

Prescription Drug Rider For Association Plan 5000A-0609

Dean Health Plan, Inc., 1277 Deming Way, Madison, WI 53717
(608) 828-1301 • 1-800-279-1301 • TTY (608) 827-4086



You have purchased this Prescription Drug Rider as part of your Association Plan issued by Dean Health Plan, Inc. **Please keep this Prescription Drug Rider with your Association Member Certificate and Benefit Summary and other important insurance papers.**

This Prescription Drug Rider has the effective date of your Association Plan and is part of the entire contract. It shall continue in force under the same provisions that govern the entire contract. All other terms, provisions, and conditions of the entire contract remain unchanged except as stated above.

In witness whereof, Dean Health Plan, Inc. has executed this Prescription Drug Rider.

Robert L. Palmer
President and Chief Executive Officer

Outpatient Prescription Drugs

HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT THESE BENEFITS:

- ▶ We cover prescribed drugs and medications according to the drug formulary. Certain prescription drugs included in our formulary require prior authorization. The drug prior authorization process can be initiated by your primary care provider (PCP), or treating physician, by filling out a Drug Prior Authorization Request form. Notification of a determination will then be mailed to you and the plan physician. You may contact your PCP for information on a particular drug, or you may contact our Customer Service Department.
- ▶ Updates to the drug formulary are provided in Notables, our quarterly news magazine sent to the member's home. Members may also obtain a listing by calling our Customer Service Department.
- ▶ Certain drugs that have a therapeutic equivalent are excluded from coverage.
- ▶ To see if a drug is listed on the formulary, you can call our Customer Service Department, or go to our website at www.deancare.com
- ▶ Drugs purchased in connection with emergency or urgent care services are not subject to the plan pharmacy requirement.

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Outpatient Prescription Drugs (RXs)	You pay
<p>TIER 1 consists of formulary generic RXs. TIER 2 consists of formulary brand-name RXs. TIER 3 provides benefits for non-formulary RXs.</p> <p>Covered Services:</p> <p>When this Policy/Rider indicates that there is coverage of RXs, this includes legend drugs which by law require a written prescription, are prescribed by a plan provider for treatment of a diagnosed illness or injury, and purchased from a plan pharmacy after a copay amount, as described in this Rider. This includes investigational drugs for the treatment of HIV. Unless otherwise specified, prescription drugs will be dispensed in maximum quantities as follows:</p> <ol style="list-style-type: none"> 1. Legend brand and generic substitutes not to exceed a 30-day supply. 2. Mail order - a 90 day supply of prescription medication for only two copays. Mail order is available for maintenance medications for allergies, cholesterol, blood pressure and more. 3. Pulmicort powder for oral inhalation shall be limited to one item for up to three copays, depending on the day's supply for which the product will last, based on the instructions of the prescription. 4. Single-packaged items, except for Pulmicort powder for oral inhalation and Estring, are limited to 2 items or a 1 month supply, whichever is less, per copay. A single-packaged item includes, but is not limited to: inhalers, blood glucose sticks, eye drops, and ear drops. If a single package item will last 30-days or longer, the member is limited to one single package per copay. If the single packaged item lasts less than 30-days, then the member is limited to two single packages per copay. Also, ointments, creams, gels, solutions and other topical medications need to be dispensed in the smallest tube or package size that will last 30-days. Oral contraceptives are not considered to be single-packaged items. Estring is limited to one item for three copays. 4. RXs dispensed in connection with mandated Home Health Care will be covered regardless of the RX coverage indicated in this Policy/Rider. Female hormones, including, but not limited to: oral contraceptives package, Prempro, and Orthoprefest, shall be dispensed per cycle package, and one copay will be charged per cycle package. 5. Members requesting brand name RXs, but whose physician did not specifically authorize brand, are responsible for the brand name copay plus the difference in cost between the brand and generic item (this cost difference does not apply to the brand out-of-pocket maximum). 6. Human growth hormones, upon prior authorization approval, for the following conditions: growth hormone deficiency in children and adults and short stature children with Turner Syndrome or kidney disease. This does not include Idiopathic short stature. 7. The Tier 1 drug copay does not apply to the Tier 2 drug out-of-pocket maximum. 	<p>TIER 1 \$10 copay per RX</p> <p>TIER 2 \$40 copay per RX</p> <p>TIER 3 \$75 copay per RX</p>
<p>Non-Covered Services:</p> <ol style="list-style-type: none"> 1. Medication for the treatment of sexual dysfunction and sexual transformation. 2. Charges for RXs that require prior authorization, unless approved by our Medical Affairs Division. 3. Charges for medications used for cosmetic purposes, compounded estrogen, progesterone or testosterone products for oral or sublingual administration, anorexic agents, or any medications prescribed for weight loss, smoking cessation products, oral progesterone products, unless specifically included on the formulary, and all over the counter drug items, except nicotinic acid, and Loratadine and Prilosec, when your health care provider writes a prescription and its filled at a plan pharmacy. 	<p>100%, Not Covered</p>

Outpatient Prescription (RX) Drugs <i>continued...</i>	You pay
<p>Non-Covered Services <i>continued...</i>:</p> <ol style="list-style-type: none"> 4. Dispensing charge for unit dose medications. A unit dose medication is an individually wrapped and labeled dosage form of drug typically used in hospitals and nursing homes. 5. Charges for injectable medications administered in a nursing home when the nursing home stays are not covered by DHP. 6. Existing drugs, and drugs recently approved by the FDA, may be reviewed by our Pharmacy and Therapeutics Committee (Committee) to determine their place in current practice. Existing drugs may be excluded from coverage when the Committee determines therapeutically equivalent alternative drugs are available and covered under this Policy/Rider. 7. New drugs, but they may be added to coverage after the Committee determines the therapeutic advantages of the drug and its medically appropriate application. 8. Certain drug products when comparable generic or therapeutic alternatives are available. Covered substitute drug products will be dispensed. In some instances, the member must obtain approval from the original prescribing practitioner before the substitute drug product is dispensed. 9. Replacement of lost or stolen RXs. 10. Human growth hormones, unless otherwise covered in this Policy/Rider. 11. Treatment for Idiopathic short stature. 	<p>100%, Not Covered</p>