

WHAT THE MEDICAL PLAN COVERS

Prescription Drugs

The Plan pays for medically necessary prescription drugs.

The Plan pays the amounts that are in excess of the prescription drug co-payment.

The Plan pays for enteral formulas for which a physician or other provider licensed to prescribe has issued a written order. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific regimen for diseases or disorders that, if left untreated, will cause chronic disability, mental retardation, or death. Diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies that, if left untreated, will cause malnourishment, chronic disability, mental retardation or death. The Plan pays the amounts in excess of the generic prescription drug co-payment.

The Plan pays for Medically Necessary Infertility Drugs that the FDA has approved specifically for the diagnosis and treatment of infertility and that are prescribed or dispensed in connection with the services covered under the Infertility Treatment Services Section of this Plan Document.

The Plan also pays for low protein or modified protein solid food products when they are provided pursuant to a written order as described above for treatment of inherited diseases of amino acid and organic acid metabolism. The Plan pays the amounts in excess of the generic prescription drug co-payment.

A prescription drug card will be issued to all covered persons. This card should be presented to the pharmacy at the time a prescription drug is purchased. If you do not use your prescription drug card, or go to a pharmacy outside of the network, then you must pay for your prescription and then file a claim with the prescription plan administrator. Any co-payments that are paid under the prescription drug program are not eligible to be considered for reimbursement under any other portion of the Plan.

The prescription drug benefits provided by the Plan are summarized as follows:

Retail Pharmacy (typically a 30 day supply, but covered up to a 90 day supply):

The covered person pays: Deductible/Coinsurance or Copay for Tier I drugs

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Mail-Order Pharmacy (typically a 90 day supply):

The covered person pays: Deductible/Coinsurance or Copay for Tier I drugs

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Prescription Drugs (Cont.)

The Plan requires pharmacies to dispense “Class A” generic drugs, which are widely accepted by the entire medical and pharmacy communities. Benefits will be provided as follows:

Tier I – drugs are typically generics and have the lowest copayment amount.

Tier II – drugs are brand name drugs that have unique, significant clinical advantages and offer overall greater value over the other products in the same drug class.

Tier III – drugs are all other brand drugs, including new brand drugs and drugs that have generic equivalents. Tier III drugs have the highest copayment amount.

Qualifying expenses as used in this prescription drug expense benefit provision are those expenses actually incurred, in excess of the co-payment, which are:

Necessary for the care and treatment of an illness;

Prescribed in writing by an authorized physician;

Reasonable and customary; and

Not listed in the Exclusion section, below.

However, there is an exception. If a prescription drug has been approved for use for one type of cancer, the Plan will also provide benefits for this prescription drug for use with other types of cancer; as long as it meets the requirements of the New York State Insurance Law.

Mail Order Program

Part of the prescription drug program includes a voluntary mail order service. This service has been designed mainly for individuals using maintenance type medications for periods of 30 days or longer for treatment of chronic or long term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure.

How to use the program:

When a doctor prescribes a maintenance drug, have it written for up to a 90 day supply. By law the mail order administrator can only fill prescriptions with the quantity indicated by the doctor. (e.g. 1 a day = 90 pills, 2 a day = 180 pills) A covered person may want to ask their physician to write a prescription for a 30 day supply that can be taken to a retail pharmacy so that they will have a supply of the medication while the mail order request is being processed.

Complete a mail order form (mail order forms can be obtained by contacting the Plan Administration Office), and for new participants, complete the confidential patient profile. This form will need to be completed with the first order only. In the future, only additional information or changes to your medical condition need to be reported. Please notify the mail order administrator in writing.

Mail the completed form with the original prescription in the pre-addressed postage paid envelope.

Be sure the enrollee’s social security number is written on the back of each prescription.

Drugs will be delivered to the covered person’s home postage paid by first class mail or Federal Express second day service. If there are any questions or problems concerning a prescription order, or if a prescription is not received within 14 days, please contact the mail order administrator. Allow a few extra days for first submissions.

Prescription Drugs (Cont.)

Refills - For refills, contact the mail order administrator via their toll-free number and give them the enrollee's social security number and prescription number. The prescription label will indicate the number of times a prescription may be refilled.

Prescription Drug Exclusions:

The following exclusions apply to the prescription drug benefit:

Non-legend drugs, other than injectable insulin.

The charges for the administration or injection of any drug.

Therapeutic devices or appliances including needles, syringes, support garments, and other non-medical substances regardless of intended use, except those specifically listed as covered in this section.

Any prescription which a person is entitled to receive without charge from any Workers' Compensation, or similar law, or municipal, state or federal program other than Medicaid.

Prescription drugs purchased prior to the effective date of this Plan.

Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

Drugs labeled "Caution-Limited by Federal Law to Investigation Use," or experimental drugs, even though a charge is made to the individual. However, the Plan will pay if required to provide coverage pursuant to the external appeal process.

Medication, which is to be taken by, or administered to, the covered person, in whole or part, while the covered person is a patient in a hospital, skilled nursing facility, rest home, sanitarium, extended care facility, convalescent hospital, or nursing home.

Immunization agents, biological sera, blood or blood plasma.

More than a 90 day supply when dispensed in any one prescription order.

Non-prescription vitamins, vitamin preparations (e.g. minerals, calcium, etc.), and nutritional supplements except for enteral formulas and modified solid food products, as described above.

Cosmetic Drugs (e.g. Minoxidil (Rogaine), Renova, Retin-A).

Growth Hormones.

Infertility Medications.

Smoking deterrent medications.

Any prescription drugs specifically excluded herein may be covered by the Plan, subject to the prescription drug co-payment, if determined by the plan administrator to be medically necessary.