

COVERED SERVICES

- *Office visits* beyond the first 26 when *prior review* was not obtained
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities when age 18 or older. Residential treatment facilities are covered for *chemical dependency*.
- Benefits for psychiatric diagnostic interview are limited to one per year per *provider*
- Marriage Counseling

Pharmacy Benefits

Prescription Drug Copayment And Benefits

A *Pharmacy Benefit Manager (PBM)*, manages administration of the *prescription drug* benefit.

Your *prescription* benefit covers federal legend *prescription drugs*, injectable medications, insulin and certain over-the-counter medications. See "*Prescription Drug Benefits Exclusions*" for those drugs that are not covered by your health benefit plan.

Some *prescription drugs* may require *certification*, also known as prior approval, or be subject to step therapy or formulary coverage review in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy.

Some *prescription drugs* may be subject to quantity limits based on criteria developed by the *State Health Plan* or its representative. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure your *provider* has received prior approval before going to the pharmacy. To get a list of *prescription drugs* that require prior approval to be covered or require approval for additional quantities, you may call Pharmacy Customer Service at the number listed in "Whom Do I Call?" or visit the *State Health Plan* website. The *State Health Plan* or its representative may change the list of these *prescription drugs* from time to time.

Additionally, there may be some *prescription drugs* that are administered by a *provider* in a medical office that may be limited to coverage under your medical benefit.

For certification of your *prescription drugs*, your physician may call the *PBM's* Prior Authorization number listed in "Whom Do I Call?" to initiate a *certification* request.

Using A Contracting Pharmacy

Most chain and independent pharmacies contract with the *PBM*. You may obtain information about which pharmacies are contracting by:

- Visiting the *State Health Plan's* website, or
- Calling the *PBM* at the number listed in "Whom Do I Call?"

When you use a pharmacy **not contracting with the *PBM***, you will be responsible for paying the total amount of the *prescription* at the time of purchase. You or the pharmacy will be required to file a paper claim with the *PBM* for reimbursement. You may obtain a claim form on the *State Health Plan's* website or by calling the *PBM*. **You are responsible for any amount above the *allowed amount* and your *copayment*.**

The convenience of mail order pharmacy is available for your maintenance medications by using the *PBM's* online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original *prescription* and appropriate *copayment* to the *PBM*. You may obtain a Mail Service Order Form on the *State Health Plan's* website or by calling the *PBM* at the number in "Whom Do I Call?" To learn how to register for the *PBM's* online pharmacy services, visit the *State Health Plan's* website at www.shpnc.org.

You may use a credit card for *copayments* for telephone or online refills.

Preferred Drug List

The *State Health Plan*, with guidance from the Pharmacy and Therapeutics Committee (P & T Committee), compiles the Preferred Drug List. The Preferred Drug List can be obtained from the *State Health Plan's* website or by calling the *PBM* at the number listed in "Whom Do I Call?" The Preferred Drug List is subject to change without notification.

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- *Generic* drugs are often an effective alternative to brand drugs. Ask your physician to consider *generic* drugs whenever possible. If a *generic* drug is not available, you will be responsible for paying the higher *copayment* based on the tier placement for the *brand name* drug.
- When there is more than one *brand name* drug available for your medical condition, it is suggested that you ask your physician to prescribe a drug on the preferred list. This will reduce your *copayment*.
- For *brand name* drugs with a *generic* equivalent, if the *brand name* drug is chosen, *members* must pay the *generic copayment* plus the difference between the Plan's cost of the *brand name* drug and the Plan's cost of the *generic* drug.

Your *prescription drug* benefit offers an open *formulary* (or a list of covered *prescription drugs*). In the *formulary*, *prescription drugs* are divided into three categories or tiers: *generic* (Tier 1), preferred *brand name drugs* with no *generic* equivalent (Tier 2), and non-preferred *brand name* drugs with no *generic* equivalent (Tier 3). The placement of drugs in the *formulary* determines what *copayment* will be charged for each 30-day supply. The specialty medications *copayment* is 25% *coinsurance* up to \$100 for each 30-day supply. Refer to the *State Health Plan* website for a list of specialty medications.

If you would like an updated copy of the *formulary* or you want to check the tier placement of a specific drug, please call the *PBM* at the number listed in "Whom Do I Call?" or visit the *State Health Plan* website.

Prescription drug copayments are limited to \$2,500 per person per *benefit period*. After the \$2,500 maximum is reached, the health benefit plan pays 100% of allowed *prescription drug* charges.

Prescription drugs are not subject to the *benefit period deductible* or *coinsurance* amounts, or applied to their maximums.

A *prescription* cannot be refilled until three fourths (3/4) of the medication has been used as prescribed by your physician; exceptions may apply to certain prior authorized drugs.

Prescription Drug Exclusions

- Any *prescription drugs* not FDA approved
- Any *prescription drugs* that are not federal legend.
- Any *prescription drugs* not specifically covered by the *State Health Plan*
- Any *prescription drugs* prescribed for *sexual dysfunction*.
- Any *prescription drugs* prescribed for hair growth
- Any *prescription drugs* prescribed for cosmetic purposes
- Any *prescription drugs* prescribed in conjunction with artificial reproductive technology
- Any *prescription drug* in excess of the stated quantity limits
- Any *prescription drug* requiring *certification* if *certification* is not obtained
- Any drug that can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other approved over-the-counter drugs
- Any compound drug that does not contain at least one ingredient that requires a *prescription*
- Any *prescription drug* that has a therapeutic equivalent available over-the-counter as determined by the *State Health Plan*.

Diabetic Testing Supplies

Diabetic testing supplies are covered under your pharmacy benefit. For a single *copayment*, insulin dependent *members* will receive 153 test strips and non-insulin dependent *members* will receive 51 test strips per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to *deductible* and *coinsurance*.

Tobacco Cessation Coverage

For information on the tobacco cessation coverage, please see the Tobacco Cessation Support section under "Special Programs."

Specialty Pharmacy

Specialty medications are usually injectable products that require special handling and patient monitoring. Some conditions, such as anemia, hepatitis C, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis are treated with specialty medications. If you use specialty medications, you must use the contracted

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specialty vendor for all non-acute specialty medications covered under the pharmacy benefit, excluding cancer medications. If you use a pharmacy other than the contracted vendor to purchase any non-acute specialty medications, you will be responsible for paying the total amount of the *prescription* at the time of purchase. For more information call the specialty pharmacy at the number listed in "Whom Do I Call?"

A list of the available specialty medications is available on the *State Health Plan's* website. Some of the specialty pharmacy benefits include:

- access to nurses who are trained in specialty medications
- answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week
- free expedited shipping
- free supplies necessary to administer your medication (needles, syringes)
- refill reminders.

How To File A Claim For *Prescription Drugs*

When you use a pharmacy contracting with the *PBM*, present your *ID card* to the pharmacist and you will not be required to pay more than the appropriate *copayment* for each 30-day supply. The pharmacist will file the claim.

If you purchased *prescription drugs* from a pharmacy not contracted with the *PBM*, you will be responsible for the total amount of the *prescription* at the time of purchase. You will be reimbursed for your costs minus the applicable *copayment* and charges in excess of the *allowed amount*. You will need to complete a *Prescription Drug Claim Form* for reimbursement and submit it to:

Medco
PO Box 14711
Lexington, KY 40512

If you are sending the original pharmacy receipts, the following information is required in order to process the claim:

- Pharmacy name
- *Prescription* number
- Drug name and National Drug Code (NDC)
- Date purchased
- Strength
- Quantity
- Drug charge
- Pharmacist's signature
- Days supply

Complete a separate form for each family member and pharmacy.

Drug receipts from the label or bag should not be submitted. Claims will be returned if not properly completed. For information on how to properly submit a pharmacy claim, call Medco Customer Service at the number given in "Whom Do I Call?"

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Medicare Part D

IMPORTANT INFORMATION REGARDING YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Effective January 1, 2006, Medicare began offering *prescription drug* coverage for all persons enrolled in Medicare. The *State Health Plan* will continue to provide *prescription drug coverage* for all *members*.

When *members* become eligible for Medicare Part D, they will receive a notice of creditable coverage from the *State Health Plan*. "Creditable Coverage" means that your *prescription drug* coverage is at least as good as Part D coverage.

If your current *prescription drug* coverage qualifies as "creditable coverage," you should not need Part D coverage, unless you are Medicaid eligible or eligible for low-income assistance. *Members of the State Health Plan* should evaluate their own coverage needs prior to purchasing a Medicare Prescription Drug Plan.