10.1 Summary

- Prescription drug coverage for you and your eligible Dependents
- Three-tier Copayment plan
- Retail and maintenance programs

Through the Prescription Drug Plan, you and your eligible Dependents may obtain your required medications at Participating pharmacies throughout Pennsylvania and the United States at a reduced, prenegotiated cost.

If you use a pharmacy that does not participate in the pharmacy Network, or you do not present your prescription drug ID card at a Participating pharmacy, you pay the full cost of your prescription. You must then file a claim with the Prescription Drug Plan in order to receive reimbursement. See “Filing a Prescription Drug Claim Form” for more information. You also may need to apply for reimbursement if you need to fill a prescription for yourself or a Dependent after you or your Dependent is eligible for Prescription Drug Coverage but before the Prescription Drug Plan has entered you or your Dependent on its records.

To find out if your pharmacy participates in the plan’s network, call the telephone number that appears on the back of your prescription drug ID Card.

Coverage also is available for a Dependent parent(s) of an Eligible Member who has no spouse/domestic partner or other Dependent enrolled for supplemental benefits. In order to apply for this coverage, the parent(s) must be totally dependent upon the Employee Member for support, according to Internal Revenue Service requirements, and be able to substantiate this dependency to the PEBTF. The Dependent parent must be ineligible to receive prescription drug coverage from any other source, including federal, state or local governments. Proper certification forms and guidelines for determination of eligibility for this coverage can be obtained through the PEBTF.
10.2 Three Tier Copayment Plan
The Prescription Drug Plan is a generic reimbursement plan. You may obtain a brand-name drug but if an FDA-approved generic is available, you will pay a higher Copayment and the cost difference between the brand name drug and the generic drug. In no event will you pay more than the actual cost of the drug.

The Prescription Drug Plan uses a three-tier system, by which the Prescription Benefit Manager maintains a list of generic and brand-name drugs called a formulary. The formulary summary is available at www.pebtf.org. Drugs included on the formulary are called “preferred.” Drugs not on that list are called “non-preferred.” The following details the Copayments under your Prescription Drug Plan.

<table>
<thead>
<tr>
<th>Prescriptions at a Network Pharmacy – up to a 30 Day Supply</th>
<th>Your Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic drug</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2: Preferred brand-name drug</td>
<td>$18, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred brand-name drug</td>
<td>$36, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order – up to a 90 Day Supply</th>
<th>Your Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic drug</td>
<td>$15</td>
</tr>
<tr>
<td>Tier 2: Preferred brand-name drug</td>
<td>$27, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred brand-name drug</td>
<td>$54, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retail Maintenance at a Rite Aid Pharmacy – up to 90 Day Supply</th>
<th>Your Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic drug</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 2: Preferred brand-name drug</td>
<td>$36, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred brand-name drug</td>
<td>$72, plus the cost difference between the brand and the generic, if one exists</td>
</tr>
</tbody>
</table>
10.3 Retail Prescriptions – up to a 30-day Supply
- Present your prescription drug ID card at the participating pharmacy along with the prescription to be filled
- The pharmacist will ask the person picking up the prescription to sign a log
- The pharmacist will request the Copayment amount, and if necessary, the difference between the cost of the brand name drug and the cost of the generic

Except as otherwise noted, prescriptions purchased at a retail pharmacy cannot exceed a 30-day supply for short-term prescriptions.

10.4 Two Ways for Obtaining Prescriptions for up to a 90-day Supply
The Prescription Drug Plan includes two options for obtaining long-term maintenance prescriptions (up to a 90-day supply):
- Mail Order
- Rite Aid Pharmacy

There are Copayment differences between the two maintenance feature options. See the chart on the preceding page for Copayment amounts.

The 90-day supply feature is appropriate if you have a Chronic condition and take medication on an on-going basis. For example, this feature works well for people who use maintenance drugs for conditions such as diabetes, arthritis, asthma, ulcers, high blood pressure or heart conditions.

10.5 Specialty Medications
Specialty medications are used to treat complex conditions and usually require injection and special handling. To obtain these specialty medications, you must use the Prescription Benefit Manager’s specialty care pharmacy or Rite Aid. If you use a pharmacy other than a specialty care pharmacy or Rite Aid to purchase specialty medications, you will be responsible for the full cost of each prescription. You may then file a Direct Claim Form. The amount reimbursed to you, however, will be limited to the amount that would have been paid to the specialty pharmacy and may result in significant out-of-pocket costs.

The specialty care pharmacy is a mail order service, and offers access to personalized counseling from a dedicated team of registered nurses and pharmacists to help you throughout your treatment. This personalized counseling provides you with 24-hour access to additional support and resources that are not available through traditional pharmacies.

Contact the PEBTF for information on the specialty care pharmacy.
10.6 Covered Drugs

- Federal legend drugs
- State restricted drugs
- Compound prescriptions (will not be covered if compound includes a drug excluded by the Prescription Drug Plan)
- Insulin or other prescription injectables
- Allergy extract serums (will not be covered if the serum includes a drug excluded by the Prescription Drug Plan)
- Federal legend oral contraceptives
- Genetically engineered drugs (with prior authorization)

10.7 Plan Exclusions

- Blood or blood products
- Charges for the administration of a drug
- Devices and appliances
- Diagnostic agents
- Drugs dispensed in excess of Quantity Limits or lifetime supply limits unless exception has been granted
- Drugs subject to Prior Authorization for which such authorization has not been obtained
- Drugs subject to Step Therapy rules if these rules have not been followed
- Drugs used for athletic performance enhancement or cosmetic purposes, including but not limited to, anabolic steroids, tretinoin for aging skin and minoxidil lotion
- FDA approved drugs for use of a medical condition for which the FDA has not approved the drug (unless prior authorization is obtained)
- Fertility medications
- Immunologic agents (including RhoGAM)
- Infusion therapy drugs
- Investigational or Experimental drugs (non-FDA approved indications)
- Sexual dysfunction drugs
- Medications lawfully obtainable without a prescription (over the counter items)
- Non-sedating antihistamines
- Medications for weight reduction
- Prescription drugs administered while you are at an outpatient facility
- Refill prescriptions resulting from loss, theft or damage
- Smoking cessation drugs
- Syringes, needles and test strips
- Unauthorized refills

This is a partial list of exclusions. If you have any questions about whether a particular expense is covered you may contact the Prescription Benefit Manager or the PEBTF.
10.8 Utilization Controls
Step Therapy, Maintenance Day Supplies and Quantity Limitations allow the Prescription Benefit Manager to better manage your use of prescription drugs to ensure that drugs are not over prescribed or under prescribed or that you are not taking medications that can cause serious side effects or counteract each other.

10.9 Quantity Limitations
There are certain prescription drugs that are subject to quantity limits. The Quantity Limit List is posted on the PEBTF website, www.pebtf.org/Resources.

You may find that the quantity of a medication you receive and/or the number of refills are less than you expected. This is because the pharmacists must adhere to certain federal/state regulations and/or recommendations by the manufacturer or Prescription Benefit Manager that restrict the quantity per dispensing and/or the number of refills for a certain medication.

10.10 Limits on Certain Drug Classes

Step Therapy
When many different drugs are available for treating a medical condition, it is sometimes useful to follow a stepwise process for finding the best treatment for individuals. The first step is usually a simple, inexpensive treatment that is known to be safe and effective for most people. Step Therapy is a type of prior authorization that requires that you try a first-line therapy before moving to a more expensive drug. The first-line therapy is the preferred therapy for most people. But, if it doesn’t work or causes problems, the next step is to try second-line therapy.

You will be required to use a first-line drug before you can obtain benefits for a prescription for a second-line drug on the following classes of drugs:

- ACE’s and ARB’s which are used for hypertension
- SSRI’s which are used for depression
- PPI’s which are used to control Gastroesophageal Reflux Disease
- COX-2 or NSAID drugs which are used for pain and arthritis
10.11  Prior Authorization Appeals
Your Prescription Drug Plan requires prior authorization for benefits to be paid for certain medications. This requirement helps to ensure that Members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA).

For most of the drugs that appear on the Prior Authorization List, the process takes place at the pharmacy. If you try to obtain a drug that appears on the Prior Authorization List, your pharmacist will be instructed to contact the Prescription Benefit Manager. Participating pharmacies will then contact your physician within 24 hours to verify diagnosis and to obtain other relevant information to make a determination of coverage.

If the request is approved, you will be notified to go to the pharmacy to obtain the medication. The approval for that specific drug will be for a period from several days up to a Maximum of one year. If the request is denied, you have the right to appeal this decision to the Prescription Benefit Manager. Please see page 117 for the Appeals Process.

The Prior Authorization List is on the PEBTF website at www.pebtf.org.

10.12  Filing a Prescription Drug Direct Claim
File a prescription drug claim with the Prescription Drug Plan if you or a covered Dependent:

- Use a pharmacy that is not part of the pharmacy Network
- Do not use the prescription drug Plan ID card when filling a prescription
- Purchase allergenic extracts from a physician
- Purchase a prescription drug from a physician

Prescription Drug Direct Claim/Coordination of Benefits Forms are available from the Prescription Benefit Manager, the PEBTF or may be downloaded from the PEBTF website, www.pebtf.org. The Prescription Benefit Manager will accept Direct Claim/Coordination of Benefits Forms completed in their entirety along with the receipt that must include:

- Pharmacy or physician's name and address
- Date filled
- Drug name, strength, National Drug Code (NDC)
- RX number, if applicable
- Quantity
- Days supply
- Price
- Patient’s name

All Prescription Drug Direct Claim/Coordination of Benefits Forms must be postmarked within one year from the date the prescription was filled.
You will be reimbursed based on the amount a Participating (Network) pharmacy would have been paid by the Prescription Drug Plan for filling the prescription minus your Copayment. In the case of an allergy extract, you will be reimbursed for the full cost of the extract itself minus your Copayment amount. The balance, if any, is your responsibility and is not eligible for consideration under any medical plan.

10.13 Filing a Claim for Residents of Nursing Homes – PPO & HMO Members
To obtain reimbursement for prescription drug claims incurred while you or a Dependent are a resident of a nursing home whose pharmacy does not participate with the Prescription Benefit Manager, claims should be submitted to the Prescription Benefit Manager using a Direct Claim/Coordination of Benefits Form.

You or your representative should notify the Prescription Benefit Manager that the direct reimbursement is being requested because the Member is a resident of a nursing home and could not use a Network pharmacy. The timely filing limitation will be enforced.

The mandatory generic provision will not apply to residents of nursing homes whose pharmacies do not participate with the Prescription Benefit Manager. You will save money by choosing generic drugs.

10.14 Using your Prescription Drug Card for Workers’ Compensation Related Prescriptions
Employees who have workers’ compensation claims that resulted from commonwealth employment and are administered by the commonwealth’s workers’ compensation carrier are required to use their prescription drug ID card to obtain medications used to treat those work-related injuries unless the workers’ compensation carrier has made other arrangements. Present your prescription drug ID card to a Participating pharmacy and pay the usual Copayment. The commonwealth will automatically reimburse you, within 45 days, for any prescription drug Copayments incurred for treatment of work-related injuries.

10.15 Coordination of Benefits
When the PEBTF is primary for coordination of benefits, and you and your Dependents have other prescription drug coverage, fill your prescription through the PEBTF Prescription Drug Plan. When another prescription drug plan is primary for you and your Dependents, submit balances to the Prescription Benefit Manager with a Direct Claim/Coordination of Benefits Form along with a copy of your pharmacy receipt and the primary plan’s Explanation of Benefits.

See page 104 of this SPD for complete Coordination of Benefits information.