



Health Net®

# Health Net Health Plan of Oregon, Inc. Prescription Benefits

WA Supplemental Benefit Schedule WP8/07 (No MAC) Pacific Trust

In this Supplemental Benefit Schedule, the terms “we,” “our” and “us” refer to Health Net Health Plan of Oregon, Inc. and the terms “you” and “your” refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

## Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide prescription benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Plan of Oregon, Inc. Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Basic Benefit Schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium and Copayments.

## Article 2 - Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, any other drug which under law may only be dispensed by written prescription of a duly licensed health care provider, diabetic supplies, and insulin. Coverage is subject to the qualifications, limitations and exclusions below:

- 2.1 The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the Physician, but in no event shall the quantity exceed a 30-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. **Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.**
- 2.2 All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.
- 2.3 Copayments shall be as follows for each prescription or refill. Prescription deductibles (if any), Copayments and other amounts you pay for prescription drugs do not apply toward your plan’s other deductibles and out-of-pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
Tier 1	\$10	\$20
Tier 2	\$50	\$100
Tier 3	\$75	\$150

- 2.4 The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment as soon as a generic becomes available.
- 2.5 Reimbursement (minus the Copayment) will be made for prescriptions filled by a pharmacy other than a Participating Provider pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation of receipts to Health Net Oregon and sufficient documentation to establish the need for Emergency Medical Care.

### **Article 3 - Exclusions**

The following items are excluded from coverage:

- 3.1 Drugs and medicines prescribed or dispensed other than as described in this Schedule.
- 3.2 Early refills other than for changes in directions.
- 3.3 Over-the-counter drugs other than insulin.
- 3.4 Therapeutic or prosthetic devices, orthotics and all supplies, even though they might require a prescription, including but not limited to: hypodermic needles and syringes other than for insulin, appliances, support garments, braces, splints, bandages, dressings and other non-medicinal substances regardless of intended use.
- 3.5 Injectable medications other than those listed as injections on the PDL.
- 3.6 Dental only drugs.
- 3.7 Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride, except for phenylketonuria and enteral formulas.
- 3.8 Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, smoking cessation, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- 3.9 Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- 3.10 Prescription refills due to loss or theft.
- 3.11 Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection are excluded under this Supplemental Prescription Benefits Schedule. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables are covered under the Basic Benefit Schedule when provided in the doctor's office.
- 3.12 Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.



# Health Net Health Plan of Oregon, Inc.

## Prescription Benefits

### YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact Health Net at 1-888-802-7001.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health Washington State Board of Pharmacy at 360-236-4825.

#### **"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"**

The Plan formulary is called the Preferred Drug List (PDL) and is maintained by the Health Net Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee includes local and national practicing physicians and pharmacists who review FDA approval information and clinical research studies to make formulary recommendations and decisions. A copy of the current PDL is available through the Customer Contact Center at (888) 802-7001 or visit our website at [www.healthnet.com](http://www.healthnet.com).

Formulary and drug product decisions are based on the following:

- Proven safety and effectiveness
- Accepted for use by the medical community
- Economical efficiency

The term "Medically Necessary" as used in the Prescription Benefits Supplemental Benefit Schedule follows the same definition as indicated in your plan contract.

An approved generic equivalent shall mean a generic drug has been given an "A" therapeutic equivalent code by the Department of Health and Human Services.

If a generic equivalent exists, but a brand name drug is requested you pay:

The applicable Tier 3 copayment.

Your out-of-pocket expense will not exceed the pharmacy's retail price for the drug.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information regarding limitations, exclusions, and substitutions for drugs.

#### **When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"**

The PDL (formulary) is reviewed and updated on an ongoing basis, and it may be revised up to four times per year based on the recommendations of the Pharmacy and Therapeutics Committee. Most changes involve the addition of new drugs to the formulary. Changes to existing formulary drugs may impact a drug you are using and may require a higher copayment.

#### **"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"**

If you receive a denial or partial denial of an authorization request you may contact a Pharmacy Services representative to discuss the determination. If additional information is presented or may be obtained from your physician for consideration against the prior authorization criteria, a second review may be requested. You may contact a Pharmacy Services representative at (888) 802-7001 between the hours of 9:00-12:00 and 1:00-5:00 Monday through Friday, excluding holidays. You have the right to appeal the denial or partial denial of an authorization request. The appeal must be submitted either orally or in writing within 180 days of the date of the denial notice. We will resolve and respond in writing to appeals within 30 days (14 days for Washington plan members). If a delay could seriously jeopardize your life or health you may request an expedited review in writing or over the phone by contacting a Pharmacy Service representative. Expedited reviews are completed not later than 72 hours following receipt. Send written appeals to:

Health Net Health Plan of Oregon

Attention: Grievances and Appeals

13221 SW 68<sup>th</sup> Parkway

Tigard, OR 97223-8328

### **"How much do I have to pay to get a prescription filled?"**

- Tier 1 is the lowest Copayment/Coinsurance level. This level includes but is not limited to most generic drugs.
- Tier 2 is the intermediate Copayment/Coinsurance level. This level includes but is not limited to preferred brand name drugs that have no generic equivalent.
- Tier 3 is the highest Copayment/Coinsurance level. This level includes but is not limited to generic and brand name drugs that are not listed in Tier 1 or Tier 2. In most cases there are alternatives in Tier 1 or 2 for drugs found in this highest tier.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information on your prescription drug costs.

### **"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"**

Prescriptions must be purchased at a Participating Pharmacy in order to be covered under the prescription benefit. Most major pharmacy chains are part of the Health Net Network. There are approximately 1,200 independent and chain pharmacies in the state of Washington that are participating with Health Net. If you need to verify that a specific pharmacy is participating with Health Net, please call the Customer Contact Center at (888) 802-7001 or visit our website at [www.healthnet.com](http://www.healthnet.com).

### **"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"**

You may receive up to a 30-day supply when ordered in a participating retail pharmacy.

You may receive up to a 90-day supply when ordered through our contracted mail order pharmacy.

Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.

If your physician has increased your dose, he needs to notify your pharmacy of the change in directions. Your pharmacy may contact us for an override if this change will result in an early refill request.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for information on the days' supply available under your benefit.

### **"What other pharmacy services does my health plan cover?"**

There are no additional pharmacy services covered under the Policy.