CVS CAREMARK

Your Prescription Benefit

PLAN C
Prescription Drug Benefit Description

Herein called "Description"

Plan C Prescription Drug Program For State of Kansas Employees Health Plan

This booklet describes the Plan C Prescription Drug benefits available through the State of Kansas program. The prescription drug program is underwritten by the State of Kansas and administered by CVS 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 CVS Caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. CVS 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:

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

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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.

Discount Medications – are medications with primary indications for use are: 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.

Health Plan Deductible – The amount You are required to pay out of your pocket before eligible medical or prescription drug claims will be reimbursed by the Plan.

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 CVS 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 CVS Caremark to provide Prescription Drug Products to Members or agreed to accept the CVS 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.

Out of Pocket Maximum – The annual limit of a Member's payments for Covered Services, as specified in the Health Plan Schedule of Benefits. The Out of Pocket maximum includes Deductible, Coinsurance and Copayments for eligible medical and pharmacy expenses paid by the member.

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 medications are prescription or nonprescription. Nonprescription or OTC drugs are medications 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 – 3hydroxy-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 medications. 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 CVS 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.

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. 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 CVS Caremark Specialty Mail Order Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

Standard Unit of Therapy – a manufacturer's pre-packaged quantity or an amount sufficient for one course of treatment at normal dosages.

Tobacco Control – a program that encourages members to discontinue using tobacco products and reduce 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. the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines;
4. it is obtained through a Network Retail, Mail order or Online Pharmacy or a Non Network Retail pharmacy;
5. Specialty Drugs for self administration or injection must be obtained from the CVS Caremark Specialty Pharmacy;

Plan C - Prescription Drug Benefits

Coverage Level	Health Plan Annual Deductible	Health Plan Annual Out of Pocket Maximum Network
Single	**$2,500**	**$2,500**
Family	**$5,000**	**$5,000**

Out of Pocket Maximum
Once the combine medical and prescription drug Deductible and Out of Pocket Maximum is met, additional eligible pharmacy claims will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Coverage Level	Prescription Drug Product	Coverage
Tier One	**Generic Drugs**	Covered prescription drugs are subject to the combined medical and drug Deductible of $2,500 for single and $5,000 for a family. After the Deductible has been satisfied, the plan pays covered prescription drugs at 100% for the remainder of the Plan Year.
Tier Two	**Preferred Drugs**	
Tier Three	**Non Preferred & Compound Medications**	
Tier Four	**Oral Cancer Medications**	

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Deductible, 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 provided that 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 Deductible. 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 CVS 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 or Injectable List is available at:
http://www2.caremark.com/kse/ or **www.kdheks.gov/hcf/sehp**.

***Generic Prescription Drug Products*:**
All prescription Generic drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plan pays 100% of the Allowed Charge for covered prescription drugs.

Preferred Brand Name Prescription Drug Products*:*
All Preferred Brand Name Prescription Drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plan pays 100% of the Allowed Charge for covered prescription drugs. The Preferred Drug List is subject to periodic review and modification.

Non Preferred Brand Name Drug Products:
Eligible Non Preferred Brand Name Drug Products (those not included on the Preferred Drug List) are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plan pays 100% of the Allowed Charge for covered prescription drugs.

Compound Medications:
Eligible Compound medications are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plan pays 100% of the Allowed Charge for covered prescription drugs. CVS Caremark Mail Order Pharmacy is a contracting compounding pharmacy. Claims for Compound Medications submitted for reimbursement must contain more than one (1) Legend Drug ingredient. If you use a Non Network pharmacy, you will need to submit a paper claim for reimbursement. You will need to obtain the following information from the pharmacy to complete the claim form:

- List the **VALID 11 digit National Drug Code (NDC) number for EACH ingredient** used in the compound prescription.
- List the ingredient name for each NDC number.
- Indicate the "metric quantity" expressed in number of tablets, grams or milliliters for each ingredient NDC Number.
- Indicate the cost for EACH ingredient (dollar amount).
- Indicate the TOTAL compounded quantity.
- Indicate the TOTAL dollar amount paid by the patient.

Please Note-If an ingredient cost is $0, a valid NDC number and quantity for the ingredient is still required. The total cost of all the ingredients in the compound must be less than the total dollar amount paid by the member for the compound.

Contraceptive Medications:
Contraceptives that are listed on the Preferred Drug List (PDL) are covered at 100% by the plan. If You elected to use a contraceptive that is not on the PDL, the medication will be subject to the plan Deductible and Coinsurance.

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.kdheks.gov/hcf/sehp. 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.

Oral Cancer Medications
Oral Cancer Medications are drugs that have been designated by the Plan as anti-cancer medication used to kill or slow the growth of cancerous cells. A complete list of eligible oral anti-cancer drugs are available at:

http://www2.caremark.com/kse/ or **www.kdheks.gov/hcf/sehp**. Once the Deductible is satisfied, the Plans pays eligible prescription drugs at 100% of the allowed amount for the remainder of the Plan Year. The Plan retains the final discretionary authority on what constitutes an oral anti-cancer prescription drug product. This list is subject to periodic review and modification.

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, Generic and Preferred Brand Name drugs are available and considered a first line therapy. 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. 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 CVS 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.

Specialty Drug

Specialty drugs are medications that have been designated by the Plan. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the CVS Caremark Specialty Pharmacy. The list of Specialty Drugs medications is subject to periodic review and modification. All Specialty Drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plans pays eligible prescription drugs purchased from the Caremark Specialty Pharmacy at 100% of the allowed amount for the remainder of the Plan Year.

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, CVS 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 CaremarkConnect at 1-800-237-2767. CVS 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 CVS 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
Enrollment in an approved tobacco control program is recommended with use of these tobacco control prescription medications. The HealthQuest tobacco control program available to You at no cost is available on the State of Kansas Web site at: **www.KansasHealthquest.com**. Prescription drugs for tobacco control are covered by the plan and subject to the Plan Deductible and Out of Pocket Maximum.

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.KansasHealthquest.com**. Prescription drugs for weight management are covered by the plan and subject to the Plan Deductible and Out of Pocket Maximum.

Women's Preventive Care Services
The Plan will pay 100% of the Allowed Charge for prescription contraceptive medications listed on the Preferred Drug List. If you and your health care provider select a prescription contraceptive medication not listed on the Preferred Drug List, the claim will be processed as a Non Preferred Brand Name Drug Product (see coverage section for Non Preferred Brand Name Drug Products). The list of covered prescription contraceptive medications is subject to periodic review and modification. Items which are classified as Over-The-Counter (OTC) are not eligible for coverage under this Plan.

Initial Prescription Drug Product Purchase
Covered Prescription Drug Products are subject to the initial fill limit of thirty-one (31) consecutive day supply or one standard unit of therapy whichever is less.

A standard unit of therapy is up to a thirty-one (31) consecutive day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

Refill Guidelines

Prescriptions may be filled through retail locations or Mail Order for up to a **ninety-three (93) day supply**. Refills for up to a ninety-three (93) day supply may be obtained at one time for most medications. The refill prescriptions must be for the same strength of Prescription Drug Product. 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
31 Day Supply	75%	23 Days
62 Day Supply	75%	46 Days
93 Day Supply	75%	75 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. The applicable Plan Deductible, Coinsurance and Copayments are required for each thirty-one (31) day supply or standard unit of therapy received. Purchases must be made at a Network Pharmacy other than the CVS Caremark Mail Order Pharmacy. 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. If drugs cross the plan year, the plan deductible and Coinsurance will apply.

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.

For Prescription drugs purchased in the United States 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 66612.

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 66612.

Home Delivery Pharmacy
CVS Caremark offers a home delivery service that may save You money on Your prescription drug services. The Home Delivery Pharmacy is a convenient and cost effective way to obtain Your medication through the mail to any location in the United States. **Home Delivery is limited to a 93-day supply and may be dispensed with member paying the applicable Deductible and out of pocket maximum.** All supply limits and plan requirements apply to home delivery pharmacy purchases.

If You have an ongoing prescription and wish to start home delivery, CVS 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. CVS 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 CVS 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.kdheks.gov/hcf/sehp** or by calling **1-800-294-6324)** to CVS 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 7-10 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 **CVS Caremark** 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 CVS 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: **CVS 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 Deductible and/or Coinsurance. Claim forms can be found on the internet at http://www.caremark.com/portal/asset/KSE_Claim.pdf.

Discount Medications:

If You purchase a medication designated by the Plan as a Discount Only Medication, You will be responsible for 100% of the Allowed Charge. The Allowed Charge is the CVS Caremark contracted reimbursement rate, and provides You with a discount off the retail price of the medication. **Discount Medications do not count toward meeting your Health Plan Deductible or Out of Pocket Maximum.**

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. The Plan retains the final discretionary authority on what constitutes a discount medication. This list is subject to periodic review and modification.

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 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 Deductible, 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 Other Plan Provisions

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 Your 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.

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.

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. Experimental, Investigational, Educational or Unproven Services, technologies which include medical, surgical, diagnostic, psychiatric, substance abuse, or other health care, supplies, treatments, procedures, drug therapies or devices.
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 damaged, 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. 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. Charges for the delivery of any drugs.
19. Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
20. Prescription Drug Products approved for experimental use only.
21. 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.
22. 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.
23. Coverage for allergy antigens under any circumstances.
24. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.
25. Drugs imported for use in the United States from foreign countries.