

Plan A
Prescription Drug Benefit Description
Herein called "Description"

Plan A 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 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:

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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 claims for compounds must list the 11 digit National Drug Code (NDC) for each ingredient used in the compound, 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.

Discount Medications – are medications **NOT** Covered by the Plan but the Plan has a negotiated discount with Network Pharmacies when purchased. 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 & nasal steroids; 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 covered under this plan include drugs that are intended to be self-administered by the Member and/or a family member as well as some injectable drugs 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. **(5)** For Non Covered Prescription Drug Products to be considered for coverage, You must have had an unsuccessful trial with one or more prescription drug listed on the Preferred Drug List for treatment of the condition. Non Covered Prescription Drug Products require Prior Authorization by the Plan and must meet all of the above Medical Necessity criteria to be considered for coverage. Your physician must contact the Plan to obtain Prior Authorization before a Non Covered Prescription Drug Product is eligible for coverage. 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 Product to Members and has agreed to accept specified reimbursement rates.

Non Covered - Prescription Drug Products for which reimbursement by the Plan is not available. The decision as to what Prescription Drug Products are not covered is determined by the Plan and subject to periodic review and modification.

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 - Covered FDA approved prescription drug products that are not listed on the Preferred Drug List and are not considered to be Non Covered drugs by the Plan.

Out of Pocket Maximum - The combined total amount You will pay in Coinsurance and Copayments for covered medications each Plan Year.

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 - 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: www.Caremark.com.

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. 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 - Up to a thirty (30) consecutive day supply of 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.

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. it is obtained through a Network Retail, Network Home Delivery or a Non Network Retail Pharmacy;
4. Specialty Drugs for self administration or injection must be obtained from the CVS Caremark Specialty Pharmacy;
5. the Prescription Drug Product is a covered service 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
Tier Four	Non Preferred & Compound Medications	60% Coinsurance
Out of Pocket (OOP) Maximum	Applies to Tiers One through Four	Combined Medical & Pharmacy Individual \$4,750 Family \$9,500

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 injected must be purchased from the CVS Caremark Specialty Pharmacy. You cannot assign benefits under this program to any other person or entity. Non Covered Prescription Drug Products are not eligible for payment under the Plan unless Prior Authorization has been obtained and the prescription is considered to be Medical Necessity by the Plan Information on the Performance Drug List, Preferred Drug List, Special Case List, Self Injectable List or Specialty Drug List is available at: www.Caremark.com or www.kdheks.gov/hcf/sehp/Caremark.htm

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 day supply, Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed \$75.

Non Preferred Brand Name Drug Products:

For covered Non Preferred Brand Name Drug Products Your Coinsurance is 60% of the Allowed Charge.

Compound Medications:

CVS Caremark Mail Order Pharmacy is a contracting compounding pharmacy. The Coinsurance will be 60% of the Allowed Charge of the Compounded Medication. All medications with a total cost of \$300 must be Prior Authorized by the Plan.

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.

ALL Compound drugs with a TOTAL cost of over \$300 must be Prior Authorized by the Plan.

Failure to do so will result in the denial of the claim.

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.

The Plan reserves the right to review all compounded claims and exclude any excessive charges including but not limited to charges for bases and bulk compounding powders.

Exclusion of Select Topical Analgesics: Select topical analgesics will be excluded from coverage by the Plan. Compounded claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are Non Covered services. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.

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 available at: <http://www.Caremark.com> or www.kdheks.gov/hcf/sehp 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.

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 pharmacists 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.

Chronic Care Benefit

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

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 for medications on the Preferred Drug List. Non Preferred drugs are not eligible for lower coinsurance and copayments. 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.

Discount Medications

Discount medications are Non Covered medications under this Plan. You will be responsible for paying 100% of the Allowed Charge for discount medications. The Allowed Charge is the CVS/Caremark contracted reimbursement rate, and provides members with a discount off the retail price of these Non Covered 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 & nasal steroids; 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.

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

www.Caremark.com or www.kdheks.gov/hcf/sehp/Caremark.htm

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.

Out of Pocket (OOP) Maximum

The Out of Pocket (OOP) Maximum for covered services in combination with the medical OOP under Plan A is \$4,750 per individual and \$9,500 per family. Once Your combined network medical and pharmacy OOP cost reaches the OOP Maximum, any additional covered medications under this Plan will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Note: Discount medications and Non Covered Prescriptions Drug Products are not covered expenses under this Plan and therefore do not count toward the OOP Maximum and are not covered at 100% once the OOP maximum has been satisfied.

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 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.

Preventive Care

The following prescription and OTC items will be covered at 100% of the allowed charge by the Plan when purchased with a prescription from your physician. For OTC items, you will need to present a physician's prescription to a Network pharmacy and have the claim run through the Caremark claim system or submit a paper claim with all proper documentation.

- Adults 65 and over: Vitamin D
- Adults 45 and over: Aspirin
- Woman 55 and over : Folic Acid
- Children 6 and under: Oral fluoride

- Infants 1 year and younger: Iron Supplements
- Tobacco Cessation Products

Tobacco Control Wellness Program

The Plan will pay 100% of the allowed amount for Preferred tobacco control products. The Plan retains the final discretionary authority on what constitutes a Preferred tobacco control drug products. This list is subject to periodic review and modification. For covered OTC products, you will need to present your physician's prescription order for the OTC item to the Network pharmacy and request that the claim be run through the Caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

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.

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

The Plan will pay as indicated above toward the cost of weight control prescription drug products. 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.

Women's Contraceptive 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, you will be responsible for paying the Non Preferred Drug Coinsurance. The list of covered prescription contraceptive medications is subject to periodic review and modification. Female contraceptive products which are classified by the FDA as Over-The-Counter (OTC) are eligible for coverage under this Plan if purchased with a prescription from your Physician. This includes contraceptive products that are FDA approved emergency contraceptives. To access coverage, you will need to present the prescription for the OTC item to the Network pharmacy and request that the claim be run through the Caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

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.

Refill Guidelines

Refills for up to a sixty (60) day supply may be obtained at one time for most medications. Refills may be obtained on the following schedule:

For Non-Controlled Substance prescriptions, the refill threshold is set at 75 percent. This means that 75 percent of a plan member's day's supply must have lapsed before the prescription can be refilled.

For Controlled Substance prescriptions, the refill threshold is set at 80 percent. This means that 80 percent of a plan member's day's supply must have lapsed before the prescription can be refilled.

Advance Purchases

Advance Purchase of maintenance Prescription Drug Products is 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 as 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 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. The Plan will reimburse you based upon the Allowed Amount for the service. You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment.
- 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 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 Drugs Products that are 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

CVS/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, CVS/Caremark will work with you and your physician to get you enrolled in home delivery. Simply call FastStart toll free at **1-866-772-9503**. 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 prescriptions, to begin home delivery, send the original prescription along with the Mail Order Service Profile form (available at www.Caremark.com 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 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 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 Coinsurance or Copayments. Claim forms can be found on the internet at <https://www.caremark.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, 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:

**** Drugs highlighted in bold italic type on the following page are Specialty Drugs that require prior authorization review. Please have your physician call 1-866-814-5506.***

***ACROMEGALY**

octreotide
(SANDOSTATIN)
Micera
Sandostatin LAR Depot
Sandostatin LAR
Somatuline Depot
Somavert

ADHD/NARCOLEPSY

Adderall
Adderall XR
Amphetamine-
Dextroamphetamine
Amphetamine-
Dextroamphetamine SR
Desoxyn
Dexedrine
Evekeo
ProCentra
Vyvanse

***ALCOHOL AND OPIOID
DEPENDENCY**

Vivitrol

***ALLERGIC ASTHMA**

Xolair

***ALPHA1-
ANTITRYPSIN (AAT)
DEFICIENCY**

Aralast NP
Glassia
Prolastin-C
Zemaira

***ANEMIA**

Aranesp
Procrit

***BOTULINUM TOXINS**

Botox
Dysport
Myobloc
Xeomin

***CARDIAC DISORDERS**

Tikosyn

***CENTRAL PRECOCIOUS
PUBERTY (CPP)**

Leuprolide
Lupron

Depot-PED
Supprelin LA

***COAGULATION DISORDERS**

Ceprotin

***CRYOPYRINASSOCIATED
PERIODIC SYNDROMES
(CAPS)**

Arcalyst
Ilaris
Kineret

***CUSHING'S SYNDROME**

Korlym
Signifor

***CYSTIC FIBROSIS (CF)**

Bethkis
Cayston
Kalydeco
Kitabis Pak
Orkambi
Pulmozyme
TOBI Podhaler
tobramycin inhalation
solution (TOBI)

Diabetic

Trulicity
Victoza

***ELECTROLYTE DISORDERS**

Samsca

***GASTROINTESTINAL
DISORDERS – OTHER**

Cholbam
Gattex
Zorbtive

***GOUT**

Krystexxa

***GROWTH HORMONE (GH)
AND RELATED DISORDERS**

Humatrope

HEART FAILURE

Entresto

***HEMATOPOIETICS**

Mozobil

Neumega

***HEMOPHILIA AND RELATED
BLEEDING DISORDERS**

Advate
Alphanate
AlphaNine SD
Alprolix
Bebulin VH
BeneFIX
Corifact
Eloctate
Feiba NF
Feiba VH
Helixate FS
Hemofil M
Humate-P
Ixinity
Koate-DVI
Kogenate FS
Monoclate-P
Mononine
Novoeight
NovoSeven
Obizur
Profilnine SD
Recombinate
RiaSTAP
Rixubis
Stimate Nasal
Spray
Tretten
Wilate
Xyntha

***HEPATITIS C**

Harvoni
Pegasys
Peg-Intron
Ribavirin
Sovaldi

***HEREDITARY ANGIOEDEMA
(HAE)**

Berinert
Cinryze
Firazyr
Kalbitor
Ruconest

***HORMONAL THERAPIES**

leuprolide
Trelstar

***HUMAN IMMUNODEFICIENCY VIRUS (HIV)**

Fuzeon
Serostim

***IMMUNE THERAPIES**

Bivigam
Carimune NF
Cytogam
Flebogamma
GamaSTAN S/D
Gammagard
Gammaked
Gammaplex
Gamunex
Hizentra
HyQvia
Octagam
Privigen

***IMMUNE (IDIOPATHIC)**

THROMBOCYTOPENIA (ITP)

Nplate
Promacta

***INFECTIOUS DISEASE**

Actimmune
Alferon-N

***INFLAMMATORY BOWEL DISEASE**

Cimzia
Entyvio
Humira
Remicade
Simponi
Tysabri

***IRON OVERLOAD**

deferoxamine
(DESFERAL)
Exjade
Ferriprox
Jadenu

***LIPID DISORDERS**

Juxtapid
Kynamro

***LIPODYSTROPHY**

Myalept

***LYSOSOMAL STORAGE DISORDERS (LSD) AND RELATED DISORDERS**

Adagen
Aldurazyme
Cerdelga
Cerezyme
Cystagon
Cystaran
Elaprase
Elelyso
Fabrazyme
Lumizyme
Myozyme
Naglazyme
Orfadin
Procysbi
Vimizim
VPRIV
Zavesca

MIGRAINE

Alsuma
Amerge
Axert
Frova
Imitrex Nasal Spray
Imitrex Tablet
Imitrex Injection
Maxalt
Maxalt MLT
Relpax
Sumavel
Treximet
Zecuity
Zomig
Zomig Nasal Spray
Zomig ZMT

***MOVEMENT DISORDERS**

Apokyn
Northera
Xenazine

***MULTIPLE SCLEROSIS_ (MS)**

Aubagio
Betaseron
Copaxone
Gilenya
Rebif

***NEUTROPENIA**

Neulasta
Neupogen

***ONCOLOGY**

Afinitor
Bosulif
Capecitabine
Gleevec
Hycamtin Capsules Nexavar
Revlimid
Sprycel
Sutent
Tarceva
Targretin
temozolomide
Thalomid
Tykerb
Votrient
Zolinza
Zytiga

***OSTEOARTHRITIS (OA)**

Gel-One
Hyalgan
Supartz

***OSTEOPOROSIS**

Forteo

PAIN

Stadol NS

***PAIN MANAGEMENT**

Prialt

***PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)**

Soliris

***PHENYLKETONURIA_ (PKU)**

Kuvan

***PRE-TERM BIRTH**

Makena

***Psoriasis**

Cosentyx
Enbrel
Humira

Otezla
Otrexup
Rasuvo
Remicade
Stelara

Retin-A Micro
Tretin-X
Tretinoin
Veltin
Ziana

***PULMONARY ARTERIAL
HYPERTENSION (PAH)**

Letairis
sildenafil
Tracleer
Tyvaso
Ventavis

***UREA CYCLE DISORDERS**

Buphenyl
Carbaglu
Ravicti

***PULMONARY DISORDERS –
OTHER**

Esbriet
Ofev

***RENAL DISORDER**

Senispar

***RESPIRATORY SYNCYTIAL
VIRUS**

Synagis

***RETINAL DISORDERS**

Avastin
Eylea
Lucentis
Macugen
Visudyne

***RHEUMATOID ARTHRITIS (RA)**

Enbrel
Humira
Rasuvo

***SEIZURE DISORDERS**

Acthar
Sabril

***SLEEP DISORDER**

Hetlioz

***SYSTEMIC LUPUS
ERYTHEMATOSUS**

Benlysta

TRETINOIN PRODUCTS

Atralin
Avita
Retin-A

Section 5 Drug Tier 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 fax a letter documenting the medical necessity for the Prescription Drug Product to the CVS/Caremark Exception Review Department at 1-888-487-9257 (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 if available in the therapeutic class and
 - The Preferred Drugs were ineffective for the patient, **or**
 - 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.

Section 6 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 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.

Appeal and External Review

Definitions

The following terms are used herein to describe the claims and appeals review services provided by CVS/Caremark:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a covered Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a covered Plan benefit based on the application of a utilization review or on a determination of a plan Member's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate. The Plan's determination of a drug's particular coverage tier is not an Adverse Benefit Determination eligible for appeal or external review. For example, the Plan's designation of a drug a "Discount Medication" (Tier 5) is not considered an Adverse Benefit Determination and therefore is not eligible for appeal or external review.

Claim – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the Member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and

- Use of medication, service or product is not solely for the convenience of the Member, Member's family, or provider.

Discount Tier Services – Claims for Prescription Drug Products not covered by the Plan benefits as Discount tier items may not be appealed.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-authorization – CVS/Caremark pre-service review of a Member's initial request for a particular medication. CVS/Caremark will apply a set of pre- defined criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include Member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the Member, and/or could result in the Member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Member's condition, would subject the Member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS/Caremark will defer to the Member's attending health care provider as to whether or not the Member's Claim constitutes an Urgent Care Claim.

Claims and Appeals Process

Pre-authorization Review:

CVS/Caremark will implement the prescription drug cost containment programs requested by the Plan Sponsor by comparing Member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS/Caremark determines that the Member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on the Member's Claim, the Member may file an appeal of that determination. The Member's appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS/Caremark within 180 days after the Member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the Member and/or the Member's attending physician may submit an appeal by calling CVS/Caremark. The Member's appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS/Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The Member's appeal and supporting documentation may be mailed or faxed to CVS/Caremark:

CVS/Caremark Appeals Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-866-

CVS/Caremark Review:

The review of a Member's Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of any State and Federal laws. Members will be accorded all rights granted to them under relevant laws. CVS/Caremark will provide the first-level review of appeals of Pre-Service Claims. If the Member disagrees with CVS/Caremark's decision, the Member can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

Timing of Review:

Pre-Authorization Review – CVS/Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS/Caremark will make a decision on the Claim within 72 hours.

Pre-Service Claim Appeal – CVS/Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the Member's appeal. If CVS/Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the Member may appeal that decision by providing the information described above. A decision on the Member's second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the Member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

Post-Service Claim Appeal – CVS/Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

Scope of Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS/Caremark shall:

- Take into account all comments, documents, records and other information submitted by the Member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the Member in a manner consistent with how such provisions have been applied to other similarly-situated Members; and
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).
- If a Member appeals CVS/Caremark's denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:
 - Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
 - Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
 - Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination:

Following the review of a Member's Claim, CVS/Caremark will notify the Member of any Adverse

Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the Member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary:

CVS/Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS/Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS/Caremark is not responsible for the conduct of any second- level Medical Necessity review performed by an IRO. Likewise, CVS/Caremark is not responsible for the conduct of any State External Review conducted by an External Review Organization (discussed below).

Procedure For Pursuing An External Review

You have 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. CVS/Caremark will notify You in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 120 days of receipt of the notice of the second appeal and notice of the Adverse Benefit Decision, You, Your treating Physician or health care provider acting on Your behalf with Your written authorization, or Your legally authorized designee 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 You 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 You and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 72 hours 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. You may not pursue, either concurrently or sequentially, an External Review under both state and federal law. You 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. 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.
3. 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.
4. 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.
5. 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 and all required information must be provided on the claim.
6. Compound claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are Non Covered services. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law unless otherwise stated as eligible for coverage in this benefit description.
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 including damaged, lost, stolen or spilled Prescriptions.
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. Experimental, investigational, or unproven prescription drug products, treatments or therapies. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
19. 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.
20. Charges for the delivery of any drugs.
21. Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
22. Prescription Drug Products approved for experimental use only.
23. 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

24. Coverage for allergy antigens under any circumstances.

25. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.

Section 7 Oral Anti-Cancer Medication 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 CVS Caremark Specialty 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 manufacturer'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 injection must be obtained from the CVS 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 cannot 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 CVS Caremark Specialty Pharmacy. Should you be prescribed a drug on the Specialty Drug list, simply call CaremarkConnect at 1-800-237-2767.

CVS/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 Oral Anti-Cancer Prescription Drug Products is available at <http://www.Caremark.com> or www.kdheks.gov/hcf/sehp/default.htm. 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

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 Oral Anti-Cancer Prescription Drug Products. You will pay Coinsurance until You reach the Plan combined medical and pharmacy Out of Pocket Maximum. Once the Out of Pocket 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. The Plan retains the final discretionary authority on what constitutes an oral cancer prescription drug product.

This list is subject to periodic review and modification. 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, 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.

For Non-Controlled Substance prescriptions, the refill threshold is set at 75 percent. This means that 75 percent of a plan member's days supply must have lapsed before the prescriptions can be refilled.

For Controlled Substance prescriptions, the refill threshold is set at 80 percent. This means that 80 percent of a member's days supply must have lapsed before the prescription can be refilled.

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 and all necessary information must be provided on the claim.
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 including damaged, lost, stolen or spilled Prescriptions.