drugs used for cholesterol lowering - statin medications (HMG's - 3-hydroxy-3-methyl-glutaryl), long-lasting reduction of gastric [stomach] acid production (PPIs - proton pump inhibitors), and high blood pressure medications (ARB's - Angiotensin II Receptor Blockers). The Caremark claim system will review Your claims history to determine whether or not You have a prior history of using a Generic product in the same therapeutic class before a claim for a Non Preferred Brand Name Drug will be paid by the Plan. The Coinsurance for all claims will be determined based on the coverage tier (Generic, Preferred Brand Name or Non Preferred Brand Name drugs) for the medication purchased.

Injectable Medications

Coverage for Injectable drugs under this Plan is limited to those medications that have been designated by the Plan Sponsor. A list of designated medications is available on the web at **http://www2.caremark.com/kse/** or **www. sehbp.org***.)* This list is subject to periodic review and modification. The Injectable treatment must be medically necessary and appropriate for the condition being treated. Some Injectable Medications are available through the Specialty Pharmacy program for home delivery. For those injectable items that require a medical professional to administer the drug, the cost for that injection is not covered under this Plan. These charges should be billed to your medical insurance.

Specialty Drugs

The complete list of Specialty Drugs is available on the web at: **http://www2.caremark.com/kse/** or **www. sehbp.org***.)* For members with Specialty Drugs, Caremark will enroll You in the Specialty Pharmacy program. The Specialty Pharmacy program focuses on patients who have complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Should you be prescribed a drug on the Specialty Drug List simply call Caremark Connect at 1-800-237-2767. Caremark will coordinate getting the prescription from the doctor, if necessary and work with You to set up delivery. As these products often require special handling, You can schedule drug delivery to Your home, office, doctor's office, local pharmacy or other location you designate. The medication along with any necessary supplies (at no additional cost) will typically be shipped overnight to you. You will not be charged any shipping charges. You will need to provide Caremark with payment information for your share of the drug cost.

You will be assigned a case manager who will be in contact with You on a regular basis to answer any question You may have regarding treatment, side effects and therapy compliance. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve You, Your physician, nurse, case manager, and clinical pharmacist in a coordinated and monitored course of treatment. In addition, You will have access to pharmacist or nurses 24 hours a day, seven days a week should you have any question or concerns about therapy. This program offers You a convenient source for these Specialty Drugs, lower potential drug–to-drug interactions and improved therapy compliance.

Tobacco Control Wellness Program

Prescription Drugs for:	Prescription Drug Product	Member Responsibility Per 30 Day Supply
Tobacco Control	**Generic Drug**	**10% to a maximum of $10**
	Brand Name Drug	**20% to a maximum of $20**

Tobacco Control Wellness Program

Enrollment in an approved tobacco control program is recommended with use of these prescription medications.

Information on the HealthQuest tobacco control program available to You at no cost is available on the State of Kansas website at: **www. sehbp.org**. The Plan retains the final discretionary authority on what constitutes tobacco control prescription drug products. This list is subject to periodic review and modification.

Weight Management Wellness Program

Prescription Drugs for:	Prescription Drug Product	Member Responsibility
Weight Control	**Generic Drug**	**20% Coinsurance**
	Preferred Brand Name Drug	**35% Coinsurance**
	Non Preferred Brand Name Drug	**60% Coinsurance**

Weight Management Wellness Program
Enrollment in an approved weight management program is recommended with use of weight control prescription medications. The Plan will pay as indicated above toward the cost of weight control prescription drug products. Information on HealthQuest weight control programs available to You at no cost is available on the State of Kansas website at: **www. sehbp.org**. The Plan retains the final discretionary authority on what constitutes weight management or weight control prescription drug products. This list is subject to periodic review and modification.

Initial Prescription Drug Product Purchase
Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy which ever is less.

Refill Guidelines
Refills for up to a sixty (**60) day supply** may be obtained at one time for most medications. The refill prescriptions must be filled within one hundred and twenty (120) days of the prior fill and must be for the same strength of Prescription Drug Product. If not filled within one hundred and twenty (120) days of the prior fill or if the drug strength changes, only a thirty (30) day supply will be allowed. Refills may be obtained on the following schedule:

Supply of Prescription Product	*Percentage Consumed*	Refill Available After
5 Day Supply	**40%**	**2 Days**
10 Day Supply	**60%**	**6 days**
21 Day Supply	**70%**	**15 Days**
30 Day Supply	**75%**	**22 Days**
60 Day Supply	**75%**	**45 Days**

Advance Purchases
Advance Purchase of Prescription Drug Products are available for active employees only who will be departing the U.S. for an extended period of time. Copayment and Coinsurance will be the applicable Network Pharmacy payments are required for each thirty (30) day supply or standard unit of therapy received. Active employees may contact their Human Resource office to obtain the Advance Purchase Certificate. The completed form must be signed by both the You and an agency employee with the authority to expend agency funds, and submitted to the State Employee Health Plan office **15 days in advance** of the anticipated departure date. Up to a one (1) year supply of medications may be obtained if the request is approved.

- When adequate time is not available to submit an Advance Purchase Request or purchases are made outside of the country the cardholder may submit the pharmacy receipts for reimbursement upon return from the extended absence. In order to be considered for reimbursement, the patient must have continuous coverage for the entire period of absence. Prescription drugs purchased by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks 66605.

- Prescription Drug Products purchased and used while outside the United States must include

documentation of the purchase to include the original receipt that contains the patient's name, the name of the product, day supply and quantity purchased and price paid. An English translation and currency exchange rate for the date of service is required from You in order to process the claim. Only prescription drug that is eligible for payment under this Plan may be claimed for reimbursement. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks 66605.

Home Delivery

Caremark offers home delivery through the mail that may save You money on Your prescription drug services. The Home Delivery option is a convenient and cost effective way to obtain Your medication through the mail to any location in the United States. **The maximum supply available is a sixty (60) day supply.** All supply limits and plan requirements apply to mail order pharmacy purchases.

If You have an ongoing prescription and wish to start home delivery, Caremark will work with you and your physician to get you enrolled in home delivery. Simply call FastStart toll free at **(866) 772-9503**. You must have Your prescription information as well as Your physician's telephone and FAX numbers available for the representative. Caremark will call Your physician directly for Your prescription information and enroll You for mail service as soon as Your physician provides the necessary information. You will need to provide Caremark with payment information for your share of the drug cost.

If you have paper prescription, to begin home delivery, send the original prescription along with the Mail Order Service Profile form (available at **http://www2.caremark.com/kse/** or **www. sehbp.org***)* or by calling **1-800-294-6324**) to Caremark. You will need to include your payment information for your share of the drug cost.

New prescriptions and refills will typically arrive directly at Your home within 10-14 business days from the day You mail Your order. The mail order pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than plan maximums per fill, the mail order pharmacy will fill the exact quantity prescribed.

For refills:

The prescription label lists the date when You can request a refill and shows how many refills You have left. Refill prescriptions on the Internet by visiting **http://www.caremark.com**. Have Your prescription number, date of birth and credit card information ready. You can also order refills by phone or through the mail. To use the automated phone service, call the toll-free number on the prescription label and have the prescription number, ZIP code and credit card information ready. Or, mail the refill slip and payment to **Caremark.com** in the envelope that was included with Your previous shipment.

Paper Claims

Members will need to file a paper claim for the following situations:

- **Anytime Prescription Drug Products are purchased from a Non Network Pharmacy.**

- If You do not present Your Identification Card at a Network Pharmacy and are charged the retail cost of the Prescription, You will be responsible for filing a paper claim for reimbursement. (The Caremark Help Desk **1-800-364-6331** can assist in transmitting a claim on-line if the Member does not have their Identification Card available.)

- If a Prescription Drug Product requires prior authorization and it has not been obtained, the Member may pay the full purchase price for the Product and submit a claim along with documentation for consideration of coverage under the Plan. Payment is not guaranteed by the Plan.

In any of these situations, You must pay full retail price at the pharmacy. A claim form should then be completed and sent (along with the original receipt and any additional information) to: **Caremark / P.O. Box 52136 /Phoenix, AZ 85072-2136**. Reimbursement to the Member for the cost of the prescription is limited to the Allowed Charge a Network Pharmacy would have been paid, less applicable Coinsurance or Copayments. Claim forms can be found on the internet at https://kse.advancerx.com.

Time Limit for Filing Claims

You are responsible for making sure the Network Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Network Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

Section 3 Coordination of Benefits

Coordination of Benefits with Medicare as Primary

When Medicare is primary, the Plan will pay the balance of the Medicare Allowed Charge in full.

Coordination of Benefits with Commercial Insurance

Only prescription drug products covered under this Plan are eligible for payment. The Allowed Charge will be the amount allowed but not covered by the other plan. Payments are subject to this Plan's applicable Coinsurance, Copayments and Plan provisions and limitations.

Order of Benefit Determination

If You are covered under more than one group plan providing drug coverage, the plan that covers You as an active employee is primary to the plan that covers You as a dependent (spouse or child) or retired employee, unless otherwise required by Medicare.

Determination of primary/secondary coverage for dependent children will be based upon the "birthday rule" unless otherwise required by court order or by law. The primary plan is the plan of the parent whose birthday is earlier (month and day) in the year.

If the parents are not married or separated (whether or not they were married) or are divorced, and the court decree does not allocate responsibility for health care or expenses, the order of benefit determination will be as follows:

a) The plan of the custodial parent;
b) The plan of the spouse of the custodial parent;
c) The plan of the noncustodial parent, and then
d) The plan of the spouse of the noncustodial parent.

Section 4 Prior Authorization

Certain Prescription Drug Products require Prior Authorization to be covered by the Plan. Prior Authorization is usually initiated by Your physician or pharmacist on Your behalf, however it remains Your responsibility. If these Prescription Drug Products are not authorized before being dispensed, You will be responsible for paying the full retail charge. In this case, You will need to submit a paper claim with supporting documentation to allow for consideration under the Plan. The Plan retains the final discretionary authority regarding coverage by the Plan. The following list of medications requires Prior Authorization to be covered. This list is subject to periodic review and modifications:

ADHD/Narcolepsy
- Adderall
- Adderall XR
- Amphetamine-Dextroamphetamine
- Amphetamine-Dextroamphetamine SR
- Desoxyn
- Dexedrine
- Dextrostat
- Vyvanse

Anemia
- ***Aranesp***
- ***Epogen***
- ***Procrit***

****Arthritis Agents***
- ***Humira***

****Asthma***
- ***Xolair***

****CAPS***
- ***Arcalyst***

Ilaris
Kineret

****Cystic Fibrosis***
Cayston
Pulmozyme
Tobi

Diabetic
Byetta
Symlin
Victoza

****Growth Hormones***
Norditropin

****Hematopoietics***
Mozobil
Neumega

****Hepatitis C***
Copegus
Infergen
Intron A
Pegasys
Peg-Intron
Rebetol
Ribavirin
Ribasphere

****Hereditary Angioedema***
Kalbitor

****Hormonal Therapies***
Eligard

****Inflammatory Bowel Disease***
Humira
Cimzia

****Lysosmal Storage Disorders***
Zavesca

Migraine
Amerge
Axert
Frova
Imitrex Nasal Spray
Imitrex Tablet
Imitrex Injection
Maxalt
Maxalt MLT
Relpax
Treximet
Zomig
Zomig Nasal Spray
Zomig ZMT

****MS Drugs***
Betaseron
Copaxone
Extavia
Rebif

****Neutropenia***
Leukine
Neulasta
Neupogen

****Oncology***
Afinitor
Gleevec
Hycamtin capsules
Intron A
Iressa
Nexavar
Oforta
Revlimid
Sprycel
Sutent
Tarceva
Tasigna
Temodar
Thalomid
Tykerb
Vidaza
Votrient
Xeloda
Zolinza

****Osteoporosis***
Forteo
Prolia

Pain
Stadol Nasal Spray

****Pulmonary Arterial Hypertension***
Letairis
Revatio
Tracleer
Ventavis

****Renal***
Senispar

****Rheumatoid Arthritis***
Humira

Tretinoin Products
Altinac
Atralin
Avita
Retin-A
Retin-A Micro
Tretin-X
Tretinoin
Ziana

****Other Drugs***
Actimmune
Botox
Crinone
Dysport
Exjade
Myobloc
Nplate
Ocetrotide acetate
Promacta
Sandostatin
Somatuline
Somavert
Vivitrol
Xenazine

**** Drugs highlighted in bold italic type are Specialty Drugs available through the Caremark Specialty Pharmacy only. For Specialty Drugs* call Caremark Connect: 1.800.237.2767.**

Section 5 Drug Override

If You are taking a Non Preferred Drug and can show that You tried at least **two (2)** different Preferred Drugs in the same therapeutic class, Your physician may call the Caremark Prior Authorization Department at 1-800-

294-5979 (for physician use only) to request a drug override. Approvals will be granted in the following situations:

1) The patient has used at least two (2) Preferred Drugs, one of which was a generic drug **and**
a) The Preferred Drugs were ineffective for the patient, or
b) The patient could not tolerate the Preferred Drugs

or

2) The patient meets other pre-established clinical criteria approved by the Plan Sponsor.

If the request is approved, an override will be entered to allow the Non Preferred Drug to be paid for at the Preferred Drug Coinsurance. Non Preferred Drugs which have been approved for an override based on the above criteria will count toward the Coinsurance/Copayment maximum.

Section 6 Fraudulent, Inappropriate Use or Misrepresentation

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

a. Misrepresent or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State of Kansas Drug Plan identification card to obtain services, supplies or medication that are not prescribed or ordered for You or a covered family member or for which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

b. Permitting the unauthorized use of Your State of Kansas Drug Plan identification card to obtain medication, services or supplies for someone not covered under Your State of Kansas Prescription Drug membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

c. Using another State of Kansas member's Prescription Drug Plan identification card to obtain medication, services or supplies for You or some other third party not specifically covered under that membership may result in the termination of your coverage and that of your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

Section 7 External Review

Procedure For Pursuing An External Review
The Covered Member has the right to request an External Review when the reason for the final second appeal and notice of an Adverse Benefit Decision was that the prescription drug was not medically necessary or was experimental or investigational. The TPA will notify the Covered Member in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 90 days of receipt of the notice of the second appeal and notice of the Adverse Benefit Decision, the Covered Member, the treating Physician or health care provider acting on behalf of the Covered Member with written authorization from the Covered Member, or a legally authorized designee of the Covered Member must make a written request for an External Review to the State Employee Health Plan, 900 SW Jackson, Rm. 900 N, Topeka, Kansas 66612. The State Employee Health Plan will work with the Kansas Insurance Department to obtain an external review.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Covered Member and other involved parties as to whether the request for External Review is granted.

For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Covered Member and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts. A Covered Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law. The Covered Member shall have the option of designating which External Review process will be utilized.

Section 8 Exclusions

The plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit referenced in Section 2.
2. Drugs which are prescribed, dispensed, or intended for use while You are an inpatient in a hospital or other facility.
3. Benefits are not available to the extent a Prescription Drug Product has been covered under another contract, certificate or rider issued by the Plan Sponsor.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
9. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
10. Replacement Prescription Drug Products resulting from lost, stolen or spilled Prescription Orders or Refills.
11. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
12. Prescription Drug Products that are not medically necessary.
13. Charges to administer or inject any drug.
14. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
15. Prescription Drug Products for which there is normally no charge in professional practice.
16. Contraceptive devices, therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
17. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
18. Experimental, investigational, or unproven prescription drug products, treatments or therapies.
19. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
20. Health care services and drugs customarily provided by the research sponsors of a clinical trial free of charge for any insured participating in a clinical trial.
21. Charges for the delivery of any drugs.
22. Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
23. Prescription Drug Products approved for experimental use only.

24. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
25. Coverage for allergy antigens under any circumstances.
26. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.

ORAL ANTI-CANCER PRESCRIPTION DRUG PRODUCT RIDER

This rider outlines the coverage provided for oral anti-cancer prescription drug products.

Definitions:

Allowed Charge – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance, the Allowed Charge will be the amount allowed but not paid by the other plan subject to the coverage provisions of this Plan.

Oral Anti-Cancer Prescription Drug Product – orally administered Prescription Drug Products used to kill or slow the growth of cancerous cells.

Specialty Drugs - Utilized by a small percentage of the population with rather complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Specialty drugs may require specialized delivery and are administered as injectable, inhaled, oral or infusion therapies. The major conditions these drugs treat include some cancer medications. Coverage under the drug plan is limited to medications that have been designated by the plan as Specialty Drugs and are either self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the Caremark Specialty Mail Order Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

Standard Unit of Therapy – Up to a thirty (30) consecutive day supply of Prescription Drug Product, unless adjusted based on the drug manufacture's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

Benefit Provisions:

Coverage for Outpatient Prescription Drug Products:

The plan provides coverage for Prescription Drug Products, if all of these conditions are met:

(1) You are an eligible Member in the Plan; and
(2) it is Medically Necessary;
(3) it is obtained through a Network Retail, Network Home Delivery, or a Non Network Retail Pharmacy;
(4) Specialty Drugs for self administration or self injection must be obtained from the Caremark Specialty Pharmacy;)
(5) the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines.

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Network Pharmacy, the Member's payment shall not exceed the Allowed Charge when You present Your identification card to the pharmacy as required. When a Non Network Pharmacy is used, You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance. Benefits for services received from a Retail Non Network Pharmacy will be paid to the primary insured. You can not assign benefits under this program to any other person or entity. Prior authorization may be required for some prescription products.

To be eligible for coverage under the Plan, Specialty Pharmacy products that are self-administered or self injected must be purchased from the Caremark Specialty Pharmacy. Should you be prescribed a drug on the Specialty Drug list, simply call Caremark Connect at 1-800-237-2767. Caremark offers home delivery through the mail of most prescription products. The Home Delivery option is a convenient way to obtain Your medication through the mail at any location in the United States.

A complete list of Anti-Cancer Prescription Drug Products is available at http://www2.caremark.com/kse/ or

www. sehbp.org. The Plan retains the final discretionary authority regarding coverage by the Plan. This list is subject to periodic review and modification.

Oral Anti-Cancer Prescription Drug Products	
Coverage	**Member Responsibility**
Coinsurance	25% Coinsurance to a Maximum of $75 dollars per Standard Unit of Therapy
Coinsurance Maximum	$750 per member per year

Oral Anti-Cancer Prescription Drug Products:

Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed $75 per standard unit of therapy for covered Anti Cancer Prescription Drug Products. You pay Coinsurance until You reach the Coinsurance Maximum of $750 per member per year. Once the Coinsurance Maximum has been met, the Plan pays 100% of the Allowed Charged for covered Oral Anti-Cancer Prescription Drug Products covered under this rider for the remainder of the calendar year.

Initial Prescription Drug Product Purchase

Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy whichever is less. Some products may be subject to additional supply limits adopted by the Plan. Specialty Medications are limited to a 30 day supply.

Refill Guidelines

Refills for up to a sixty (**60) day supply** may be obtained at one time for most medications. The refill prescriptions must be filled within one hundred and twenty (120) days of the prior fill and must be for the same strength of Prescription Drug Product. If not filled within one hundred and twenty (120) days of the prior fill or if the drug strength changes, only a thirty (30) day supply will be allowed. Refills may be obtained on the following schedule:

Supply of Prescription Product	*Percentage Consumed*	Refill Available After
5 Day Supply	**40%**	**2 Days**
10 Day Supply	**60%**	**6 days**
21 Day Supply	**70%**	**15 Days**
30 Day Supply	**75%**	**22 Days**
60 Day Supply	**75%**	**45 Days**

Time Limit for Filing Claims

You are responsible for making sure the Network Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Network Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

Exclusions:

The plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit allowed under this rider.
2. Drugs which are prescribed, dispensed, or intended for use while You are an inpatient in a hospital or other facility.
3. Benefits are not available for any Prescription Drug Products for which a claim for benefits has already been processed under another contract, certificate or rider issued by the Plan Sponsor.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided

or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.

5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable and Prescription Drug Products administered by a Health Professional in an inpatient or outpatient setting.
9. Prescription Drug Products that the Plan determines are not medically necessary.
10. Experimental or unproven prescription drug products, treatments or therapies.
11. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
12. Health care services and drugs customarily provided by the research sponsors of a clinical trial free of charge for any insured participating in a clinical trial.
13. Charges to administer or inject any drug.
14. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
15. Prescription Drug Products for which there is normally no charge in professional practice.
16. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
17. Charges for the delivery of any drugs.
18. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
19. Replacement Prescription Drug Products resulting from lost, stolen or spilled Prescription Orders or Refills.