PLAN N
Prescription Drug Benefit Description

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

This booklet describes the Plan N Prescription Drug benefits available through the State of Kansas program. The prescription drug program is funded by the Kansas State Employees Health Care Commission 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://www.caremark.com

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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.

Biosimilar – is a biologic medication made from the same type of sources as its original biologic and has the same treatment risks and benefits. "For biosimilars to be approved by FDA, studies must show that there are no differences in the safety and effectiveness of biosimilars and the original biologics." For more information see: https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients

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/Copay – 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, and Preferred Medications.

Discount Medications – are medications Not Covered by the Plan but the Plan has negotiated discounts from Network Pharmacies for their purchase. These items include 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 & 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 and other prescription medications designated by the Plan.

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. Coverage of clinical trials is provided as required under the ACA.

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 include 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 a 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 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. **(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 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 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 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 annual limit of a Member's payments for Covered prescriptions drugs and 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.

Patient Assistance Programs - Pharmaceutical manufacturers may sponsor patient assistance programs that provide financial assistance to individuals to augment any existing prescription drug coverage. Amounts paid through these patient assistance programs will not count toward meeting Plan Deductibles or Out Of Pocket Maximums. Patient Assistance Programs may include Copay cards, coupons and other such manufacturer sponsored

assistance programs.

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://www.caremark.com** and at the SEHP website: **https://sehp.healthbenefitsprogram.ks.gov/benefits/medical/cvs-caremark**

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

Prescription Drug Product– a medication, productor 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.

Rescission: is a retroactive cancellation of coverage. In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when premiums and contributions are not timely paid (in full), or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A failure to timely pay premiums includes a failure to pay premiums for continuation coverage under COBRA.

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 Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

The PrudentRx program provides members the opportunity to get their Specialty Medications through CVS/Caremark at no cost to members after the Deductible has been met.

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 administration or injection must be obtained from the CVS Caremark Specialty Pharmacy;

Plan N - Prescription Drug Benefits

Coverage Level	Health Plan Annual Deductible	Health Plan Annual Out of Pocket Maximum
Single	**$2,900**	**$6,900**
Family	**$5,700**	**$13,800**

The Deductible for all "non-single" policies (employee/spouse; employee/children; employee/family) will be $3,500 for an individual within the family. However, the overall family Deductible for these policies will remain at $5,700.

ALL Covered prescription drugs are subject to the combined medical and pharmacy Deductible of $2,750 for single & $5,500 for a family and then Coinsurance until the Out of Pocket Maximum is met.

Coverage Level	Prescription Drug Product	Coinsurance
Tier One	Generic Drugs	Deductible then 20% coinsurance
Tier Two	Preferred Drugs	Deductible then 35% coinsurance
Tier Three	**Specialty Medications***See PrudentRx Specialty Program	Deductible then 30% coinsurance
Tier Four	Non Preferred Brand Name	Deductible then 60% Coinsurance
Tier Five	Discount Tier	100% of discounted prescription cost
Tier Six	Anticancer Oral	Deductible then 20% coinsurance

Out of Pocket Maximum
Once the combine medical and prescription drug 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.

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 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 Medically Necessity by the Plan. Information on the Preferred Drug List or Injectable List is available at: **http://www.caremark.com** or **https://sehp.healthbenefitsprogram.ks.gov/benefits/medical/cvs-caremark**

***Generic Prescription Drug Products*:**

All prescription Generic drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 20% of the Allowed Charge for

eligible 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, Your Coinsurance is 35% of the

Allowed Charge for eligible prescription drugs. The Preferred Drug List is subject to periodic review and modification.

Non Preferred Brand Name Drug Products:
For covered Non Preferred Brand Name Drug Products are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 60% of the Allowed Charge for eligible prescription drugs.

Compound Medications:
Compound claims are only eligible for payment under this Plan when dispensed by a Network pharmacy. Eligible Compound Medications are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 60% of the Allowed Charge for eligible prescription drugs.

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.

ALL Compound Medications must be purchased at a Network pharmacy and if the TOTAL drug cost of the compound is over $300 the claim must be prior authorized by the Plan. Claims for Compound Medications over $300 that have not been prior authorized will be denied ~~by the Plan~~.

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.

Contraceptive Medications for Women:
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 subject to the Plan Deductible and the Non Preferred Drug Coinsurance.

The list of prescription contraceptive medications covered on the Preferred Drug List is subject to periodic review and modification. Female contraceptive products which are classified by the FDA as Over The Counter (OTC) and are included on the Preferred Drug List are eligible for coverage under this Plan if purchased with a prescription from Your Physician. This includes female contraceptive products that are FDA approved emergency contraceptives. To access coverage, You will need to present the prescription for the OTC item at the Network pharmacy and request that the claim be run through the CVS Caremark claim system or submit a paper claim with proper

documentation of purchase and a copy of the prescription.

Discount Medications:
Discount Medications are Non Covered prescription medications under this Plan. If You purchase a medication designated by the Plan as a Discount 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 these Non Covered medications. The Discount tier classification cannot be appealed or modified by a prior authorization. The Plan will not pay for these items. **Discount Medications do not count toward meeting Your Health Plan Deductible or Out of Pocket Maximum.**

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://www.caremark.com** or**https://sehp.healthbenefitsprogram.ks.gov/benefits/medical/cvs-caremark**. 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.

Opioids
For prescription Opioids additional limitations may apply including but not limited to quantity limits, and prior authorizations requirements depending upon the prescription product. Contact CVS Caremark customer service for details.

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://www.caremark.com** or **https://sehp.healthbenefitsprogram.ks.gov/benefits/medical/cvs-caremark**. Once the Deductible is satisfied, Your Coinsurance is 20% of the Allowed Charge for eligible prescription drugs. 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.

Out of Pocket (OOP) Maximum
The Out of Pocket (OOP) Maximum for covered services in combination with the medical OOP under Plan N is $ 6,900 per individual and $13,800 per family. Once your combined network medical and pharmacy OOP cost reaches the OOP Maximum, any additional claims received for 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. Prescription drug claims not processed by CVS Caremark using non CVS Caremark discount cards or store discount programs are not eligible for inclusion in the OOP or Deductible.

Preventive Care

The following Preventive Care 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 for reimbursement of the Allowed Amount. This list is not all inclusive and subject to periodic review and modification as federal guidelines for preventive care are updated. For a complete list of Preventive Services visit https://www.HealthCare.gov.

- Adults age 45 and over: Aspirin
- Adults age 40 to 75: low-dose Statin
- Pregnant Women at high risk for pre-eclampsia: Aspirin
- Immunizations: Children and Adult
- Screening for Colorectal Cancer age 50 and over: Bowel Preparation Medications
- Women Breast Cancer Prevention age 35 and over
- Women under age 55 and under: Folic Acid
- Woman Preventive Services: See Women's Contraception Section of this document
- Children age 6 and under: Oral fluoride
- Preexposure Prophylaxis (PrEP) for HIV
- Tobacco Cessation Products: See Tobacco Control Section of this document

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 is available at **www.caremark.com** and is subject to periodic review and modification. All Specialty Drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, eligible prescription drugs purchased from the Caremark Specialty Pharmacy are subject to the appropriate Coinsurance tier.

For members requiring 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 Caremark Specialty 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, 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.

PrudentRx Specialty Drug Program

PrudentRx is an independent third party organization that partners with Caremark to provide cost savings on specialty medications by utilizing drug manufacturers Copay assistance programs. PrudentRx would assist members in enrolling in the manufacturer's non needs based Copay assistance programs. Members who participate in the PrudentRx program will have no member out of pocket costs for their Specialty medications, after the Deductible is met. Members that elect not to participate in the Prudent Rx program will be responsible for a 30% Coinsurance.

Members who participate in the Prudent Rx program utilizing available Copay assistance programs will have no member out of pocket for their Specialty medications after the Deductible is met. Members that elect not to participate in the Prudent Rx program will be responsible for a 30% Coinsurance.

Comprehensive Site of Care Specialty Program

The Plan has identified certain Specialty Drugs for exclusive coverage under the Comprehensive Site of Care Specialty Program. CVS Specialty will work with You and Your provider on delivering these Specialty drug to You for self-administration or to Your provider for clinician administration or infusion. A complete list of prescription drugs included in the Comprehensive Site of Care Specialty Program is available on the Caremark website.

CVS Specialty may work with You and Your provider to provide Your treatment in an outpatient or home setting when appropriate. When CVS Caremark arranges the site of care for the administration of the prescription drug, claims must be submitted to Caremark for payment. All services are subject to the plan Deductible and then Coinsurance will apply. Specialty prescription drugs through the Prudent Rx program are eligible for a zero dollar Copay after the Deductible is met. Members that elect not to participate in the Prudent Rx program will be responsible for a 30% Coinsurance, after the Deductible is met.

Tobacco Control Wellness Program

"The Plan will pay 100% of the Allowed Amount for tobacco control products listed on the Preferred Drug List (PDL). The Plan retains final authority on what constitutes tobacco control drug products. This list may be subject to periodic review and/or modifications. For Over The Counter (OTC) products, you will need to present a physician's prescription for the OTC product to the Network

pharmacy, and request the claim be submitted by the pharmacy through the CVS Caremark claims system to be covered at 100%. You may also submit a paper claim to CVS Caremark with proper documentation and a copy of the physician prescription for direct reimbursement.

Enrollment of an approved tobacco cessation program is recommended in conjunction with the use of these tobacco control prescription products. You should consult your network physician or other qualified provider about available programs in your area. These programs are also covered by the Plan at 100%. To review the Tobacco Cessation Learning Module offered through the HealthQuest Wellness Program, log into your personal portal at https://sehp.healthbenefitsprogram.ks.gov/benefits/healthquest

For additional information about tobacco cessation products and other preventive products, please visit LET'S TALK PREVENTION at:

HYPERLINK "https://www.lung.org" https://www.lung.org

Weight Loss

Coverage for GLP-s when prescribed as an Anti Obesity Medication (AOM) for the intended purpose of promoting weight loss are Non Covered services if at the time a new course of therapy is initiated, the member has a Body Mass Index (BMI) of under 35. Medication must be purchased from a Network pharmacy and Prior Authorization of all GLP-1 mediations purchases is required. Members must meet the BMI requirement when a new course of treatment begins or if there has been a break in therapy for the services to be eligible fore coverage. For continuous treatment with GLP-1s, members must meet all of the continuation of therapy requirements for coverage at each Prior Authorization period.

Initial Prescription Drug Product Purchase

Covered Prescription Drug Products are subject to the initial fill limit of thirty-day (30) consecutive day supply or one standard unit of therapy whichever is less.

A standard unit of therapy is up to a thirty-day (30) 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 (90) day supply** if allowed by law or Plan guidelines. The refill prescriptions must be for the same strength of Prescription Drug Product.

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

Advance Purchases

Active employees may request an Advance Purchase of maintenance Prescription Drug Products when visiting outside of the United States. for an extended period. For most medications it is >90days and in all cases for a period not to exceed one(1) year. The applicable Plan Deductible, and Coinsurance are required for each thirty (30) day supply or standard unit of therapy received. Purchases must be made at a Network Pharmacy other than a CVSCaremark Mail Service 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. The Member must maintain continuous coverage under the SEHP for the entire period the member is outside of

the U.S. 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 U.S. You may submit the pharmacy receipts for reimbursement upon return to the U.S. 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 Charge for the service. You will be responsible for the difference between the pharmacy's billed charged and Allowed Charge in addition to applicable Deductible and Out of Pocket Maximum.

For Prescription drug Products purchased in the United States by the Member in excess of the supply limits of the Plan may be reimbursed once the time period covered by the excess supply has elapsed so long as the member is continuously enrolled and 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, 109 SW 9th Suite #600, Topeka, KS 66612.

Prescription Drug Products purchased and used while outside the U.S. must include documentation of the purchase to include the original receipt that contains the patient's name, the name of the Prescription Drug 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 to process the claim. Only Prescription Drug 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, 109 SW 9th Suite #600, 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 ninety (90) day supply and may be dispensed with member paying the applicable Deductible and Coinsurance.** 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://www.caremark.com or **https://healthbenefitsprogram.ks.gov/sehp/vendors/CVS** 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. Box52136 /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**.

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, Cops and other 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

Termination Of Coverage-Situations When Coverage is Terminated

The eligibility of an individual Member will terminate in the following situations:

1.) When the Plan is notified that a Member is no longer eligible for benefits.

2.) Termination of Marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce or legal separation was granted by court action. In such cases ,the Member whose coverage is terminating will be eligible for Continuation of Coverage under COBRA.

3.) Eligible Dependent who no longer meets the requirements of an Eligible Dependent. In such cases, the Member whose coverage is terminating will be eligible for Continuation of Coverage under COBRA.

If a Member fails to disclose information requested by Plan or is abusive toward providers or Plan personnel in applying for or seeking any benefits under this Benefit Description, then the rights of such Member under this Benefit description may be prospectively terminated upon written notice. At the effective date of such termination, prepayments received on account of such terminated Member applicable to periods after the effective date of termination shall be refunded and the Plan shall have no further liability or responsibility under this Benefit Description.

Fraud or Intentional Misrepresentation: You and Your Eligible Dependent's coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor if You or Your Eligible Dependents participate in any act, practice or omission that constitutes fraud or intentional misrepresentation of material fact in applying for or seeking benefits under the Plan. This includes, but is not limited to:

Allowing unauthorized persons use of Your Plan identification card(s) to obtain health care services, supplies or medications that are not prescribed or ordered for You or a covered family member, or health services which You are not otherwise entitled to receive.

Permitting the unauthorized use of Your Plan identification card(s) to obtain health care services or supplies for someone not covered under Your Plan membership. In this instance, Coverage of the Member and/or Eligible Dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor may be taken.

Using another Plan Member's identification card(s) to obtain health care services, medication or supplies for You or another third party who is not specifically covered under Your Membership in the Plan may result in the termination of Your coverage and that of Your Eligible Dependents by the Plan and any other action determined appropriate by the Plan Sponsor or Plan.

In any instance of fraud or intentional misrepresentation of material fact, with proper 30-day advance written notice, coverage for You and/or any covered Eligible Dependent(s) may be retroactively cancelled effective the first day of the month following the date on which the Member became ineligible for coverage.

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.

Non Covered Services – claims denied because the prescription drug product, item or service are not a covered service under the Plan may not be appealed for external review. This would include prescription drug products included in the Discount Tier.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service or Urgent Care 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
MC 109
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: 1-866-443-1183

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 decide 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 decide 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.

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:

review

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 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

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. CVS Caremark 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 right to External Review shall not be construed to change the terms of coverage under this Benefit Description. 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. 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. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.
8. Compound drugs purchased from a Non Network pharmacy.
9. 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 under in this benefit description.
10. Injectable drugs administered by a Health Professional in an inpatient setting.

11. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
12. Replacement Prescription Drug Products resulting from damaged, lost, stolen or spilled Prescription Orders or Refills.
13. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
14. Prescription Drug Products that are not medically necessary.
15. Charges to administer or inject any drug unless eligible under the Comprehensive Site of Care Specialty Program.
16. 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.
17. Prescription Drug Products for which there is normally no charge in professional practice.
18. Therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
19. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
20. Charges for the delivery of any drugs.
21. Prescription Drug Products approved for experimental use only.
22. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with any normal medical or pharmaceutical practice.
23. 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.
24. Coverage for allergy antigens under any circumstances.
25. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.
26. Drugs imported by the member for use in the United States from foreign countries.

Section 5 Prior Authorization

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

Section 6 Amino Acid-based Elemental Formula Program Rider

Amino Acid-based Elemental Formula Program

The SEHP has been authorized by the Kansas Legislature with conducting a program providing coverage for amino acid-based elemental formula for the treatment or diagnosis of food protein-induced enterocolitis syndrome, eosinophilic disorders or short bowel syndrome. Formula must be purchased from a Network Pharmacy and Prior Authorization is required to ensure the member meets the criteria established for the program. Approved formula products will be subject to the applicable Deductible and Coinsurance tier for the type of formula purchased.

Members will need to take eligible Over The Counter formula products to the pharmacy counter along with the physician's prescription and their Caremark id card to have the claims processed for eligible benefits. Coverage is limited to the following list of eligible formula products for the treatment or diagnosis of food protein-induced enterocolitis syndrome, eosinophilic disorders or short bowel syndrome when Prior Authorized and purchased from a Network Pharmacy:

- Alfamino products
- Elecare products
- Neocate products
- Puramino products
- Tolerex products
- Vivonex products

The plan retains final discretionary authority on what constitutes an amino acid-based elemental formula. The list of eligible formula is subject to periodic review and modification.

Kansas State Employee Health Plan
Preferred Drug List
2027

Effective 01/01/2027

For questions or additional information, access the State of Kansas website at **http://KHDOWKEHQHILWVSURJUDP.NV.JRY/VHKS/YHQGRUV/&96** or call the **Kansas State Employees Prescription Drug Program** at **1-800-294-6324**.

The Preferred Drug List is subject to change. To locate covered prescriptions online, access the State of Kansas website at **http://KHDOWKEHQHILWVSURJUDP.NV.JRY/VHKS/YHQGRUV/&96** for the most current drug list.

What is a Preferred Drug List?

A Preferred Drug List is a list of safe and cost-effective drugs, chosen by a committee of physicians and pharmacists. Drug lists have been used in hospitals for many years to help ensure quality drug use. The Kansas State Employees Preferred Drug List will be continually revised to reflect the changing drug market.

Should I ask my physician to switch my current medications to a medication that is on the Preferred Drug List?

Many of your medications will already be on the Preferred Drug List. However, if you have a medication that is not, ask your physician to choose a similar Preferred Drug List product for you to use.

Should I use generics?

There are many medications on the market that do not come in generic form. For those drugs that do, your pharmacist should suggest safe and effective generic alternatives.

This document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

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