MariPlan 2003
Frequently Asked Questions

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Terms

Copayment
The flat dollar amount shown in the schedule of copayments that you pay at the time that certain covered services and supplies are delivered.

Coinsurance
The percentage of charges for covered expenses that an insured person is required to pay under the Plan after the applicable deductible is met.

CAT Scan
CAT stands for computed tomography. A CAT is a special radiographic technique that uses a computer to assimilate multiple x-ray images into a two-dimensional cross-section image. The CT machine rotates 180 degrees around the patient's body, sending out an x-ray beam at 160 different points. Data are picked up and recorded and then relayed to a computer that turns the information into a picture on a screen. The picture produces an entire slice of the body.

EOB (Explanation of Benefits)
A document sent to the medical plan enrollee from the insurance carrier describing claim payment and/or denial reason(s), as well as enrollee payment responsibility.

Mariflex
A pre-tax, flexible spending account plan for health care and dependent care.

MRA
MRA stands for magnetic resonance angiography, which is a magnetic resonance study of blood vessels. It uses magnetic resonance technology to detect, diagnose and aid the treatment of heart disorders, stroke and blood vessel diseases. MRA provides detailed images of blood vessels without using contrast material.

MRI

MRI stands for magnetic resonance image. MRI is a method of producing extremely detailed pictures of body tissues and organs without the need for x-ray. The electromagnetic energy that is released when exposing a patient to radio waves in a strong magnetic field is measured and analyzed by a computer, which forms two- or three-dimensional images that may be viewed on a TV monitor.

PCP
A primary care physician is one who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you. Your primary care physician is responsible for managing all treatment rendered to you, including referrals to specialists.

Prior Authorization
The approval a participating or non-participating provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain services and supplies to be covered under the medical insurance agreement. If prior authorization is not approved for out-of-network Prime Option POS or in-network and out-of-network PPO services, a $400 penalty will be applied. (Please note that all conditions of eligibility and enrollment must be met in addition to prior authorization in order for payment to be made.)

R&C (Reasonable and Customary)
A charge is considered reasonable and customary if it is the normal charge made by the provider for a similar service or supply, and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received. R&C rates are adjusted periodically.

PET
PET stands for positron emission tomography. A PET is a highly specialized research imaging technique using short-lived radioactive substances. Tomographic images are formed by computer analysis of photons; the images, often enhanced with a color scale, show the uptake and distribution of substances in the tissue, permitting analysis and localization of metabolic and physiological function.

Services Provided by a Specialist

1. Are well-woman examinations that are provided by an OB/GYN considered to be services provided by a specialist?

   Yes. An OB/GYN is considered to be a specialist. Some products charge a higher copayment for services provided by a specialist. These products include CIGNA Prime Option POS and PPO. OB/GYN well-woman services may be accessed directly without a referral from your primary care provider (PCP).

   Your PCP may also provide your well-woman examination. In that case, your PCP office visit copayment for your product applies.

2. Is treatment by a physical therapist considered to be a service provided by a specialist?

   While a physical therapist is considered a specialist, the Specialist Copay does not apply. There is a separate copayment or coinsurance for physical therapy services that varies depending on the medical product in which you are enrolled.

3. Is treatment by a chiropractor considered to be a service provided by a specialist?

   While a chiropractor is considered a specialist, the Specialist Copay does not apply. There is a separate copayment or coinsurance for chiropractic services, that varies depending on the medical product in which you are enrolled.

Lab/X-Ray/Scans

4. Are lab and x-ray (radiology) services considered to be services provided by a specialist?

   No. Lab and x-ray services are not considered to be services provided by a specialist. The lab and x-ray copayment or coinsurance for the product will apply. For example, general lab and x-ray procedures for the CIGNA HMO and the in-network provision of the Prime Option POS products have no copayments or coinsurance. However, for the higher cost scans, these two CIGNA products charge a $50 copayment for MRIs, MRAs, PETs, and CATs.

5. Is there a copayment for MRI or CAT scans when an in-network facility is used?

   The CIGNA products charge a copayment of $50 for the HMO and Prime Option POS products ***when MRI, MRA, PET or CT scanning technology is used by a facility within the network.*** The PPO product covers 80% (20% member coinsurance). However, when other radiological technology is used to diagnose a condition within the network for the HMO and POS products, the copayment may be either $0 or the copayment related to the place of service.

   For example, no copayment is charged for the HMO or POS products for ultra-sound imaging, which is a radiological technique that uses high-frequency sound waves. However, a copayment for the place of service is charged for a mammography, which is an x-ray picture of the breast.

   It is suggested that you refer to the schedule of benefits in the Group Service Agreement before accessing services or that you call the CIGNA Member Services Department so you are aware if a copayment or coinsurance applies.

   Scans do require prior authorization to demonstrate medical necessity.

6. What is the copayment for bone scans used to detect osteoporosis if received within the network?

Bone density is detected using an x-ray called a quantitative computed tomogram. The x-ray measures the amount of bone tissue in a certain volume of bone. Because the x-ray used to measure the bone density is not an MRI, MRA, PET or CAT scan, no copayment is required for the HMO and POS products. The PPO product requires a 20% coinsurance after the deductible is met.

Bone density scans do require prior authorization to demonstrate medical necessity.

Alternative Medicine

7. Is the alternative medicine benefit still available?

   Yes. The alternative medicine benefit continues to be available for both the CIGNA and HealthSelect plans. Services are available when performed at a designated alternative medicine center. Alternative medicine benefits are not available on an out-of-network basis for the HMO, the Prime Option POS or the PPO products.

   Six office visits per calendar year are available for a $5 per visit copayment. Services may be accessed by self-referral. Additionally, a $60 allowance is provided for purchase of herbal and homeopathic products.

   Designated Centers for the CIGNA products include the Southwest Naturopathy Center located at 8010 E McDowell, # 205, Scottsdale, telephone number 480/970-0000 and Naturopathic Family Care located at13832 N 32nd St., Phoenix, telephone number 602/493-2273.

   For HealthSelect, the Designated Centers include Dr. Abraham Kuruvilla. Dr. Kuruvilla and his staff offer alternative medicine services for HealthSelect at three designated sites located at 1492 S Mill, Tempe, telephone number 480/968-4200, 3201 W. Peoria, Peoria, telephone number 602/863-2111, and 1402 S 9th Ave., Phoenix, telephone number 602/258-1651.

Prime Option and/or PPO Benefit Questions

8. Will the Prime Option POS product continue to have out-of-network services available?

   Yes. Characteristics of a POS (point of service) product include the availability of services through either a contracted, in-network provider or through a non-

contracted, out-of-network provider. The new PPO product also has these characteristics.

9. When does out-of-network coverage apply for the Prime Option POS product?

   Out-of-network benefits apply when:
   - You obtain care from a doctor who does not participate in the CIGNA network;
   - You go to a specialist without a referral from your primary care physician (unless it is a participating gynecologist you are seeing for your annual well-woman exam);
   - You enter a hospital for non-emergency services without going through your primary care physician;
   - You receive outpatient service for conditions that are neither emergencies nor urgent care without authorization from your primary care provider; or
   - You receive services from a PCP (without an association to your assigned PCP) other than the one to whom you are assigned.

   Other limitations you should be aware of include:
   - Preventive care is not covered (100% of the charge is the responsibility of the member, and the charge is not applied to your deductible);
   - Your out-of-network coverage is only for treatment, not for periodic physical exams or immunizations or injections;
   - You have to pay a deductible and coinsurance;
   - You have to pay for out-of-network medical services yourself until you reach the deductible amount specified in your Benefit Summary. Then, you'll have to pay a percentage (called coinsurance) of each eligible medical bill, as specified in your certificate;
   - You have to keep track of the out-of-network expenses you pay; there is an out-of-pocket maximum for each covered individual and for the family as a whole. Only certain services apply to the out-of-pocket maximum. After reaching the out-of-pocket maximum, all eligible charges are covered 100 percent. Your deductible does not count toward your out-of-pocket maximum.
   - Services are covered up to the reasonable and customary amount. In addition to your deductible and coinsurance, you are responsible for any portion of a medical bill that goes beyond established reasonable and customer charges for your geographic area. This is sometimes referred to as the "excess charge".
   - Services requiring prior authorization in-network also require prior authorization when services are provided out-of-network. You are responsible to co-ordinate such prior authorization through your out-of-network provider.

10. Who is responsible for obtaining prior authorization when out-of-network services are accessed under the Prime Option POS or the PPO products?

    You are ultimately responsible for obtaining prior authorization before services are accessed when you use your **out-of-network** services under the Prime Option POS or the PPO product. Since clinical information such as diagnosis ICD9 codes and CPT procedure codes are usually required by CIGNA to prior authorize services, you may be able to persuade the non-contracted, out-of-network provider to contact CIGNA to provide such information. However, you are responsible for an increased cost if a prior authorization is not approved before accessing non-emergency services. Payment for services will be reduced by a $400 penalty if prior authorization is not obtained.

11. When does the **in-network** deductible apply for the **PPO** product?

    The in-network deductible for the PPO product applies to services *that do not have a copayment.* A copayment is a flat dollar amount. For example, an office visit to a PCP has a $20 copayment. Since a flat dollar copayment is your cost for the service, the deductible does not apply. *Copayments* do not reduce your deductible amount.

    For services that have coinsurance (percentage coverage), either the in-network individual or family deductible must be met before any payment is made. For example, inpatient services are covered at 80%. 20% is considered coinsurance because services are covered at a percentage amount instead of at a flat dollar amount. Before 80% of the services are covered, the remaining individual deductible amount will be subtracted from the contracted rate first and then 80% of the remaining balance will be calculated and subtracted. The amount you owe is the unmet deductible amount plus 20% coinsurance of the remaining amount.

    You have protection that limits the amount you pay per calendar year with your medical out-of-pocket (OOP) maximum. OOP maximums apply to the accumulated cost of your coinsurance amounts throughout the calendar year for inpatient, outpatient, home health care, and skilled nursing care services. If your coinsurance for one or more of these services accumulates to more than the OOP individual or family maximum amount ($2,000/$6,000 In-Network; $4,000/$12,000 Out-of-Network), then services will be a no cost to you for the remainder of the calendar year.

    Deductibles and copayments do not count towards your OOP maximum.

    Example of In-Network Calculation (assuming individual or family deductible is not met)

Individual In-network Deductible	$250
Contracted Rate for In-Patient Services	$3000

$3000 contracted rate for services
-$250 individual deductible
=$2750
x .80 percentage covered by Plan
$2200 costs paid by medical Plan

$2750 service cost after deductible
-$2200 amount covered by PPO
$550 20% coinsurance

$250 individual deductible
+$550 20% coinsurance
$800 Your cost for this service

12. When accessing **out-of-network** services on either the **Prime Option POS** or the **PPO** product, will CIGNA cover the provider's full-billed charges after my deductible and coinsurance amounts are met?

    The answer depends on the amount of the full-billed charges. When a non-contracted, out-of-network provider provides services, payment is calculated on the reasonable and customary rate (R&C) charged within the provider's geographic region. Your individual (or family) out-of-network deductible must be met before any payment is made on the claim. Then the coinsurance amount (30% or 40% depending on your product) is multiplied by the R&C rate. The remaining balance plus the excess charge between the R&C rate and full-billed charges will be your liability (cost).

    For example, for **the PPO product**, if full-billed charges were $100 for an out-of-network office visit and the R&C rate for this service was $70, and assuming that your individual or family out-of-network deductible ($750/$1500) had already been met, then CIGNA would cover 60% of $70 of the R&C rate. This calculates to $42. Your liability (cost) would be $100 (full-billed charge) minus $42 (60% coinsurance of R&C amount) which equates to a $58 liability (cost) (40% coinsurance of the R&C amount, $28, plus the excess amount between full-billed charges and R&C amount, $30.

Full-billed charges	$100
R&C rate	$70
Percentage covered by Plan	x.60
Cost paid by medical Plan	$42

Full-billed charges	$100
Cost paid by medical Plan	-$42
Your cost for this service	$58

The **POS** product would be calculated the same as in the above example, except that the coinsurance amounts of 70%/30% would be used.

13. Is there still a $250 copayment for in-patient hospital services under the Prime Option POS product?

    No. The inpatient hospital benefit was enhanced to reduce the in-patient hospital services copayment from $250 to $100. The County continues to reimburse you the cost of this copayment after you submit your Explanation of Benefits (EOB) and a completed reimbursement request form to the Employee Benefits Department. This reimbursement form is available on the EBC Intranet Benefits Home page located at http://ebc.maricopa.gov/benefits/ or via the Internet at http://www.maricopa.gov/benefits/. Go to the "Forms" link.

14. Since HealthSelect is no longer covering dental services as part of its medical coverage, can I enroll in other dental coverage?

    Yes, that is advisable. As part of your benefit package, you have dental insurance available for your purchase. Our current vendors, EDS and United Concordia, continue to provide dental coverage for 2003. Dental benefits for these two plans remain unchanged. Your cost for either of these vendors costs a little less than last year.

15. Can I see a PCP who participates in the CIGNA HMO Medical Group (staff model) and in the CIGNA Private Practice network? (Can I switch back and forth between the two types of offices?)

    If you choose to enroll in the Prime Option POS product, you can access services at either thee Medical Group model (staff model) or in a PCP's private office as long as the PCP you select is a PCP on both the private practice list and on the HMO Medical Group physician list.

    For this to work properly, you must select the primary care physician identification number from the private practice directory as your PCP.. If you choose the PCP's identification number from the HMO Medical Group directory, you will be restricted to receiving services at the HMO Medical Group setting.

MARIFLEX

16. How are we to calculate the costs of medications under the Universal Pharmacy benefit (the new self-funded pharmacy benefit attached to the CIGNA products), if costs of medications vary from month to month?

    The contracted cost of medications under the Universal Pharmacy benefit is based on a discounted Average Wholesale Price (AWP). AWP is subject to change as often as weekly. However, AWP does not change weekly on each medication. You will find that the change in cost for each medication is infrequent and minimal. However, since funds contributed to a flexible spending account, such as the Mariflex program, are forfeited if not used, the Employee Benefit Administration suggests taking a conservative approach when calculating your medical costs for 2003.

17. Can I sign up for Mariflex any time?

    No. Mariflex enrollment is available to new hires during their 60-day election period, during open enrollment, or when a qualifying event occurs.

18. If I enroll in Mariflex and set aside $300 for calendar year 2003, and then I incur an expense of $500, can I increase my election to a greater amount?

    No. Once your election is made for the calendar year, no changes can be made to your elected amount, unless you have a qualifying event.

19. Does Employee Benefits offer a Brown Bag Seminar to explain Mariflex?

    No. However, that is an excellent idea and Employee Benefits will pursue developing educational material with the Mariflex administrator.

20. Do I need to submit proof of payment of a claim before being reimbursed by Mariflex?

    With the exception of orthodontic coverage as described above, claims do not have to be paid prior to being reimbursed through your Mariflex funds.

Universal Pharmacy Benefit for CIGNA Plans

21. Will mail-order prescriptions be available under the new Universal Pharmacy benefit? If so, how will it work?

It is the intent of the Benefits Department to offer a mail-order prescription benefit because this mode of delivery offers employees convenience and cost-savings.

The design of the mail-order benefit will probably change from what is offered today (90-day supply for two copayments). Further details will be given as soon as the design is completed.

22. Will I be able to continue to obtain my prescriptions at the CIGNA Medical Group pharmacy?

    At this time, the Benefits Department has not been able to work out an arrangement with CIGNA to allow for the dispensing of prescriptions at the CIGNA Medical Group pharmacy through the new Universal Pharmacy Benefit administered by Walgreens Health Initiatives (WHI). Instead, you will have your prescriptions filled at one of the over 50,000 conveniently located pharmacies within the WHI network. This includes independents and all major pharmacy chains such as Albertsons, Bashas, Fry's, Kmart, Osco, Safeway, Target, Walgreens, Wal-mart, Sam's Club and CVS(the newest pharmacy chain in the valley).

23. If I am covered by a CIGNA product and access Urgent Care after normal office hours, where can I get my prescriptions filled?

    The Walgreens Health Initiative (WHI) network contains 50,000 + pharmacies many of which are open 24 hours per day, 7 days per week.

24. If I'm covered under the Universal Pharmacy Benefit, will I need to call my pharmacist each month before I pick up my prescription to find out my cost for the medication?

    If you want to know the exact amount of a **refill** of an existing prescription, your pharmacist will be able to provide you with your exact cost once the prescription is refilled. The cost is identified through the refill process when the pharmacist enters information about your prescription into the on-line system that is connected to Walgreens Health Initiatives (WHI) claims processing software. When the claim processes (usually in just a few seconds), your cost is passed back to the pharmacist.

    After January 1, 2003, you will also have the option of calling the WHI Member Services number. A Member Services Representative will be able to run a test claim to identify the approximate cost of your prescription. Prescription quotes

may vary slightly depending on manufacturer pricing and the NDC (national drug code) used by the pharmacy.

It is anticipated that there will be only minimal changes to the cost of medications from month to month.

From now through the end of December 2002, the Benefits Department can assist you in determining the coinsurance amount of your current prescription drugs. Information needed to fulfill a request includes the name of the medication, the strength of the drug, and the quantity (# of pills, etc.) for a one-month supply. You may email this information to BenefitsService email address found on the Global address list in Outlook.

25. Will the pharmacist know the Average Wholesale Price (AWP) of a medication?

    While the pharmacist will not have access to the Average Wholesale Price of a medication, the pharmacist will have access to the amount of your coinsurance cost, which is based on a discounted AWP, after processing your claim.

26. We use the term Brand On and Brand Off to identify Tier 2 and Tier 3 of the Universal Pharmacy benefit. The pharmacist uses the terminology of Preferred and Non-Preferred. What do those terms mean?

    The Universal Pharmacy benefit chose to describe the three tiers in more understandable terms. Generic describes Tier 1 that has a 25% coinsurance and a $2 minimum and a $10 maximum. Brand On describes Tier 2 that has a 30% coinsurance and a $5 minimum and a $25 maximum for medications contained on the approved list (formulary). Brand Off describes Tier 3 that has a 30% coinsurance and a $20 minimum and a $50 maximum for medications not contained on the approved list (formulary).

    Pharmacists may use the term “Preferred” to mean what is referred to as “Brand On” and “Non-Preferred” to mean what is referred to as “Brand Off. “Brand On” means the medication is on the approved drug list. “Brand Off” means the medication is not on the approved drug list. See the chart below for further clarification of terms.

Three-Tier Coinsurance Level	Type of Medication	Also referred to as:
Tier 1: Lowest Coinsurance	Most generic medications	Generic
Tier 2: Middle Coinsurance	Medications on the formulary with no generic available	Brand On, Preferred Brand, Formulary Brand
Tier 3: Highest Coinsurance	Brand name drugs not listed on the formulary or brands with a generic available	Brand Off, Non-Preferred Brand, Non-Formulary Brand, Multi Source Brand

27. Is there an appeal process if I disagree with the tier or cost of a prescription?

    Yes, there will be an appeal process. The process is not yet fully defined. Further information will be supplied on how the appeal process will work closer to the effective date of the benefit (January 1, 2003).

28. What drugs are covered on Tier 1 of the Universal Pharmacy benefit?

    The 1st tier of the pharmacy benefit includes generic medications. (Generic medications are less costly than brand name drugs.) Only A and AB rated generic drugs, which are the highest quality ratings for generics, will be dispensed.

29. What drugs are covered on Tier 2 of the Universal Pharmacy benefit?

    The 2nd tier includes preferred brands that are on the formulary. The formulary is a list of approved drugs that have been selected based on clinical advantage and cost effectiveness. Brand name drugs are under patent protection for up to 17 years, during which time a generic equivalent in not available. Additionally, some brand-name drugs are chosen for Tier 2 based upon safety, efficacy (effectiveness), and cost.

30. What drugs are covered on Tier 3 of the Universal Pharmacy benefit?

    The 3rd tier includes brand name drugs not listed on the formulary **OR** brand name drugs that have a generic equivalent. Generally, if two drugs are equally safe and effective, but one drug costs more than another, then the higher cost brand-name drug will be on Tier 3. If your physician determines that there is a medical reason for you to take a non-formulary, Tier 3 medication, you may still obtain the drug, however you will be responsible for the higher Tier 3 coinsurance amount.

31. Will drugs change from one tier to another tier during the year?

    Certain drugs will change from one tier to another tier during the calendar year. This mostly happens when a brand-name drug is on Tier 2 and a generic equivalent becomes available for the drug. In that case, the generic equivalent becomes available on Tier 1 and the brand-name drug moves to Tier 3.

32. Will new drugs be added during the year?

    Yes. New drugs will be added during the calendar year. WHI's Pharmacy and Therapeutics Committee must first review new drugs before adding them to the formulary. For the most up-to-date formulary information, go to the Walgreens Health Initiatives website at www.whphi.com. See question and answer below regarding the Pharmacy and Therapeutics Committee.

33. Will drugs be taken off the approved list during the year?

    No. Drugs will not be taken off the approved list during the year. However, drugs may change from one tier to another tier during the year. For example, if a generic becomes available for a brand name drug that is currently on Tier 2, the generic drug would be placed on Tier 1 and the Tier 2 brand name drug would be placed on Tier 3.

    There may be some drugs taken off the formulary at the beginning of each calendar year. The Benefits Department will communicate the formulary changes that will be effective January 1, 2003, as soon as those changes have been identified by WHI. The formulary that is available today is currently being used by WHI for 2002. The 2003 formulary has not been created to date.

34. Will any drugs require prior authorization?

    Yes. Certain drugs or classes of drugs will require clinical prior authorization. Prior authorization includes, but is not limited to, Proton Pump Inhibitors (PPIs) such as Prilosec and Cyclooxygenase (Cox2) Inhibitors such as Vioxx.

35. Will any drugs have quantity level limits?

    Yes. Certain drugs will have the number of pills or units dispensed for a monthly supply limited.

36. How will I know when a drug has moved from Tier 2 to Tier 3 because a generic equivalent became available?

WHI will notify the Benefits Department when a generic equivalent for a brand-name Tier 2 drug becomes available. The Benefits Department will communicate this information electronically to employees via e*Nouncements. Department managers or supervisors will need to communicate this information to any of their employees that do not have daily access to a computer and/or the EBC.

37. How will my out-of-pocket maximum be tracked? Will I be responsible for tracking it?

    The on-line system used by your pharmacist is linked to WHI's claims system. The WHI claim system will accumulate all of your coinsurance costs, including minimum and maximum amounts as each prescription is filled. Once your individual or family pharmacy out-of-pocket maximum is reached, then your future covered prescriptions will be dispensed at no charge for the remainder of the calendar year.

38. If my physician prescribes a brand-name drug, can the pharmacist fill the prescription with a generic?

    The answer depends upon how your physician completed the prescription form. On the prescription form, there is an area where the physician can indicate if generic substitution is allowed. If generic substitution is allowed and a generic equivalent is available, the pharmacist should ask you if you would like to have the prescription filled with a generic. If the pharmacist does not ask you, you should ask the pharmacist.

    While a generic equivalent of the brand-name drug may not always be available, there may be other generic drugs within the drug classification that may work for you. While your pharmacist may not change the drug prescribed by your physician, the pharmacist can call your physician and ask for the prescription to be changed to a generic alternative. Your pharmacist is an excellent resource to answer questions about medications. You should take advantage of his/her knowledge by asking questions about less expensive alternative drugs or call WHI Member Services or ask a pharmacist a question online via the Internet site for Walgreens, http://www.walgreens.com.

    Physicians and pharmacists work very closely together to meet your health care needs.

39. How large is the formulary for the Universal Pharmacy benefit?

    The formulary (the approved list of medications) contains approximately 600 drugs. The names of drugs prescribed most frequently and covered on the

formulary are listed on the formulary guide. The formulary guide is available online through the http://mariplan.tripod.com web site under a link found in the Walgreens Health Initiative text (through the EBC or the Internet) or through the Internet via Walgreens Health Initiative site at http://www.whphi.com.

40. How does the pharmacist know if a brand-name drug is on Tier 2 or Tier 3?

    When the pharmacist inputs your prescription information in the on-line system that interfaces with the WHI system, the WHI system checks to see to which tier the drug is assigned and returns the appropriate coinsurance. A message may return to the pharmacist indicating preferred alternatives, if the drug is on Tier 3.

41. If the prescription I'm taking is on the 3rd tier and there is no generic equivalent available, can I get the medication for the Tier 1 generic cost?

    No. If you are taking a drug on Tier 3 and there is no generic equivalent, you will be charged the Tier 3 coinsurance (with the minimum or maximum applied). You have the option of speaking with your physician about a brand-name drug on Tier 2. You more than likely also have the choice of having your physician prescribe a generic within the same drug class. Either option will reduce your out-of-pocket expenses.

42. Is Walgreens on the Internet (worldwide web)?

    Yes. Walgreens is available via the Internet at www.walgreens.com. The web site is a virtual retail site where you can order prescriptions*, refill your prescriptions*, print prescription records*, view prescription history*, update health history*, ask a pharmacist a question online, visit the health library, purchase non-prescription items, etc. Visit this site soon to see additional features! (*These options only apply to prescriptions purchased through Walgreens stores.)

    Walgreens Health Initiatives, the company that will be managing our pharmacy benefit, also has a website, www.whphi.com. This is the web site that contains the formulary.

43. Can I ask my physician to write my prescriptions for generic medications so I can pay the less expensive Tier 1 price?

    Yes. It is advisable to discuss with your physician the type of medication being prescribed. Let your physician know that you are willing to take generic medications if there is one that meets your needs. Take a copy of the formulary with you when you visit your physician for quick reference of what is covered.

44. Who determines if drugs are added to or deleted from the approved list (formulary)?

    Walgreens Health Initiatives' (WHI) Pharmacy and Therapeutics Committee reviews medications to determine placement on the appropriate tier. The Committee is comprised of pharmacists and physicians. Medications may be added to the formulary on a quarterly basis but will only be removed/deleted at the beginning of each calendar year.

    The P&T committee evaluates clinical efficacy (effectiveness) 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 formulary
    - 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-formulary 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.

    The P&T committee's evaluation is based solely on clinical criteria. It is only after the P&T committee's clinical assessment is made that the economics of the drug are considered. Drugs are reviewed for clinical efficacy prior to contact with manufacturers for contracting purposes.

    New drugs that arrive on the market are automatically available to members and are initially placed into the 3rd Tier excepting those excluded under the benefit plan. Based on the P & T committee's decision, the new drug may then be placed on the 2nd Tier. The formulary updates will appear on a revised formulary that will be posted on the WHI website. WHI will also provide updates to the Benefits Department via their "Initiatives" newsletter and through quarterly meetings. To see a full listing of commonly prescribed preferred brand medications, please log onto WHI's web site at www.whphi.com/formulary.

45. How am I assured that I am paying the correct price for my prescriptions?

The Benefits Department will audit the pharmacy claims to ensure that claims process according to contracted rates (Discounted average wholesale price plus dispensing fee). Should you ever have a concern about the accuracy of the coinsurance cost of your prescription, you may either contact WHI's Member Services Department or you may call the Employee Benefits Department for assistance.

46. Should I shop around for the best prices on prescriptions?

    Generally, you will not save money by shopping around for the best price on prescriptions. However, the different pharmacies buy from different manufacturers so there is a possibility that your coinsurance could vary slightly from one pharmacy to another. Additionally, sometimes pharmacies will give a lower price than our contracted rate on a few medications in order to obtain your business.

47. Will I get my diabetic supplies at the pharmacy? What tier are they on?

    You have a choice on where to obtain your diabetic supplies. They will be available through your prescription benefit at the pharmacy for your coinsurance amount. They will also be available through the CIGNA Medical Group pharmacies for a $10 copayment for each supply or medication. Even if you are covered under the CIGNA Prime Option POS or PPO plan, you will be able to obtain your diabetic medications and supplies at the CIGNA Medical Group pharmacy.

    While this provision may seem contradictory to a previously answered question regarding why you are not able to use the CIGNA Medical Group pharmacy for your other prescription medications, it is not. There is a state statute that requires the medical plan to provide diabetic medications and supplies through the medical benefit, instead of the pharmacy benefit.