

MEDTRAK

Your Prescription for X Service

PHARMACY BENEFIT PLAN

MedTrak Services			
	Name	Phone	Email
Account Executive	Bart Hoolehan	913-387-5118	bhoolehan@medtrakrx.com
Account Manager	Stephanie Thomas	913-322-8488	stthomas@medtrakrx.com

Organization	
Org. Type:	<input checked="" type="checkbox"/> Third Party Administrator <input type="checkbox"/> Health Insurance Carrier <input type="checkbox"/> Other
Org. ID:	BM000000
Org. Name:	Benefit Management, Inc.
Primary Contact:	Sarah Sampson
Title:	Account Manager
Address:	P.O. Box 1090/2015 16 th Street
City, State Zip:	Great Bend, KS 67530
Email :	ssampson@bmikansas.com
Phone:	620-793-1160
Fax:	620-792-0535
Day-to-Day Contact:	Same as above
Day-to-Day Contact's Phone:	
Day-to-Day Contact's Email:	

Carrier/Billing	
Carrier ID:	BM000ALN
Carrier:	Benefit Management, Inc.
Group Name:	Allen County
Primary Contact:	Sarah Sampson
Title:	Account Manager
Address:	P.O. Box 1090/2015 16 th Street
City, State, Zip:	Great Bend, KS 67530
Email:	ssampson@bmikansas.com
Phone:	800-290-1368 ext. 2076
Fax:	620-792-0535
Day-to-Day Contact:	Same as above
Day-to-Day Contact's Phone:	
Day-to-Day Contact's Email:	
Billing Type: (Box #1)	<input checked="" type="checkbox"/> Billing to match current TPA or Group set-up <input type="checkbox"/> New billing set-up to be established, proceed to Box #2
PHI Method: (Box #2)	<input type="checkbox"/> Yes – Contains PHI <input type="checkbox"/> No – Does not contain PHI <input type="checkbox"/> FTP <input type="checkbox"/> Secure Email <input type="checkbox"/> Mail <input type="checkbox"/> FTP <input type="checkbox"/> Secure Email <input type="checkbox"/> Mail

Agent	
Agency:	Bukaty Companies
Contact:	Phil Drescher
Title:	Sales Account Manager
Address:	11221 Roe Avenue, Ste 200
City, State, Zip:	Leawood, KS 66211
Email:	pdrescher@bukaty.com
Phone:	913-345-0440
Fax:	913-345-2608

Carrier ID	BM000ALN	Group Name	Allen County
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Group			
Group ID:	10001107		
Group Name:	Allen County		
NAICS Code:	9211		
Address/Contact Information			
Address 1:	1 North Washington		
Address 2:			
City, State, Zip:	Iola, KS 66749		
Contact:	Jill Allen		
Title:			
Phone:			
Fax:			
E-Mail:	vote@allencounty.org		
Day-to-Day Contact:			
Day-to-Day Contact's Phone:			
Day-to-Day Contact's Email:			
Plan Effective Date:	04/01/09	Plan Renewal Date:	04/01/12

New Group or Renewal:	
<input type="checkbox"/> New Group	<input checked="" type="checkbox"/> Renewal

Eligibility (Check one in each category):	
Number of Employees: 117	Number of Lives: 135
In which of the following formats will member eligibility be provided?	
<input type="checkbox"/> Email (encrypted)	<input type="checkbox"/> Manual <input checked="" type="checkbox"/> FTP <input type="checkbox"/> Client Access
How often will eligibility be sent?	
<input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly	<input type="checkbox"/> Other _____
Eligibility will be sent from:	
<input checked="" type="checkbox"/> TPA <input type="checkbox"/> Group <input type="checkbox"/> Other _____	
Eligibility Day-to-Day Contact Person:	IT Eligibility File Contact Person:
Contact Name: Melissa Lutt	Contact Name:
Contact Phone: 620-792-1779 ext 2102	Contact Phone:

Previous Prescription Benefits:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claims Experience:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Pharmacy Benefits Manager:	
Previous Co-pays:	

Unique Member ID Numbers:	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, assigned by: <input type="checkbox"/> MedTrak <input checked="" type="checkbox"/> TPA <input type="checkbox"/> Other _____ Sample ID# _____

Age and Rx Limits:	
Depend Look-up:	<input checked="" type="checkbox"/> DOB or First Name Required Otherwise Reject
Rely on Eligibility File for Term?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If no, what is the Cut-off Age?(Complete the following.)	
Child: _____ yrs old	Student: _____ yrs old Other: _____ yrs old
Coverage:	<input type="checkbox"/> Up to Date of Birth <input type="checkbox"/> Through Birth Month
	<input type="checkbox"/> Through Birth Date <input type="checkbox"/> Through Birth Year
	<input type="checkbox"/> Through Birth Week <input type="checkbox"/> Other _____

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Cards:			
Who Produces Cards:	<input type="checkbox"/> MedTrak or	<input checked="" type="checkbox"/> TPA or	<input type="checkbox"/> Other
If MedTrak:	<input type="checkbox"/> Laser or	<input type="checkbox"/> Plastic	
Packets: (Check the information that will be included in new member packets)			
<input type="checkbox"/> Plan Information Sheets	<input type="checkbox"/> Pharmacy Directories	<input type="checkbox"/> Cards	<input type="checkbox"/> Mail Order Packets
<input type="checkbox"/> Formulary	<input type="checkbox"/> How many Packets?		
Mail Packets/Cards to:	<input type="checkbox"/> Cardholder or	<input checked="" type="checkbox"/> Group or	<input type="checkbox"/> TPA
Company:	Allen County		
Address:	1 North Washington		
City, State, Zip:	Iola, KS 66749		
Contact:	Jill Allen		
Title:			
Phone:			
Fax:			

Company Sales Tax Status	
<input type="checkbox"/> For Profit	<input checked="" type="checkbox"/> Not for Profit (If Not for Profit, provide the Tax Exempt number:48-6039815)

Maximum Dollar per Rx: (Mandatory prior authorization for high cost medications)		
	Retail Max	Mail and/or P90 Max
<input type="checkbox"/> MedTrak Default Option	\$750	\$1,500
<input checked="" type="checkbox"/> Other	\$500	\$1,000

	Deductible	Out-of-Pocket	Maximum Benefit
Individual:	\$	\$	\$
Family:	\$	\$	\$
Mark "X" in the box below if the option should NOT be applied.			
Generics			
Brands			
Retail			
Mail			
Specialty Drugs			
Benefit Rollover Date (Mo.):			

Lifetime Benefit Maximum?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Lifetime Benefit Max Amt?
Out-of-Pocket Max:	<input type="checkbox"/> Deductible + Co-pays	<input type="checkbox"/> Co-pays Only	
Deductible Type:	<input type="checkbox"/> HSA or HRA	<input type="checkbox"/> Standard	<input type="checkbox"/> Other
Deductible Satisfaction:			
	<input type="checkbox"/> Lesser of Individual or Family (Embedded) <input type="checkbox"/> Coverage Type Determines Family/Individual Only (Aggregate) <input type="checkbox"/> Family Only <input type="checkbox"/> Individual Only <input type="checkbox"/> Other		
Cap Satisfaction for Maximum Benefit:			
	<input type="checkbox"/> Both Family and Individual Maximums Apply (Embedded) <input type="checkbox"/> Coverage Type Determines Family/Individual Only (Aggregate) <input type="checkbox"/> Family Only <input type="checkbox"/> Individual Only		
Cap Satisfaction for Out-of-Pocket Maximum:			
	<input type="checkbox"/> Both Family and Individual Maximums Apply (Embedded) <input type="checkbox"/> Coverage Type Determines Family/Individual Only (Aggregate) <input type="checkbox"/> Family Only <input type="checkbox"/> Individual Only		

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Brand/Generic Rules: (Check one of the following options)

- Generic Incentive** – Member pays co-pay plus the difference in cost between the brand and generic.
 If Generic Incentive is checked:
 DAW (*Dispense as Written*) Policy – Do not penalize member if doctor mandates brand.
- Standard** – Member will pay appropriate co-pay; no additional cost when generic is available.
- Mandatory Generic** – Only generic and single-source brands may be purchased.
 If Mandatory Generic is checked:
 DAW (*Dispense as Written*) Policy – Do not penalize member if doctor mandates brand.
- Workers Compensation** – No brand restrictions, only covered drugs may be purchased.
- Other** _____

DESI Drugs

Covered Not Covered

Plan Design – Co-payments:

	Retail Acute				Retail Maintenance		
Day Supply Limits:	<input type="checkbox"/> 30	<input type="checkbox"/> 34	Other <u>>34DS or 100U</u>		<input type="checkbox"/> 30	<input type="checkbox"/> 34	Other <u>>34DS or 100 U</u>
Co-pay Structure:	Tier 1	Tier 2	Tier 3	Specialty	Tier 1	Tier 2	Tier 3
Co-pay Method*	1	1			1	1	
Co-pay \$	\$15	\$30			\$15	\$30	
Co-pay %							
Max Co-pay							

	Performance 90			Mail Order		
Day Supply Limits:	<input type="checkbox"/> 90	Other _____		<input checked="" type="checkbox"/> 90	Other _____	
Co-pay Structure:	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Co-pay Method*				1	1	
Co-pay \$				\$30	\$60	
Co-pay %						
Max Co-pay						

***Co-pay Method:**

- 1 – Use Dollar Co-pay ONLY (e.g. \$5)
- 2 – Use Percentage Co-pay ONLY (e.g. 20%)
- 3 – Use Dollar PLUS Percentage Co-pay (e.g. \$5 + 20%)
- 4 – Use GREATER OF Dollar or Percentage Co-pay, without Max Co-pay (e.g. > \$5 or 20%)
- 5 – Use GREATER OF Dollar or Percentage Co-pay, with Max Co-pay (e.g. >\$5 or 20%, up to \$100)
- 6 – Use LESSER OF Dollar or Percentage Co-pay (e.g. <\$5 or 20%)
- 7 – Other: _____

Other Co-pay Rules: Insulin, Symlin & Byetta will be treated as generic for copay purposes.

Refills: (Select appropriate percentage that must be used before member can refill medication)

<input checked="" type="checkbox"/> MedTrak Default	<i>Retail / Performance 90:</i>	75% of Rx used
	<i>Mail:</i>	60% of Rx used
<input type="checkbox"/> Other	<i>Retail / Performance 90:</i>	_____% of Rx used
	<i>Mail:</i>	_____% of Rx used
Maximum # of refills per Rx:	<u>12</u> - Acute	<u>12</u> - Maintenance

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Plan Design – Pharmacy Network:			
<input checked="" type="checkbox"/> Preferred	<input type="checkbox"/> Performance 90	<input type="checkbox"/> Customized	<input checked="" type="checkbox"/> Mail Order <u>WMS</u>
Plan Design – Formulary:			
<input type="checkbox"/> National	<input type="checkbox"/> MedTrak Drug List (MDL)	<input checked="" type="checkbox"/> None	
Specialty Pharmacy Network:			
<input type="checkbox"/> Retail Specialty Pharmacy Network		<input checked="" type="checkbox"/> Best-In-Class Specialty Pharmacy Network	

Do you want to allow Secondary Coverage:		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Direct Member Reimbursement	Process Members Manual Claims?	Penalize Members Reimbursement?	
In-Network Manual Claims	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Out-of-Network Manual Claims	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Compound Claims	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Max. # days allowed from fill date for Member to submit manual claims:		<input checked="" type="checkbox"/> 365	<input type="checkbox"/> Other _____

MedTrak Generic Plus Programs: (Check all options that apply)	
<input checked="" type="checkbox"/>	ScriptChoice SM (Direct Mail: Informs member about available savings on select drug options.)
<input checked="" type="checkbox"/>	eScriptChoice SM (Online Resource: Educates member on lower costing alternatives.)
<input checked="" type="checkbox"/>	MedTrak Tablet Splitting Program (Applicable to flat dollar co-pay plan only. Reduction in Plan Cost and Member Co-pay.)
<input checked="" type="checkbox"/>	First-Fill-Free (Website Coupon: Allows member to get first fill of select generics for \$0 co-pay.)
<input checked="" type="checkbox"/>	Co-pay Waiver (Direct Mail: Informs members about select generics available for six (6) months at \$0 co-pay)

Compound Drugs	
<input checked="" type="checkbox"/> Covered	<input type="checkbox"/> Not Covered

If Compounds are covered:			
	Retail Co-pay for Compound Rx		
Co-pay Structure	Tier 1	Tier 2	Tier 3
Co-pay Method*	1	1	
Co-pay \$	\$15	\$30	
Co-pay %			
Max Co-pay			

- *Co-pay Method:**
- 1 – Use Dollar Co-pay ONLY (e.g. \$5)
 - 2 – Use Percentage Co-pay ONLY (e.g. 20%)
 - 3 – Use Dollar PLUS Percentage Co-pay (e.g. \$5 + 20%)
 - 4 – Use GREATER OF Dollar or Percentage Co-pay, without Max Co-pay (e.g. > \$5 or 20%)
 - 5 – Use GREATER OF Dollar or Percentage Co-pay, with Max Co-pay (e.g. >\$5 or 20%, up to \$100)
 - 6 – Use LESSER OF Dollar or Percentage Co-pay (e.g. <\$5 or 20%)
 - 7 – Other: _____

Division Reporting Required (Location Codes):		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Who will receive Quarterly Reports and Correspondence?		
<input checked="" type="checkbox"/> Group	<input checked="" type="checkbox"/> Organization	<input checked="" type="checkbox"/> Agent

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Insulin/Needles: (Check one of the options below)	
<input checked="" type="checkbox"/>	Same day purchase NOT required
<input type="checkbox"/>	Same day purchase IS required (Separate Co-pays charged for each Rx)
<input type="checkbox"/>	Charge one (1) co-pay; same day purchase IS required
<input type="checkbox"/>	Charge one (1) co-pay; same day purchase IS NOT required (<i>If purchased on the same day, only one Co-pay will be charged</i>)
<i>Note: These rules only apply if Insulin/Needles are Drug Inclusions.</i>	

Starter Dose Program:	
Starter Dose Limit: _____ Days Supply	Look-back Period: _____ Days from Fill Date
<i>Note: A Starter Dose will apply when the generic drug name, strength, and dosage form of the submitted drug has not been filled within the Look-Back Period.</i>	

Step Therapy Programs: (Check all options that apply)	
<input type="checkbox"/>	Alpha 1 Blockers for BPH
<input type="checkbox"/>	Alpha Beta Blockers for BPH
<input type="checkbox"/>	Anti-Hypertensives ARBs (<i>High Blood Pressure Medications</i>)
<input type="checkbox"/>	Bisphosphonates
<input type="checkbox"/>	Bladder Antispasmodics
<input type="checkbox"/>	Dihydropyridine Calcium Channel Blockers
<input type="checkbox"/>	Lipid Lowering (<i>Cholesterol Lowering Medications</i>)
<input type="checkbox"/>	Nasal Steroids (Nasal Allergy Steroids)
<input type="checkbox"/>	Non-Selective Beta Blockers
<input type="checkbox"/>	Proton-Pump Inhibitors (<i>Medications to treat GERD, Reflux, and Peptic Ulcers</i>)
<input type="checkbox"/>	Muscle Relaxants
<input type="checkbox"/>	Nuvigil - Provigil
<input type="checkbox"/>	Oral Acne Agents
<input type="checkbox"/>	SNRI Anti-Depressants
<input type="checkbox"/>	SSRI Anti-Depressants
<input type="checkbox"/>	Sedatives and Hypnotics (<i>Sleep Aids</i>)
<input type="checkbox"/>	Triptans (<i>Migraines</i>)

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Drug Inclusions/Exclusions

DIRECTIONS: Please check the appropriate boxes below (INCL for include; EXCL for exclude; PA for prior authorization). Indicate any limits on day supply, quantity, sex or age in the adjacent box.

Therapeutic Drug or Drug Class	INCL	EXCL	PA	DS, Quantity, Sex and Age Limits
Common Inclusions				
Federal Legend	X			
Injectable Anti-Diabetes (e.g. Insulin-OTC*)	X			
Common Exclusions				
Abortifacients		X		
Anabolic Steroids		X		
Testosterone (For Male Hypogonadism)			X	
Anti-Obesity/ Anorexiants Drugs		X		
Botox		X		
Contraceptive Implants and Topicals (i.e. IUD's and Diaphragms)		X		
Cosmetic Drugs (i.e. Rogaine, Propecia)		X		
Diagnostic Test Supplies		X		
Emergency Contraceptives		X		
Erectile Dysfunction Drugs (ED)		X		
Viagra (PRN dosing)				<input type="checkbox"/> Limit _ per month
Levitra (PRN dosing)				<input type="checkbox"/> Limit _ per month
Cialis 10 mg & 20 mg (PRN dosing)				<input type="checkbox"/> Limit _ per month
Cialis 2.5 mg & 5 mg (daily dosing)				<input type="checkbox"/> Limit _ per month
Experimental/Investigational Drugs		X		
Fertility Agents		X		
Fluoride Preparations		X		
Growth Stimulating Products			X	<input checked="" type="checkbox"/> Preferred Product Program: Norditropin
For Short-Stature Syndrome (SSS)				
Homeopathic Drugs		X		
Inhaler Devices		X		
Non-Legend Drugs (OTC*)		X		
Ostomy Supplies		X		
Therapeutic Devices & Appliances (OTC*)		X		
Vaccines/Serums/Toxoids/Allergens		X		
HPV Vaccine				GPI: 1710006510
Influenza Vaccine				GPI: 17100020
Shingles Vaccine				GPI: 1710009510

* OTC = Over-the-Counter

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Therapeutic Drug or Drug Class	INCL	EXCL	PA	DS, Quantity, Sex and Age Limits
Other Categories				
Acne Medication – ALL	X			
Accutane			X	<input type="checkbox"/> Covered up to age ____; then PA required
Retin-A, Avita	X			<input checked="" type="checkbox"/> Covered up to age 35; then PA required
Other Vitamin A Derivatives (i.e. Differin)	X			<input checked="" type="checkbox"/> Covered up to age 35; then PA required
Anti-Fungals	X			
Anti-Migraine Medications – ALL	X			
Oral				<input checked="" type="checkbox"/> Limit 9/30 DS; 27/90 DS
Spray				<input checked="" type="checkbox"/> Limit 6/30 DS; 18/90 DS
Injectable				<input checked="" type="checkbox"/> Limit 3/30 DS; 9/90 DS
ADD/ADHD Medications	X			
Contraceptives – ALL	X			
Oral				
Seasonale/Seasonique (91 DS only)				<input checked="" type="checkbox"/> Retail NW - Mail/P90 Co-pay; <input type="checkbox"/> Retail NW - 3 Retail Co-pays/91 DS
Injectable (90 DS only)				<input checked="" type="checkbox"/> Retail NW - Mail/P90 Co-pay; <input type="checkbox"/> Retail NW - 3 Retail Co-pays/91 DS
Patches (Ortho Evra)				
Rings (Nuvaring)				
Cox-2 Inhibitors (Celebrex)	X			GPI: 66100525
Diabetic Administration Supplies				
Syringes/Needles, Insulin Only (OTC*)	X			
Other (i.e. Pumps/Supplies)		X		
Diabetic Test Supplies – ALL	X			
Lancets				
Monitors				
Strips				
Other				
Injectables – ALL	X			
Epipen/Glucagon Kit				
Other				
Non-Insulin Syringes (OTC*)	X			
Schedule V Cough Syrups (OTC*)	X			
Schedule II Narcotic Pain Medication	X			<input checked="" type="checkbox"/> PA required for chronic use
Smoking Deterrents		X		<input type="checkbox"/> Include OTC smoking deterrents
Wellbutrin		X		
Vaginal Estrogen (90-day packaging)	X			<input checked="" type="checkbox"/> Retail NW - Mail/P90 Co-pay; <input type="checkbox"/> Retail NW - 3 Retail Co-pays/91 DS
Estring and Femring	X			<input checked="" type="checkbox"/> Retail NW - Mail/P90 Co-pay; <input type="checkbox"/> Retail NW - 3 Retail Co-pays/91 DS
Vitamins – ALL		X		
Prenatal	X			
Vitamin D				
Vitamin K				
Prilosec (OTC*)		X		Co-pays:

*OTC=Over-The-Counter

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Therapeutic Drug or Drug Class	INCL	EXCL	PA	DS, Quantity, Sex and Age Limits
Miscellaneous				
Zofran (Ondansetron)	X			Limit up to 30 pills per claim.
Provigil (Modafinil)			X	Exclude for members 16 years and below.
Insulin, Symlin & Byetta	X			Generic Copay

*OTC=Over-The-Counter



 Plan Sponsor's Approval

April 15, 2014

 Date

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