

Prescription Drug Benefits

THE STATE OF MARYLAND PRESCRIPTION DRUG PLAN ADMINISTRATOR IS SUBJECT TO CHANGE.

DETAILS TO FOLLOW IN SUPPLEMENTAL COMMUNICATION BULLETIN.

The State's Prescription Drug Plan is administered by a Pharmacy Benefit Manager called a "PBM." The PBM can provide you with additional plan information, the location of participating pharmacies, the identification of preferred drugs, the cost for your prescriptions, and other plan information. Outpatient prescription drug coverage is not included in any medical plan coverage. **You must enroll separately in the prescription drug benefits plan; there is a separate premium for this coverage.**

If you or your covered dependents are eligible for Medicare, you may have additional options for prescription drug coverage through the Medicare prescription drug plans (Part D) that became available January 1, 2006. Please see the Notice of Creditable Coverage in this guide for more information.

NEW! Copays and Out-of-Pocket Maximums for Active Employees

Effective July 1, 2011, the prescription plan copays and the annual out of pocket maximums have changed for active employees, other non-retirees and their dependents. Please see the chart on the following page.

How the Plan Works

BRAND NAME VERSUS GENERIC DRUGS

The State prescription plan only covers up to the cost of a generic drug when a generic is available. If you purchase a brand name drug when a generic drug is available, even if it is prescribed by your physician, you must pay the difference in price between the brand name and the generic, plus the applicable copay. The plan does not pass judgment on a physician's determination as to the appropriate medication for treatment, but the plan does have limitations as to the types and amounts of reimbursement available. This same rule applies to prescriptions filled either at a retail pharmacy or through the mail order program.

PBM contact information to follow.

Preferred Brand Name Drugs

Preferred brand name drugs are those medications that the PBM has on its preferred drug list. **This list may change at any time.**

The PBM's physicians and pharmacists evaluate the medications approved by the Food and Drug Administration (FDA). Each drug is reviewed for safety, side effects, efficacy (how well the drug works), ease of dosage, and cost. The drugs that are judged the best overall are selected as preferred brand name drugs. You pay less if you choose preferred brand name drugs. Preferred drugs are reviewed quarterly and are subject to change.

ACTIVE EMPLOYEES ONLY —

NEW! SAME COPAYS FOR RETAIL PHARMACIES OR THROUGH THE VOLUNTARY MAIL ORDER PROGRAM

When you have a prescription filled, your copay is based on the type of drug you purchase and the quantity. As shown in the chart below, you will pay less if you fill your prescription with a generic or preferred brand name drug.

NOTE: If you choose a brand name drug when a generic is available, you will pay the generic copay plus the difference in cost between the generic and brand name drug.

The PBM also offers a voluntary mail order program that enables you to have long-term or maintenance medications (for conditions such as high blood pressure, high cholesterol, or diabetes) delivered to your home. You may refill your medications online or by phone.

Type of Drug	Prescriptions for 1-45 Days (1 copay)	Prescriptions for 46-90 Days (2 copays)
Generic drug	\$10	\$20
Preferred brand name drug	\$25	\$50
Non-preferred brand name drug	\$40	\$80

The Prescription Drug plan has an annual out-of-pocket copay maximum of \$1,000 per individual and \$1,500 per family. This means that when the total amount of copays you pay during the plan year reaches \$1,000 or the total amount of copays combined for you and your covered dependents pay during the plan year reaches \$1,500, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year (through June 30).

If you choose to purchase a brand name drug when a generic drug is available, the amount of the generic copay will be counted toward your \$1,000 or \$1,500 annual copay maximum, but the amount you pay that is the cost difference between the generic and brand name drugs will not.

Special Note for Retired Employees

Please note that a proposal has been made to change the retiree drug plan benefits as follows:

- Prescription coverage will closely mirror the basic Medicare Part D plan:
- Retiree pays first \$310 in Rx costs each year.
- After \$310 annual deductible is met, retiree pays 25% of prescription costs and Plan pays 75%, up to \$4,550 in retiree out of pocket costs.
- After maximum retiree out of pocket cost reached, Plan pays 100% for remainder of the plan year.

This proposal may be passed as is, amended and passed, or not passed at all.

If this proposal is passed, these benefits are effective July 1, 2011.

If the proposal is amended, the plan design in the chart to the left will change and you will be sent a supplemental communication detailing the changes. This information will also be posted on the Employee Benefits Division website.

If the proposal is not passed at all, Retirees will have the same new prescription copays and out of pocket limits as Active employees outlined in this section.

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

Zero Copay for Generics Program

The copayment for specific classes of generic drugs is zero dollars (\$0) at both retail and mail order pharmacies. The five drug classes including some examples of generic drugs covered under this program are listed in the chart below.

If you are currently taking a brand name medication in one of these drug classes, please consult with your physician to determine if a generic alternative is appropriate.

Specialty Drug Management Program

The Specialty Drug Management Program is a program that is designed to ensure the appropriate use of specialty drugs. Many specialty drugs are biotech medications that may require special handling and may be difficult to tolerate.

The specialty drugs included in this program may be used for the treatment of Rheumatoid Arthritis, Multiple Sclerosis, Blood Disorders, Cancer, Hepatitis C, or Osteoporosis. Specialty drugs in this program will be automatically reviewed for step therapy, prior authorization, and quantity or dosage limits. These specialty drugs will be limited to a maximum 30-day supply per prescription fill. Some of these specialty drugs are listed in the chart on page 43.

Details on Specialty Drug Management Program to follow.

Voluntary Specialty Pharmacy

The PBM offers a voluntary specialty pharmacy that helps members who need specialty drugs. The specialty pharmacy has nurses, pharmacists and other health care professionals who can help you understand the special characteristics of these drugs. They can also help you with health educational materials, monitoring, and other health assistance.

Details on Specialty Pharmacy Benefits to follow.

ZERO COPAY FOR GENERICS PROGRAM

Drug Class	Used to Treat	Generic Drugs*
HMG CoA Reductase Inhibitors (Statins)	High Cholesterol	simvastatin (generic Zocor) pravastatin (generic Pravachol)
Angiotensin Converting Enzyme Inhibitors (ACEIs)	High Blood Pressure	lisinopril (generic Zestril) lisinopril/HCTZ (generic Zestoretic) enalapril (generic Vasotec) enalapril/HCTZ (generic Vaseretic)
Proton Pump Inhibitors (PPIs)	Ulcer/GERD	omeprazole (generic Prilosec)
Inhaled Corticosteroids	Asthma	budesonide (generic Pulmicort Respules)
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression	fluoxetine (generic Prozac) paroxetine (generic Paxil) sertraline (generic Zoloft) citalopram (generic Celexa)

*The standards of quality are the same for generics as brand-name. The Food and Drug Administration (FDA) requires that all drugs be safe and effective. When a generic drug product is approved and on the market, it has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity and potency.

Disease	Specialty Drugs in the Specialty Drug Management Program
Rheumatoid Arthritis	Cimzia, Enbrel, Humira, Kineret, Orenzia, Orthovisc, Remicade, Euflexxa, Hyalgan, Supartz, Synvisc
Multiple Sclerosis	Avonex, Betaseron, Copaxone, mitoxantrone, Novantrone, Rebif, Acthar HP, Tysabri
Blood Disorder	Aranesp, Arixtra, Epogen, Fragmin, Innohep, Lovenox, Nplate, Procrit, Leukine, Neulasta, Neupogen, Neumega, Proleukin, anti-hemophiliac agents
Cancer	Afinitor, Gleevec, Iressa, Nexavar, Revlimid, Sprycel, Sutent, Tarcva, Tasigna, Temodar, Thalomid, Treanda, Tykerb, Xeloda, Zolanza, Eligard, Plenaxis, Trelstar, Vantas, Viadur, Zoladex, Thyrogen, Aloxi IV, Anzemet IV, Kytril IV, Zofran IV
Hepatitis C	Alferon N, Copegus, Infergen, Intron A, Pegasys, Peg-Intron, Rebetol, ribasphere, ribavirin, Roferon-A
Osteoporosis	Forteo, Reclast
*This list is subject to change without notice to accommodate new drugs and to reflect the most current medical literature.	

Prior Authorization Drugs

Some drugs require prior authorization from the PBM before they can be covered under the Prescription Drug plan. These drugs are medications that have serious or toxic side effects, or are at a high risk for misuse or abuse. Prior authorization drugs include, but are not limited to:

- 🌸 Retin-A
- 🌸 Growth hormones
- 🌸 Lamisil
- 🌸 Desoxyn
- 🌸 Dexedrine
- 🌸 Adderall

Details on how to obtain Prior Authorization from the PBM to follow.

Drugs with Quantity Limits

Some drugs have limits on the quantities that will be covered under the State plan. Drugs with quantity limits include drugs the FDA only approved for short-term use. Other drugs with quantity limits may be less effective or harmful when overused. Quantity limits encourage the safe and appropriate use of prescription drugs. Some drugs with quantity limits include, but are not limited to:

- 🌸 Erectile Dysfunction medications
- 🌸 Proton pump inhibitors
- 🌸 Sedatives
- 🌸 Hypnotics (e.g., sleeping pills)
- 🌸 Nasal inhalers

When you go to the pharmacy for a prescription drug with a quantity limitation, your copay will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. The cost of the additional quantities will not count toward your \$1,000 individual/\$1,500 family annual copay maximum.

The list of quantity limitation drugs is subject to change at any time.

Details on Quantity Limits to follow.

Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate drug therapy and helping to reduce prescription costs.

The first step in the process is usually a treatment known to be safe and effective for most people, called first-line therapy. The next step is second-line therapy. First- and second-line drugs are selected by the PBM after careful review of medical literature, manufacturer product information, and consultation with medical professionals.

Example: The prescription drug Celebrex is a mandatory step therapy drug for those under age 60. Before first-time coverage for Celebrex is provided, you may need to try other first- and second-line medications. Your physician will need to submit medical documentation to the PBM's Prior Authorization Unit for Celebrex to be covered for first-time treatment.

Details on Step Therapy to follow.

Leukotriene Modifier Step Therapy Program




Leukotriene Modifiers (Singulair, Accolate and Zyflo) are medications used to treat asthma and generally should not be taken as first-line therapy for asthma or allergic rhinitis (allergy). Members and their dependents over the age of 12 who are not currently taking other asthma medications or first-line allergy medications (such as a non-sedating antihistamine and a nasal steroid), must request prior authorization for coverage.

Requirements for Approved Use of Singulair

1. Patient is 12 years old or younger or
2. Patient must have a history of asthma or
3. Patient must have tried other allergic rhinitis therapies without success

DRUG EXCLUSIONS

Some drugs and medications are excluded from coverage, including, but not limited to:

-  Weight-loss drugs;
-  Vitamins and minerals (except for prescription pre-natal vitamins); and
-  Drugs that are labeled by the FDA as "less than effective."

Information regarding Drug Exclusions to follow.

DIRECT MEMBER REIMBURSEMENT

If you or your covered dependent purchase a covered prescription drug without using your prescription drug card you must pay the full cost of the medication.

Details on how to file Direct Member Reimbursement claims to follow.

Allergy Serum Claims

When you receive an allergy medication, there may be two costs: one for the allergy serum and one for the physician's professional services.

Details on how to file Allergy Serum claims to follow.

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