

Maricopa County Pharmacy Benefit Plan



Administered Through
Walgreens
Health Initiatives

Effective July 1, 2008

Revision 04/14/08

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SUMMARY PLAN DOCUMENT

MARICOPA COUNTY PHARMACY BENEFIT PLAN

ADMINISTRATIVE INFORMATION

Plan Name:	Maricopa County Pharmacy Benefit Plan
Plan Sponsor:	Maricopa County
Group Number:	512229
Type of Plan:	Pharmacy Benefit Plan
Plan Administrator:	Walgreens Health Initiatives (WHI)
Address: (Pharmacy Benefit Manager)	2275 Half Day Road, Suite 250 Bannockburn, IL 60015
Funding Mechanism:	Self-Insured
Plan Year:	July 1 to June 30

ABOUT THIS DOCUMENT

- This Summary Plan Document (SPD) is intended to describe your pharmacy benefit plan. Every effort has been made to ensure the information contained in this SPD is accurate. If there is a discrepancy in the information, the plan sponsor will make the final determination.
- The plan sponsor reserves the right to amend or terminate any benefit described in this document at any time. Notices of changes will be communicated through the Electronic Business Center (EBC), Maricopa County's Intranet.
- The plan and/or WHI has the right to deny benefits for any drug prescribed or dispensed in a manner that does not conform to normal medical or pharmaceutical practices or that are received in a manner that does not conform to the plan design.
- When the words "we," "us," "our," and "plan" are used in this document, they refer to Maricopa County. When the words "you" and "your" are used, they refer to the Maricopa County employees, retirees and COBRA participants who are covered for medical care through certain CIGNA medical products (CIGNA Health Maintenance Organization, and Open Access Plus).
- The Maricopa County Employee Health Initiatives Department has two Web sites for employee use. The address of the Internet site is www.maricopa.gov/benefits, and the EBC/Intranet site is located at ebc.maricopa.gov/ehi. Both of these Web sites are collectively referred to as the "Employee Health Initiatives home page" in this document.

INTRODUCTION AND DESCRIPTION OF BENEFITS

This SPD explains your pharmacy benefits, how you are able to access these benefits and limitations and exclusions that apply. This document and the pharmacy benefit plan are effective July 1, 2008.

If you are a benefit-eligible active employee, retiree or have elected COBRA and are enrolled in a CIGNA medical plan, except for CIGNA Choice Fund Health Savings Account or CIGNA for Seniors, this pharmacy benefit plan applies to you.

If your medical coverage is CIGNA HealthCare for Seniors, a group Medicare Advantage plan, or CIGNA Choice Fund Health Savings Account, your pharmacy benefit is available through CIGNA instead of through Walgreens Health Initiatives.

NOTE: DIABETIC SUPPLIES AND MEDICATIONS MAY BE OBTAINED AT A CIGNA MEDICAL GROUP PHARMACY FOR \$10 PER ITEM FOR A 30-DAY SUPPLY. PLEASE SHOW YOUR CIGNA ID CARD SINCE THESE COSTS WILL BE CHARGED TO YOUR MEDICAL PLAN INSTEAD OF YOUR PHARMACY PLAN. YOU MAY ALSO VOLUNTARILY ENROLL IN THE DIABETIC MANAGEMENT PROGRAM AND MAY QUALIFY FOR FREE DIABETIC MEDICATIONS AND SUPPLIES. CONTACT THE EMPLOYEE HEALTH INITIATIVES DEPARTMENT FOR DETAILS.

Prescriptions may be purchased at either a retail pharmacy or through Walgreens Mail Service (Refer to the "Obtaining Pharmacy Benefits" section) with the exception of Specialty medications. (Refer to the "Specialty Pharmacy Program Section" for details.)

If you are eligible under this pharmacy benefit, there are two plans from which to choose: the Co-insurance plan or the Consumer Choice plan.

CO-INSURANCE PLAN

The Co-insurance plan is a multi-level plan in which a co-insurance amount (percentage of the cost* of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. This plan covers generic, preferred brand-name and non-preferred brand-name medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetic, smoking cessation, and non-steroidal anti-inflammatory medications, are excluded.

- **Level One** covers generic medications
- **Level Two** covers brand-name medications that are on the **Preferred Medication List (PML)**
- **Levels Three and Four** cover brand-name medications that are not on the PML (non-preferred)
- **Level Five** covers specialty medications

You will be charged the minimum or the maximum copay or the co-insurance amount for the medication based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic equivalent and the non-preferred brand-name medication. Refer to the "Co-insurance Schedule of Costs" section for details.

The co-insurance or the minimum or maximum copay you pay toward any covered medication counts towards your out-of-pocket maximum, except when a non-preferred brand-name medication with a generic equivalent is purchased, the difference between the non-preferred

brand-name and the generic equivalent does not count. Refer to the “Maximum Out-of-Pocket Limit” section for details.

PREFERRED MEDICATION LIST (PML)

A PML is a list of medications that have received FDA approval as safe and effective, and have been chosen for inclusion on the PML by a committee of physicians and pharmacists. The PML applies to the Co-insurance plan and can help you and your physician maximize your pharmacy benefit while minimizing overall prescription drug costs for you *and* Maricopa County.

WHI’s Pharmacy and Therapeutics (P&T) committee evaluates clinical efficacy and safety of each drug and votes the drug into one of three categories:

- **Therapeutically Unique** – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile, prompting automatic addition to the PML.
- **Therapeutically Equivalent** – Clinical effectiveness and safety profile are comparable to existing drugs.
- **Therapeutically Inferior** – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable, prompting automatic non-PML status.

Products classified by the P&T committee as therapeutically equivalent are then further evaluated from an economic perspective to determine which clinically appropriate drugs are most cost-effective for clients. The P&T committee’s evaluation is based solely on clinical criteria. Only after the P&T committee’s clinical assessment is made are the economics of the drug considered.

New FDA-approved drugs that arrive on the market are automatically available to you and are initially classified as non-preferred, except those excluded under your benefit plan. Based on the P&T committee’s decision, the new drug may then be classified as a preferred medication. Additions to the PML may be made on a quarterly basis throughout the year, with deletions most often occurring annually and effective January 1.

The most up-to-date PML for Maricopa County is available on the Employee Health Initiatives home page. A PML is also available on the WHI web site.

Certain drugs that are listed on the PML posted on the WHI web site at www.mywhi.com may not be covered under the Maricopa County Pharmacy Benefit Plan. Refer to the “Exclusions and Limitations” section for details.

Because so many generic (level one) medications are available, only the most frequently used generics are listed on the PML. However, all generics are covered unless specifically excluded. Generic medications are listed in lowercase on the PML.

Preferred brand-name medications (level two) are also listed on the WHI PML in uppercase.

Non-preferred brand-name medications (levels three and four) are not listed on the WHI PML. These are brand-name medications that are covered at a higher out-of-pocket cost.

Co-insurance Schedule of Costs

Retail Pharmacy 30 Day Supply or Advantage90 Pharmacy 84-91 Day Supply of Maintenance Medication

Level One	You are responsible for 25% of the contracted cost.* The cost of each prescription will be at least \$2 (the minimum copay) but no more than \$12 (the maximum copay) for a 30-day supply or at least \$6 but no more than \$36 for a three-month (84-91 days) supply.
Generics (on the Preferred Medication List (PML)):	
Level Two	You are responsible for 30% of the contracted cost.* The cost of each prescription will be at least \$5 but no more than \$30 for a 30-day supply or at least \$15 but no more than \$90 for a three-month (84-91 days) supply.
Preferred brand-name medications (on the PML):	
Level Three	You are responsible for 50% of the contracted cost.* The cost of each prescription will be at least \$20 for a 30-day supply or at least \$60 for a three-month (84-91 days) supply. There is not a maximum copay amount for the cost of medications in this level.
Non-preferred brand-name medications (not on the PML) with no generic equivalent:	
Level Four	You are responsible for 50% of the contracted cost* plus the difference between the cost of the generic medication and the non-preferred brand-name medication. The cost of each prescription will be at least \$20 for a 30-day supply or at least \$60 for a three-month (84-91 days) supply. There is not a maximum copay amount for the cost of medications in this category.
Non-preferred brand-name medications (not on the PML) with a generic equivalent:	
Level Five	Many specialty medications are on the PML as either a Level one or Level two medication. If the specialty medication is not on the PML, you are responsible for a \$50 copayment for a 30-day supply. Specialty medication is not available at a Retail or Advantage90 pharmacy. All specialty pharmacy medication is received through home delivery. Refer to the "Specialty Pharmacy Program" section for details.
Specialty pharmacy medications (not on the PML):	

Mail Service 84-91 Day Supply

Level One	You are responsible for 15% of the contract cost.* The cost of each three-month (84-91 days) supply will be at least \$6 (minimum copay) but no more than \$28 (maximum copay).
Generics (on the PML):	
Level Two	You are responsible for 25% of the contract cost.* The cost of each three-month (84-91 days) supply will be at least \$15 but no more than \$70.
Preferred brand-name medications (on the PML):	
Level Three	You are responsible for 50% of the contract cost.* The cost of each three-month (84-91 days) supply will be at least \$60. There is not a maximum copay amount for the cost of medication in this level.
Non-preferred brand-name medications (not on the PML) with no generic equivalent:	
Level Four	You are responsible for 50% of the contract cost* plus the difference between the cost of the generic and non-preferred brand-name medication. The cost of each three-month (84-91 days) supply will be at least \$60. There is not a maximum copay amount for the cost of medications in this level.
Non-preferred brand-name medications (not on the PML) with a generic equivalent:	
Level Five	Specialty medication may only be purchased in 30-day quantities; you are responsible for \$50 for a 30-day supply.
Specialty pharmacy medications (not on the PML) and received through home delivery:	

*Contracted cost is the discounted average wholesale price or the maximum allowable cost of the medication plus the dispensing fee. Discount varies by place of service (Retail pharmacy, Advantage90 pharmacy, mail service, or home delivery) and number of days supplied (up to 30 or between 84-91).

CONSUMER CHOICE PLAN

The Consumer Choice benefit is a four-level plan in which Maricopa County fully funds the first level, you fund the second level, and you and Maricopa County share the cost of the third level through co-insurance. Any unused portion of the first level is rolled over to the next plan year (if you re-enroll in the Consumer Choice plan), creating a credit balance that you can use to pay for future prescriptions, except for specialty medications. Any credit balance will be available for reimbursement up to three years following termination of employment with Maricopa County if enrolled in the Consumer Choice plan at the time of termination. The roll-over credit amount is available to whichever family members use the pharmacy benefit first, but any one individual cannot use more than the \$300 individual amount in a plan year.

One-time roll-overs of credit balances are allowed for employees dis-enrolling from the Consumer Choice plan and enrolling in the CIGNA Choice Fund Health Savings Account plan, upon request within one year of dis-enrollment from the Consumer Choice plan. Credit balances for employees dis-enrolling from the Consumer Choice plan and enrolling in the Co-insurance plan are no longer available to the employee following the date of dis-enrollment.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step-therapy). Other medications that could be used in a more cost-effective manner have messages advising the pharmacist to alert you if you've chosen a more expensive medication when a more cost-effective medication is available. You may also receive a letter in the mail advising you of a less expensive alternative to your current medication. A Guide to Cost-Effective Medications is available on the Employee Health Initiatives home page to assist in finding the most cost-effective medications. Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetic, smoking cessation and non-steroidal anti-inflammatory medications, are excluded.

The amounts you pay toward any covered medication, including specialty medication, will be applied to your annual maximum out-of-pocket limit. Refer to the "Maximum Out-of-Pocket Limit" section for details.

Certain generic preventive medications are provided to you at no cost. Because there is no cost to you, the costs of these medications do not count in any of the levels or towards the out-of-pocket maximum. The Preventive Drug List is available on mywhi.com and the Employee Health Initiatives home page.



Level 1

Pharmacy Account: This level is funded 100% by Maricopa County at the rate of \$300 per individual or \$500 per family (more than one enrolled person) as a credit balance for the plan year. Regardless of family size, the total family amount is \$500. This amount is available to whichever family members use the pharmacy benefit first, but any one individual cannot use more than \$300 of the allocated \$500 family amount. You use this credit to pay for prescription medications, excluding specialty medication, at the contracted cost.* Any unused credit in your pharmacy account is rolled over to the next plan year if you re-enroll in the Consumer Choice plan. After using up the credit in the pharmacy account, you move to level 2.

Level 2

Employee Responsibility: This level is funded 100% by you at the rate of \$300 per individual or \$500 per family. Regardless of the family size, the total family amount is \$500. This amount is applied to whichever family members use the pharmacy benefit first, but any one individual will not be charged more than \$300 of the allocated \$500 family amount. You pay for your prescription medications, excluding specialty medication, at the contracted cost.* If you have enrolled in the Mariflex health care flexible spending account, you can use your pre-taxed funds to be reimbursed for medication purchased at this level. After you meet your employee responsibility, you move to level 3.

Level 3

Traditional Pharmacy Insurance: This level covers the cost of the medication at 80% of the contracted cost* of the medication. You pay 20% of the contracted cost* (excluding specialty medication). If you have enrolled in the Mariflex health care flexible spending account, you can use your pre-taxed funds to be reimbursed for medication costs spent at this level. If you reach your out-of-pocket maximum of \$1,500 for individuals or \$3,000 for families, you pay nothing further for covered medications during the plan year.

Level 4

Specialty pharmacy medications: These medications will not be charged against your Level one pharmacy account or Level two employee responsibility levels, or Level three traditional pharmacy insurance. Instead, a \$50 copay will be charged for each 30-day supply of specialty medication. Specialty pharmacy copays count toward the \$1,500 for individuals or \$3,000 for families out-of-pocket maximum. Once you reach your applicable out-of-pocket maximum, you pay nothing further for covered medications during the plan year.

**Contracted cost is the discounted average wholesale price or the maximum allowable cost of the medication plus the dispensing fee. Discount varies by place of service and number of days supply.*

OBTAINING PHARMACY BENEFITS

You can obtain your prescriptions from three different sources. The three sources include a retail pharmacy within the WHI national pharmacy network for up to a 30-day supply, a WHI Advantage90™ retail pharmacy for an 84-91 day supply, and Walgreens Mail Service for an 84-91 day supply (Refer to the Specialty Pharmacy Program section for information regarding the centralized distribution of specialty medication). All three sources have contracted pharmacies within the WHI network. Refer to the “WHI National Retail Network” section for details. Prescriptions filled at non-contracted pharmacies are not covered under your pharmacy benefit plan, except in emergency situations.

Medication obtained in a 31-83 day quantity or greater than a 91-day quantity are not covered under your pharmacy benefit.

Federal law prohibits the return of dispensed prescription medication. It is advisable to check your medication before leaving the pharmacy to make sure you are charged correctly and that you received the correct number of pills.

SHORT-TERM NEEDS

UP TO A 30-DAY SUPPLY AT RETAIL PHARMACIES

WHI's retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or for up to two fills of maintenance medication. You can choose from thousands of participating network pharmacies nationwide, and you can obtain up to a 30-day supply at one time. You can find the nearest participating network pharmacy by calling **WHI's Member Services at 800-207-2568** or by going online via the Internet to www.mywhi.com. A small number of medications are limited by the manufacturer or the Federal Drug Administration to a 30-day or less supply, such as, but not limited to, Accutane (including generic equivalents) and Peg-Intron.

LONG-TERM NEEDS

THREE MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™

When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service after two fills at a retail pharmacy. You may purchase a three-month supply of maintenance medication on you first fill, if you so choose. The physician must write your prescription for an 84-91 day supply. Refer to the “WHI National Retail Network” section to locate a participating pharmacy.

THREE MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY

Prescriptions for maintenance medications or long-term health conditions can also be ordered through the Walgreens Mail Service pharmacy. Ordering through the mail is both a safe and convenient way to receive prescriptions and save money. You must use a specific order form when placing your first order to provide Walgreens Mail Service with important health, allergy and plan identification information. This form is called the **Tempe Registration and Order Form** and is available online at the Employee Health Initiatives home page or at WHI's Web site: www.mywhi.com. You can even register online at the WHI Web site instead of completing a hard copy of the form. **Forms are not available through Walgreens Customer Service.**

Send the completed form, along with your original written prescription, to **Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038**. Be sure to include your group number, **512229**, on the form. You may pay by check, money order, VISA, MasterCard, Discover or American Express. Please do not send your debit card number or cash.

You can have your prescriptions delivered to the location of your choice, such as your home address, your work location or even to a local Walgreens retail pharmacy.

Your doctor cannot phone in new prescriptions. However, your doctor can send a new prescription via facsimile (fax) by using the required form, **Tempe Physician Fax Order Form**, available at www.mywhi.com or by selecting the Member Forms link or the WHI link on the Employee Health Initiatives home page.

When your order is filled, it will be promptly delivered via U.S. mail. Your package usually arrives within seven to 10 days. Your order will include medication container(s), instructions for refills and information about your medication.

To ensure that you don't run out of medication, remember to reorder by the refill date indicated on your refill slip or medication container, or when you have 14 days of medication left.

FINDING THE LOWEST COPAY OR CO-INSURANCE FOR YOUR MEDICATION

The cost of medication varies based on the discount amount off the average wholesale price, the dispensing fee, the place of purchase (retail 30, Advantage90™ or mail service), the drug type (generic, preferred brand, non-preferred brand), and in some cases the maximum allowable cost (MAC).

Generally, the cost of medication is least costly at mail service and then at a retail pharmacy participating in Advantage90™, and lastly at a retail pharmacy for a 30-day supply. However, in some cases, this is not true.

In order to determine where to make the most cost-effective purchase of medication, you should go to www.mywhi.com and check the copay link.

DRUG UTILIZATION ALERTS AT TIME OF PURCHASE

Drug Utilization Review (DUR) is an effective tool used by WHI in monitoring your drug use to assure that it is appropriate, safe and effective. At the time of purchase, WHI's DUR program monitors your claim submissions across all pharmacies and prescribing physicians, compares each claim with your active prescriptions and notifies the pharmacist if any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) guidelines and monitors every prescription for numerous conditions. The pharmacist may decide not to dispense medication based on the DUR alert received at the point of service. Examples of some of the DUR alerts are listed below.

DRUG/DRUG INTERACTION

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more medications at the same time. The possible results of the interaction could include an increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these interactions occur, the WHI system advises the dispensing pharmacist that the drug about to be dispensed may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgment to intervene, if necessary, to prevent the patient from being harmed.

OVERUTILIZATION

The submission of prescription drug claims across all contracted pharmacies is monitored. When a prescription claim request is received, the WHI system reviews the patient's drug profile, searching for a previous prescription for the same drug or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim if the request for the medication is being submitted sooner than the plan recognizes as appropriate.

THERAPEUTIC DUPLICATION MONITORING

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed drug may duplicate the therapeutic effects of another drug already prescribed for the patient. This duplication can occur even when the two drugs are prescribed for different medical conditions.

When a duplication of therapy is detected, WHI transmits this information to the dispensing pharmacist, including the name of the drug that is duplicating the therapy, for further evaluation and intervention.

RETROSPECTIVE DRUG UTILIZATION REVIEW

WHI reviews all prescriptions after they are purchased to assist your health care providers in their effort to ensure safe and appropriate use of medications for you. As part of this program, WHI pharmacists may confidentially analyze your medication history in order to determine appropriateness of therapy. The prescribing doctor may be provided with the most recent educational materials based on nationally accepted therapy guidelines to assist in this determination.

MAXIMUM OUT-OF-POCKET LIMIT

The co-insurance or copay, including minimum and maximum amounts and excluding the difference between the cost of a non-preferred brand-name medication and its generic equivalent (for the Co-insurance plan), paid towards covered drugs, including specialty medication, will be applied to your maximum out-of-pocket limit:

- Individual coverage, \$1,500
- Family coverage, \$3,000

Once you and/or your covered dependents meet the out-of-pocket maximum, covered prescriptions are paid 100% by the plan for the remainder of the plan year. Any number of family members can contribute to the family out-of-pocket maximum. The amount you pay for any *excluded drug* will not be included in calculating your annual out-of-pocket maximum. You are responsible for paying 100% of the contracted cost for any excluded drug.

Note: Diabetic supplies and medications obtained at a CIGNA Medical Group pharmacy under your medical insurance are not included in the calculation of your maximum out-of-pocket limit since the cost of these supplies and/or medications are covered under your medical plan instead of your pharmacy plan.

COVERED ITEMS

The following items are covered under the pharmacy benefit plan, unless specifically listed in the “Exclusions and Limitations” section.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications and supplies such as blood glucose monitors, test strips, disposable insulin syringes, lancets (including automatic lancing devices), glucagon, prescribed oral agents for controlling blood sugar and any of the devices listed above that are needed due to being visually impaired or legally blind

Note: Insulin pumps and cartridges are not available through your pharmacy benefit. Your medical insurance provides these through their durable medical equipment (DME) provider.

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including, but not limited to, certain anti-fungals, hair loss treatments, those used for pigmenting/depigmenting and reducing wrinkles
- Fertility drugs (oral and injectable)
- Diabetic urine tests and alcohol swabs
- Nutritional/dietary supplements

Note:

- Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your medical insurance according to Arizona state statute.
- Over-the-counter medications and other over-the-counter items
- Prescription strength medication that is available over-the-counter in lower doses

- Certain injectable medication obtainable through and administered by a physician in an office setting. If the medication is available to and administered through your physician's office, then it may be covered through your medical insurance in-network plan
- Miscellaneous medical supplies
- Coverage of prescription drug products for an amount that exceeds the supply limit (either days supply, age or quantity limit)
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws
- Charges to administer or inject any drug
- Certain self-injectable drugs
- Prescription drugs not deemed medically necessary
- Charges for delivering any drugs except through the mail service. Express or overnight delivery costs are not covered
- Experimental or investigational medications
- Prescription drugs purchased from an institutional pharmacy for use while you are an in-patient of that institution (hospital, skilled nursing facility or alternate facility), regardless of the level of care
- Prescription drugs furnished by the local, state or federal government
- A specialty medication prescription drug product (such as immunizations and allergy serum) which, due to its characteristics as determined by the plan administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting
- Replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill
- Prescription drug products for smoking cessation, unless they are provided through and in accordance with an approved wellness program through Maricopa County
- Prescription drugs for the treatment of erectile dysfunction for sex offenders who have been convicted of the violations indicated under A.R.S. § 13-3821
- The difference between the cost of a non-preferred brand-name medication and the generic equivalent
- Maintenance Medication purchased in a 30-day quantity after two fills
- Botulinum Toxin

Note:

- Reimbursement for prescription drugs purchased at full retail cost is limited to the contracted cost less co-insurance or copay. Refer to the "Direct Member Reimbursement" section.
- Maricopa County does not coordinate benefits with other pharmacy benefit plans.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization (approval before they will be covered). Types of prior authorizations include, but are not limited to, medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe, where an age limitation has been reached and/or exceeded or where appropriate utilization must be determined. WHI, in its capacity as the pharmacy benefit manager, administers the clinical prior authorization process on behalf of Maricopa County.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the physician, you or your covered dependents by calling 1-877-665-6609 Monday through Friday, 8 a.m.-8 p.m., Central Standard Time (CST). The pharmacy *may* call after being prompted by a medication denial with a message stating, "*Prior authorization required; call 1-877-665-6609.*" The pharmacy may also pass the information on to you and require you to request the prior authorization.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that Maricopa County participates in a CPA program for the particular drug category. The Clinical Services Representative generates a drug-specific form and faxes it to the prescribing physician. Once the fax form is received from the physician by the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from WHI's receipt of the completed form from the prescribing physician, not including weekends and holidays.

If the prior authorization request is approved, the WHI Clinical Services Representative calls the person who initiated the request and enters an override into the WHI claims processing system for a limited period of time. The pharmacy will then process the prescription.

If the prior authorization request is denied, the WHI Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the reason for denial. The letter will include instructions for appealing the denial. For more information, see the "Appeal Procedures" section.

Drug categories or medications that require prior authorization include, but are not limited to:

- Actiq
- Anabolic steroids (all forms)
- Anti-obesity medications
- Anti-fungals (i.e., Lamisil, Sporanox and Diflucan)
- Atopic Dermatitis
- Byetta
- Crinone 8
- Fentora
- Insomnia medications
- Penlac
- Ranexa
- SSRI (Selective Serotonin Reuptake Inhibitor)
- Symlin
- Viral Hepatitis (Specialty medication)
- Erythropoietins (Specialty medication)

The criteria for the CPA program are based on nationally recognized guidelines, FDA-approved indications and accepted standards of practice. Each guideline has been reviewed and approved by WHI's P&T committee for appropriateness.

To confirm whether you need prior authorization and/or to request a prior authorization, call **WHI's Clinical Member Services at 877-665-6609** Monday through Friday, 8 a.m.-8p.m., CST. Please have the information listed below available when initiating your request for prior authorization:

- Name of Your Medication
- Prescribing Physician's Name
- Prescribing Physician's Phone Number
- Prescribing Physician's Fax Number, if available
- WHI Member ID Number (from your WHI ID card)
- Maricopa County Group Number: **512229**

In some instances, a therapeutically equivalent prerequisite medication may be required to be tried before other medication is approved. This is called step therapy.

Drug categories or medications that require step therapy include, but are not limited to:

- Proton Pump Inhibitors (PPIs such as Nexium, Protonix and Aciphex)
- Cox II inhibitors (i.e., Celebrex and Bextra)
- Stadol
- Leukotrienes
- Select Serotonin Reuptake Inhibitors (SSRI)
- DDP-4 Inhibitors
- Long-Acting Beta 2 Agonists (LABA)
- Non-Sedating Antihistamines

Note: Certain prior authorization and step-care programs do not apply to members enrolled in the Consumer Choice plan including prior authorization for anti-obesity medications, and step-care programs for OTC Prilosec, OTC Non-sedating antihistamines, Cox-II Inhibitors and SSRIs.

AGE AND QUANTITY LIMITATIONS

Some medications are subject to age and quantity limits. Your claim will be denied at the time of purchase if these limitations are exceeded. Limitations are based on criteria developed with guidelines from various national medical agencies in conjunction with WHI's clinical review process.

AGE LIMITATIONS

Certain medications have an **age** limitation, including, but not limited to, the following health conditions:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Impotency*
- Narcolepsy
- Topical Acne

If your prescription is denied due to age limitations, but you and your physician believe that it is medically necessary for you to take this medication to treat one of the above conditions, you may request prior authorization. Refer to the "Prior Authorizations" section for details.

QUANTITY LIMITATIONS

Certain medications have **quantity** limitations, including, but not limited to, the following health conditions and medications:

- Antiemetics
- Butorphanol
- Duragesic
- Impotency*
- Insomnia
- Migraine Medications
- Oxycontin

If your prescription is denied due to quantity limitations, except for impotency, and you and your physician believe that it is medically necessary for you to take a larger quantity of this medication, you may request prior authorization. Refer to the “Prior Authorizations” section for details.

***Note:** Impotency limitation is a set monthly quantity. The limitation for this condition is not appealable. Prior authorization does not apply.

SPECIALTY PHARMACY PROGRAM

Certain medications used for treating chronic or complex health conditions are handled through the WHI Specialty Pharmacy Program.

The purpose of the Specialty Pharmacy Program is to assist you with monitoring your medication needs for conditions such as those listed below and to provide patient education. The program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage handling and delivery.

Medications covered through the Specialty Pharmacy Program may include, but are not limited to, the following conditions:

- Acromegaly
- Chronic granulomatous disease
- Cystic Fibrosis
- Deep vein thrombosis
- Gaucher disease
- Growth Hormone Deficiency
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis
- Psoriasis
- Respiratory Syncytial Virus (RSV)
- Rheumatoid Arthritis
- Solid Organ Transplant
- Some oncology-related conditions
- Viral Hepatitis

Medications through the Specialty Pharmacy Program may be obtained only in 30-day increments through **Walgreens** centralized distribution center. Your specialty medication will be delivered to your home or any other location you choose.

You may enroll in the Specialty Pharmacy Program by contacting **WHI's Specialty Care Pharmacy Center** at **1-888-782-8443**, or a Specialty Care Representative may contact you to facilitate your ongoing prescription needs. Trained Specialty Care pharmacy staff are available 24 hours a day, seven days a week to assist you.

Effective July 1, 2008 certain self-administered injectables may only be obtained through the WHI Specialty Pharmacy Program and may not be covered if administered in your physician's office. Examples of these self-administered injectables may include, but are not limited to the following conditions:

- Biologic Response Modifiers (i.e. Enbrel, Humira, Kineret, Raptiva)
- Growth Hormone (i.e. Genotropin, Humatrope, Norditropin, Nutropin, Saizen, Serostim, Tev-tropin, Zorbitive)
- Multiple Sclerosis (i.e. Avonex, Betaseron, Copaxone, Rebif)
- Narcolepsy (i.e. Xyrem)
- Osteoporosis (i.e. Forteo)
- Parkinson's Disease (i.e. Apokyn)
- Pulmonary Hypertension (i.e. Revatio)
- Viral Hepatitis (i.e. Copegus, Infergen, Intron A, Pegasys, Peg Intron, Rebetol, Ribapak Dosepack, Ribasphere, Ribatab, Ribivirin, Roferon A)

TERMINATION

Coverage ends the last day of the payroll period in which you cease to be eligible for coverage or for which a premium was paid while you were eligible, whichever comes first. Please refer to "When Does Coverage End?" and "Do Benefits Continue While on a Leave of Absence?" sections of the *Know Your Benefits* guide for details. This guide is available on the Employee Health Initiatives home page. Refer to the "About this Document" section for details.

You are responsible for immediately notifying the Employee Health Initiatives Department when a dependent no longer meets the eligibility requirements listed in the "Are Dependents Covered?" section of the *Know Your Benefits* guide. Prescription and administrative costs paid or incurred on behalf of an ineligible dependent become your responsibility.

When any of the following happen, we will provide you written notice that coverage has ended on the date we identify in the notice.

- **Fraud, Misrepresentation or False Material Information:** You provided false information related to another person's eligibility or status as a dependent.
- **Improper Use of ID Card:** You permitted an uncovered person to use your ID card to obtain services under this plan.
- **Failure to Pay:** You failed to pay the required premium for coverage.
- **Threatening Behavior:** You commit an act of physical or verbal abuse that poses a threat to administrative or clinical personnel associated with the management of this plan.

RIGHT OF RECOVERY

If the amount of payment for pharmacy claims we made is more than we should have paid, we may recover the excess from you or from one or more of the persons we paid. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

IDENTIFICATION CARDS

WHI issues ID cards to you for identification purposes only. The ID card is not proof of coverage or of eligibility for services on a particular date of service. The ID card contains the name of the employee (Subscriber) and each covered dependent. Each covered dependent is identified by a person code. The pharmacies must enter the appropriate person code in order for the prescription to process.

You must show your ID card at the time you obtain your prescription drug product at a contracted (participating) pharmacy or provide the pharmacy with identifying information that can be verified with the Employee Health Initiatives Department during regular business hours.

The computer system at the pharmacy will confirm your eligibility for benefits even if you do not have your WHI ID card with you, as long as you provide the pharmacist with the following information:

- RxBIN 603286
- RxPCN 01410000
- RxGrp 512229
- Issuer (80840)
- Your name
- Your WHI ID number (either your Employee ID Number, your Social Security Number or your Alternative ID Number)

If you don't show your ID card or provide verifiable information, you will be required to pay the full cost for the prescription product at the pharmacy.

You may receive reimbursement for covered medication in covered quantities as described in the "Direct Member Reimbursement" section. When you submit a claim on this basis, you may pay more because you did not show proof of your eligibility when the prescription drug product was dispensed. The amount you are reimbursed will be based on the contracted cost plus dispensing fee, less the required co-insurance or copay.

To be entitled to the covered prescription medication, you must be the employee or a covered dependent on whose behalf all applicable premiums have been paid, and all eligibility requirements have been met. Any person receiving a covered prescription medication who is not entitled, including, but not limited to, fraudulent information submitted to WHI, will be fully responsible for reimbursement of the cost of the covered prescription medication to the Benefits Trust Fund.

If you lose your ID card or need additional cards for covered dependents, call **WHI Member Services** at **800-207-2568** and provide your name and ID number. Your ID number is either your Social Security Number, your Employee ID Number or an Alternative Identification Number. Two additional cards will be sent to your address that is on file with Maricopa County's Payroll computer system.

DIRECT MEMBER REIMBURSEMENT

There may be instances where you are in need of a prescription for which you are eligible but are unable to have your claim processed through a WHI pharmacy due to situations such as being outside the service area, an emergency or being a new member whose enrollment has not been processed. In situations such as these, you will be required to pay the full retail cost of the covered medication.

You can receive reimbursement for covered prescriptions you've paid for under the plan by following these steps:

1. Pay the pharmacist the full amount of your prescription. Keep your prescription receipt(s).
2. Obtain and complete a Direct Member Reimbursement (DMR) claim form available via the Employee Health Initiatives home page.
3. Send your completed form and itemized receipts to the Employee Health Initiatives Department at 301 W. Jefferson, Suite 201, Phoenix, AZ 85003. DMR requests must be received at the Employee Health Initiatives Department within one year from the date of service in order to be eligible for reimbursement.

The Employee Health Initiatives Department will make a determination and, if approved, will forward your claims to WHI to process your request for reimbursement according to the plan's guidelines, coverages, limitations, and exclusions. If the request is approved, you should receive your reimbursement within four weeks.

Please note that you will be reimbursed according to the plan's guidelines. Your reimbursement will be calculated at the contracted cost for the medication or the maximum allowable cost plus dispensing fee, less your co-insurance or copayment instead of the full retail price of the medication.

COMPLAINT PROCEDURE

If you are dissatisfied with the service received under this pharmacy benefit plan, you are encouraged to contact **WHI's Member Services Department, 24 hours a day, seven days a week at 1-800-207-2568**. Frequently, your concern can be resolved with a telephone call to a Member Services Representative.

If WHI Member Services cannot resolve your concern, you may file a complaint with the Employee Health Initiatives Department either telephonically by calling (602) 506-1010 or in writing. Examples of concerns for which you may file a complaint include, but are not limited to, quality of service received, payment amount of a claim, plan design, or Preferred Medication List content.

You will receive a response from the Employee Health Initiatives Department within 30 calendar days from the date the Employee Health Initiatives Department receives your written complaint. If additional research is required to resolve your complaint, you will receive a written progress report prior to the 30th day and at 30-day intervals until a determination is rendered. For issues that are clinical in nature, such as denied prior authorization, you may file an appeal as explained below.

APPEAL PROCEDURE

You may file an appeal in writing by completing the **Pharmacy Program Appeal Form** that is available on the Employee Health Initiatives home page. You may submit this form in person or by mail to the Maricopa County Employee Health Initiatives Department at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, Monday through Friday, 8 A.M. - 5 P.M. You will be notified of receipt of the appeal within five business days.

If the appeal is regarding a denial of a Clinical Prior Authorization (CPA) or other clinical issue, either WHI or an independent review organization (IRO) contracted by WHI, will provide you with the resolution to your appeal. Please note that denials of a CPA due to medical information not being received by WHI from your physician will not be considered for the appeal process. Also note that plan design and Preferred Medication List content are not issues that can be appealed.

For denied CPA appeals, the Employee Health Initiatives Department will track and forward the appeal form and medical necessity documentation that you submit from the prescribing physician to WHI's Clinical Call Center. WHI will either review the appeal internally or forward the appeal request to the IRO for review. The IRO assigns an independent physician to review your appeal based on the issue. The IRO physician will review the appeal and make a recommendation. The IRO submits its recommendation to WHI's Clinical Call Center, which notifies you by mail of the resolution, with a copy to the Employee Health Initiatives Department. The turnaround time for a CPA appeal is ten business days from the date the appeal is received by the IRO, excluding holidays and weekends.

If the appeal is regarding a clinical issue such as prospective reviews, quality of care, retrospective reviews or other types of appeal requests that are not classified as a CPA, the appeal follows the same process as above, with a turnaround time of 30 business days from the date the IRO received your information, excluding holidays and weekends.

WHI NATIONAL RETAIL NETWORK

You can choose from more than 63,000 contracted pharmacies. Below are some of the many pharmacies participating in the WHI nationwide 30-day retail network. For additional participating pharmacies, call **WHI's Member Services at 800-207-2568** 24 hours a day, seven days a week or visit the WHI Web site at www.mywhi.com. Refer to subsection "Three Month Supply through Mail Service" section for details about mail service.

- Albertsons/Osco*
- Bashas*
- CIGNA CMGs*
- Costco
- CVS*
- Fry's*
- Kmart
- Safeway*
- Sam's Club*
- Target*
- Walgreens*
- Wal-Mart*

**Indicates participating in the 90-day Advantage90™ network*

IMPORTANT PHONE NUMBERS

NAME	PHONE	HOURS	WHO	REASONS TO CALL (Including but not limited to)
WHI Member Services	800-207-2568 Toll free	24 hours a day, 7 days a week	<ul style="list-style-type: none"> Members Dependents Pharmacies Maricopa County Employee Health Initiatives personnel 	<ul style="list-style-type: none"> Eligibility Prescription will not process Find out if a drug is covered Find out if drug is on PML Find out your co-insurance
WHI Clinical Call Center	877-665-6609 Toll free	Monday – Friday, 8 a.m.–8 p.m. (Central Standard Time)	<ul style="list-style-type: none"> Members Dependents Pharmacies Physicians Maricopa County Employee Health Initiatives personnel 	<ul style="list-style-type: none"> Initiate a clinical prior authorization (CPA) review Check status of a CPA review Check to see if prior authorization is required for a drug (See <i>PRIOR AUTHORIZATIONS</i> section for details.)
WHI Specialty Pharmacy Center	888-782-8443 Toll free	Monday – Friday, 8 a.m.–10 p.m. (Eastern Standard Time)	<ul style="list-style-type: none"> Members Dependents Physicians 	<ul style="list-style-type: none"> Obtain a specialty medication Check on status of a specialty drug (See <i>SPECIALTY PHARMACY PROGRAM</i> section for details.)
Walgreens Mail Service Pharmacy	888-265-1953 Toll free	Monday – Friday, 7 a.m.–7 p.m. Saturday, 7 a.m.–Noon (Mountain Standard Time)	<ul style="list-style-type: none"> Members Dependents 	<ul style="list-style-type: none"> Check on status of a mail service prescription
Maricopa County Employee Health Initiatives Department	602-506-1010	Monday – Friday, 8 a.m.–5 p.m. (Mountain Standard Time)	<ul style="list-style-type: none"> Maricopa County employees and dependents 	<ul style="list-style-type: none"> Eligibility File an appeal (See <i>APPEAL PROCEDURES</i> section for details.) Reimbursement for prescriptions for which you paid (See <i>DIRECT MEMBER REIMBURSEMENT</i> section for details.)



www.mywhi.com