PRESCRIPTION DRUG PLAN

The Plan Administrator will pay a portion of the cost of covered prescriptions. Maximum benefits are paid when prescriptions are filled through the CVS Caremark network pharmacies.

To view the Formulary List, visit http://benefits.sd.gov/Forms.aspx and choose FY15 Formulary.

All prescriptions are subject to the coverage guidelines and limitations as determined by the Plan.

CVS CAREMARK NETWORK PHARMACIES

Participating pharmacies submit claims and are reimbursed by the Plan for charges allowed under the Pharmacy Network contract. If enrolled in the $750 Deductible Plan or the $1,250 Deductible Plan, there is a Plan year $50 Deductible per Member for filled prescriptions. When the $50 Deductible per Member is satisfied, the Member pays a Copayment for each covered prescription.

If the Member purchases a prescription at a nonparticipating pharmacy, or does not show a Member ID card to the pharmacist, the Member will be required to pay the full price for the prescription at the time of purchase and then submit a claim for reimbursement. Reimbursement is limited to the CVS Caremark contracted rates cost, minus the applicable Copayments and Deductible. Required claim forms can be obtained from the Bureau of Human Resources or online at http://benefits.sd.gov/Forms.aspx and choose Pharmacy Claim Form

PHARMACY DEDUCTIBLE PER MEMBER PER PLAN YEAR

A $50 Deductible per Member per Plan year exists on prescription drug coverage for those enrolled in the $750 Deductible Plan or the $1,250 Deductible Plan. Before pharmacy benefits are paid, each Member must satisfy the $50 Deductible. Once the pharmacy Deductible is met, applicable Copayments under the Five-Tier Prescription Drug Plan will apply.

For the $1,800 Deductible Plan (HSA Compatible), special rules affect this Plan.

COPAYMENTS

When the $50 Deductible is satisfied, member is responsible for applicable Copayments for covered prescriptions. If the price is less than the defined Copayment, you will pay the lesser of the two amounts.

FIVE-TIER PRESCRIPTION DRUG PLAN

The State of South Dakota offers coverage for generic medications and formulary brand products. Non-formulary products are not covered.

When enrolled in the $750 Deductible Plan or the $1,250 Deductible Plan, the State of South Dakota offers a Five-Tier Prescription Drug Plan with various levels of Copayment for each tier. The tiers are:

PHARMACY NETWORK PRESCRIPTION BENEFITS	
Tier	**Up to 30 day supply**
Tier 1-Generic	$10
Tier 2-Brand Preferred	$40
Tier 3-Brand Non-Preferred	$60
Tier 4-Specialty Preferred	$60
Tier 5-Specialy Non-Preferred	$85

SPECIAL RULES FOR THE $1,800 DEDUCTIBLE PLAN

Under the $1,800 Deductible Plan, a single $1,800 Deductible and $3,600 family Deductible applies to both medical expenses and prescription drug expenses combined.

When enrolled in the $1,800 Deductible (HSA Compatible), there is not a pharmacy Deductible, no tiered Copayments, and no pharmacy Out-of-Pocket Maximum. Member pays the Deductible and Coinsurance until they satisfy the Out-of-Pocket Maximums. Members who have met the deductible will continue to pay the full plan cost for a prescription at the pharmacy and will be reimbursed the 75% coinsurance by a check from DAKOTACARE. Members who have met the Out-of-Pocket Maximum will continue to pay the full plan cost for a prescription at the pharmacy and will be reimbursed the full plan cost by a check from DAKOTACARE. The member does not have to submit a claim form to DAKOTACARE for pharmacy reimbursement.

PHARMACY OUT-OF-POCKET MAXIMUMS

Under the pharmacy Plan, there is a separate Out-of-Pocket Maximum for prescriptions. Pharmacy Copayments or other prescription drug costs do not apply to the medical out-of-pocket Deductible or medical Out-of-Pocket Maximum.

The maximum annual cost per Plan Year for covered medications for those enrolled in the $750 Deductible Plan or $1,250 Deductible Plan is:

(a) $1,000 per Member; and

(b) $2,500 per family of three or more. No one family member is eligible to meet more than the per Member Out-of-Pocket Maximum each Plan Year. The family Out-of-Pocket Maximum is satisfied when at least three family members have prescription drug expenses totaling the $2,500 Out-of-Pocket Maximum. If a family has met the Out-of-Pocket Maximum for the year, a family member does not have to pay the $50 deductible.

The pharmacy Out-of-Pocket Maximum includes the $50 Deductible per Plan year and pharmacy Copayments.

The pharmacy Out-of-Pocket Maximum does not include:

a. Ancillary charges (the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available);
b. Excess amounts paid at nonparticipating pharmacies;
c. Charges which are not covered by the Plan; or
d. Penalties for not pre-authorizing when required.

For the $1,800 Deductible Plan (HSA Compatible), special rules affect this Plan.

COVERED PRESCRIPTIONS

Generally, the following are covered benefits:

(a) Coverage is limited to the Plan formulary;

(b) Prescriptions prescribed by a licensed provider, that require a prescription, either by federal or state law;

(c) DESI drugs (drugs in use prior to 1962 that have been permitted to remain on the market while evidence of their effectiveness is reviewed under the FDA's Drug Efficacy Study Implementation [DESI] program);

(d) Compounded medications, submitted with a valid National Drug Code (NDC) for a legend medication;

(e) Insulin and other diabetic supplies which are prescribed by a licensed provider;

(f) Insulin and syringes—syringes are covered by the insulin copayment if purchased at the same time. If syringes are purchased separately from the insulin, they are covered under a separate copayment;

(g) Diabetic test strips and lancets—lancets are covered by the diabetic test strips copayment if purchased at the same time. If lancets are purchased separately from the diabetic test strips, they are covered under a separate copayment;

(h) Legend smoking cessation aids which are approved by the Plan Administrator (Limited to a 180-day lifetime supply);

(i) Legend prenatal vitamins;

(j) Legend pediatric fluoride vitamins;

(k) Oral/topical Contraceptives, excluding emergency contraceptives;

(l) Drugs that are self-administered; or

(M) Fertility agents when Medically Necessary (up to the $3,000 maximum pharmacy benefit) as determined by HMP.

PREVENTIVE MEDICATIONS

The Plan covers qualified preventive prescription and over-the-counter (OTC) products as listed in the table below. These medications will be covered at 100% when the member meets the preventive care guidelines. All medications require a prescription from a provider and must meet the definition of qualified preventive care as defined under preventive medications.

ELIGIBLE PREVENTIVE MEDICATIONS

Preventive Service/Item	**Requirements**
Aspirin to prevent cardiovascular events	Men age 45 to 79 and Women age 55 to 79 where the benefit outweighs potential risk.
Breast cancer medications to reduce risk	Medications such as tamoxifen or raloxifene for women at increased risk for breast cancer.
Fluoride supplements	Children age 6 months to 5 years with a fluoride deficient water supply.
Folic acid supplements	Women through age 50 years.
Iron Supplements	Children age 6 to 12 months who are at risk for iron deficiency.
Smoking Cessation	Members may utilize the South Dakota QuitLine resources for product coverage. Select Rx products covered by the Plan.
Vitamin D Supplement	Men and women 65 years of age or older at risk for falls.
Bowel Preparations for Preventive Colonoscopy	Men and women between 50 and 75 years of age. Limit 2 preparations per year under preventive benefit.
Women's Services/Contraception	Contraceptive methods approved by the Food and Drug Administration (FDA) covered for women through age 50 years. Generic and select brand name medications included.

Prescription medications listed above will be processed through the pharmacy benefit. Over the counter medications may be submitted for preventive service coverage using the medical claim form found at http://benefits.sd.gov/Forms.aspx and choosing Preventive Medications under claim form.

The claim form along with the provider prescription and a receipt for the product must be submitted in order to be reimbursed.

GENERICS POLICY

If a generic drug is available, and a Member chooses to take the brand product, the Member will be responsible for the ancillary charge. The ancillary charge is the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available.

PRESCRIPTION DRUG PLAN EXCLUSIONS

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs":

(a) Non-formulary medications;

(b) Non-legend drugs, including any over-the-counter (OTC) medications;

(c) Blood glucose monitors, diabetic swabs, and calibration solutions;

(d) Emergency contraceptives;

(e) Injectable medications which are not considered self-injectable;

(f) All vitamins, except as noted under "Covered Drugs";

(g) All Durable Medical Equipment (DME),except as noted for diabetic supplies;

(h) Prescriptions used for cosmetic purposes;

(i) Drugs labeled "Caution-limited by Federal law to investigational use," or experimental medications that do not have NDC numbers even though a charge is made to the Member;

(j) Charges for prescription drugs that exceed the CVS Caremark contracted rate;

(k) Medication which is to be taken by or administered to a Member, in whole or in part, while a Patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; NOTE: Benefits for covered medications administered during an approved inpatient confinement are payable under the South Dakota State Employee Health Plan;

(l) Charges for the administration or injection of any drug. Within the provisions of Plan coverage, these drugs, services, or supplies may be covered under the South Dakota State Employee Health Plan;

(m) Drugs used for indications not approved by the FDA;

(n) Legend drugs with OTC equivalents;

(o) Homeopathic or nutritional supplements (or combination of these with legend drugs);

(p) Prescription medications obtained by illegal means;

(q) Replacement of supplies or medications that are lost, damaged, stolen, or used inappropriately including medications determined to be abused or otherwise misused;

(r) Prescriptions used to treat Erectile Dysfunction and Cialis for BPH;

(s) Allergy Serum is covered under the health plan. The claim should be submitted to DAKOTACARE as a medical claim and member will be responsible for a medical copayment; and

(t) Medications as identified on the Listing of Prescriptions Not Covered Under Pharmacy. To view the list of excluded medications visit http://benefits.sd.gov/Forms.aspx and select FY15 Listing of Prescriptions Not Covered Under Pharmacy.

EARLY REFILL POLICY

A minimum of 75% of the medication must be used before a refill will be allowed. In a special circumstance of a Member needing to refill the medication before leaving on vacation, the Member may have one prescription refilled early per Plan Year.

In these situations, the Member should contact the Benefits Program at 605.773.3148 or 877.573.7347 for pre-authorization.

DRUGS REQUIRING PRE-AUTHORIZATION

The Member's Physician must contact DAKOTACARE at www.dkc-pa.com to arrange for Pre-authorization if one of these drugs is prescribed. For the current Pre-authorization list, visit http://benefits.sd.gov/Forms.aspx and choose Pre-authorization list. The Pre-authorization list is updated throughout the year.

STEP THERAPY PROGRAMS

Step therapy programs are implemented on certain therapeutic classes of drugs. The programs are designed to have Members begin with the most cost-effective and safest drug available (known as first-line drug therapy). The step therapy program will allow for more costly and higher-risk drug therapies if a member fails the first-line drug therapy prescribed. The goal of these programs is to control costs and minimize side effects (from medications) that a Member may experience. The Step Therapy list is updated throughout the year. To view the list of current step therapy programs, visit http://benefits.sd.gov/Forms.aspx and choose FY15 Pre-authorization Listing.

HOME DELIVERY PRESCRIPTION PROGRAM

Members may use the CVS Caremark Home Delivery Prescription Program when they need to fill or refill up to a 90-day supply of certain maintenance drugs. The same Copayments apply to mail-order pharmacy as the retail pharmacy.

SUBMITTING CLAIMS

If a Member visits a nonparticipating pharmacy, or does not present a Member ID card, the Member must submit a claim for reimbursement to the pharmacy network's Claims Administrator. The claim must be submitted within one year from the end of the Plan Year in which the medication was purchased.

Reimbursement is limited to the State cost had the Member used a participating pharmacy, minus the applicable Copayments.

NOTE: Prescription drugs administered in a Physician's office (e.g., an injection of an allergy serum) also require the Member to file a claim for reimbursement. The Member should pay the provider when receiving this service.