



Harvard Pilgrim
Health Care



Commonwealth of Massachusetts
Group Insurance Commission

Primary Choice Plan Premium Three-Tier

Prescription Drug Brochure

This brochure is a legal document that explains the prescription drug benefits provided by the Group Insurance Commission (GIC) to their Members on a self-insured basis. Harvard Pilgrim Health Care has arranged for the availability of a network of pharmacy providers and will be performing various benefit and claim administration services on behalf of the GIC.

EFFECTIVE DATE: 07/01/2016
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PRESCRIPTION DRUG COVERAGE

Prescription medications can play an important role in keeping you healthy. Your coverage includes an outpatient prescription drug benefit to help make paying for these medications more affordable. Your benefit covers most outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

- Our Premium Three-Tier prescription drug benefit
- Your Member Cost Sharing
- Covered and non-covered drugs
- Where to buy your prescriptions
- Our Mail Service Prescription Drug Program
- Drug coverage policies

You will find words in this brochure that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this brochure are defined in the Glossary in your Benefit Handbook.

THREE-TIER PRESCRIPTION DRUG BENEFIT

We place all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount, which is listed in this brochure and on your Member identification (ID) card. The three tiers are listed below.

Tier 1:

Tier 1 is primarily made up of generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 1 may also include brand name drugs that we have determined to be more effective, less costly or to have fewer side effects than similar medications. You pay the lowest Copayment amount for Tier 1 drugs.

The Tier 1 Copayment is: \$10 up to a 30-day supply

Tier 2:

Tier 2 is primarily made up of brand name drugs for which generic equivalents are not available. These drugs have been selected based on review of the relative safety, effectiveness and cost of the many brand name drugs on the market. Tier 2 may also include generic drugs that we have determined to be more costly than their brand name alternatives. The Copayment amount for Tier 2 drugs is higher than the Copayment amount for Tier 1 drugs, but lower than for Tier 3 drugs.

The Tier 2 Copayment is: \$30 up to a 30-day supply

Tier 3:

Tier 3 is made up of drugs that we have not included in Tier 1 or Tier 2. Generally, a Tier 3 drug has at least one equivalent, either a generic drug or another brand-name drug, which is available in Tier 1 or Tier 2. You pay the highest Copayment amount for Tier 3 drugs.

The Tier 3 Copayment is: \$65 up to a 30-day supply.

Please note: The Plan covers certain orally administered medications for the treatment of cancer that are purchased at a pharmacy to the extent Medically Necessary. You must get a prescription from a physician and present it at a participating pharmacy for coverage. These covered medications are covered in full at participating Retail Pharmacies and participating

Mail Order Pharmacies. A list of participating pharmacies is available from the Member Services Department or at www.harvardpilgrim.org.

Getting a Copy of the Drug List

You can get a copy of the Premium Three-Tier Prescription Drug List online at www.harvardpilgrim.org by clicking **Pharmacy Program** or by calling the Member Services Department at 1-888-333-4742. For TTY services call 711.

MEMBER COST SHARING

You are required to share the cost of the prescription drug benefits provided under the Plan through Copayments. The specific Copayment amounts that apply to your Plan are listed on your Member ID card as well as in this brochure.

Discount Rate

In this brochure, we refer to the term "Discount Rate." The Discount Rate is a price for prescription drugs that has been negotiated with participating pharmacies. The Discount Rate is the basis for calculating the Member Cost sharing.

Note: The Discount Rate is not a fixed discount. It may be modified as market conditions change. Our cost for covered drugs is generally lower than the Discount Rate.

How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price pharmacies charge for drugs. If a participating pharmacy's retail price is less than the Discount rate, your Member Cost Sharing is always based on the lower amount.

Copayments

Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Different Copayment amounts apply to each of the three drug tiers. Your Copayments are listed on your Member ID card as well as in this brochure.

What You Pay

Copayments are calculated in two ways, depending on whether you use a participating or non-participating pharmacy:

Participating Pharmacy

If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy's retail price for the drug.

Non-Participating Pharmacy

If you buy your prescriptions at a non-participating pharmacy, you pay the lower of the Copayment or the pharmacy's retail price for the drug.

Please see "Buying Prescriptions" for more information on participating and non-participating pharmacies.

What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill, except where limited by us. If your physician prescribes less than a 30-day supply of a medication, each

Copayment covers the amount prescribed. We may limit the quantity of a drug available per 30-day period or per Copayment.

Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket maximum that applies to both medical and prescription Member Cost Sharing. The Out-of-Pocket Maximum is the total amount you are required to pay in Member Cost Sharing.

Your Out-of-Pocket Maximum is \$5,000 per Member up to \$10,000 per family per Plan Year.

Participating pharmacies will not charge you Member Cost Sharing once you have reached your Out-of-Pocket Maximum.

WHAT IS COVERED

Your prescription drug benefit covers all Medically Necessary drugs that require a prescription by law, except drugs we exclude or limit. Your benefit also covers the non-prescription items listed below when you have a prescription. All covered drugs are subject to the applicable Member Cost Sharing. Please check your Member ID card, as well as this brochure, for the Member Cost Sharing amounts that apply to your drug coverage.

Your Plan covers the following prescription and non-prescription items:

Covered Prescription Drugs	Covered Non-Prescription Items
• FDA approved prescription drugs prescribed by a physician • Needles and syringes needed to administer covered drugs • FDA approved contraceptive drugs and devices • Prenatal vitamins • FDA approved hormone replacement therapy (HRT) • Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS • Compounded prescriptions are covered if: (1) all of the active ingredients in the compound are FDA approved prescription drugs; and (2) either the patient is under the age of 18 or HPHC has given prior approval for coverage of the compound.	• Insulin • Oral agents for controlling blood sugar • Lancets • Blood glucose testing strips • Urine diabetic testing strips • Ketone diabetic testing strips • Certain over-the-counter drugs that are an alternative to a prescription drug

Please Note: No Member Cost Sharing applies to certain preventive care services, including FDA approved contraceptive drugs and devices, oral fluoride for children up to age five, aspirin for prevention of myocardial infraction, and folic acid for women planning or capable of pregnancy. Please go to www.harvardpilgrim.org/GIC to see a complete list of covered preventive services. To receive one of these items at no cost, you must get a prescription from your physician and present it at any participating pharmacy for coverage.

Please see your Benefit Handbook and Schedule of Benefits for information about contraceptives provided as part of an office visit.

BUYING PRESCRIPTIONS

PARTICIPATING PHARMACIES

It's easier and often less expensive to fill prescriptions at a participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your ID card and pay the applicable Member Cost Sharing amount. If you do not use a participating pharmacy, you must pay the retail price for the medication and submit a claim for reimbursement.

There are over 60,000 participating pharmacies in the United States, including:

• CVS/pharmacy • Kmart Pharmacy • Rite Aid • Stop & Shop	• Target Pharmacy • Walgreens • Walmart • Many independent drug stores
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You can get more information on participating pharmacies online at www.harvardpilgrim.org by clicking **Pharmacy Program** or by calling our Member Services Department at 1-888-333-4742.

We also offer a Mail Service Prescription Drug Program if you prefer the convenience and savings of receiving prescriptions for maintenance medications through the mail. Please see the Mail Services Prescription Drug Program below for more detail.

THE SPECIALTY PHARMACY PROGRAM

We have designated pharmacies that you must use to obtain certain specialty medications. These include drugs for the treatment of infertility, hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. A list of the drugs that must be purchased from the specialty pharmacies may be obtained on our website at www.harvardpilgrim.org (click **Pharmacy Program**, then select your drug tier, then click either **Infertility Pharmacy Program** or **Specialty Pharmacy Program**). This information is also obtained by calling our Member Services Department at 1-888-333-4742.

Our specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give you instructions for the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Your Member Cost Sharing at the specialty pharmacies is the same as at other participating pharmacies. The specialty pharmacies are not part of the Mail Service Prescription Drug Program available for non-specialty maintenance medications.

NON-PARTICIPATING PHARMACIES

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, then submit a claim for reimbursement. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus the Copayment. Payment will be limited to the Allowed Amount for the drug.

No benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

90-DAY PRESCRIPTION DRUG BENEFIT AT A PHARMACY

You may purchase up to a 90-day supply of maintenance medications from a participating pharmacy. When you obtain a 90-day prescription you will pay the equivalent of three monthly Member Cost Sharing payments. Although most maintenance medications are available for a 90-day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90-day supply.

Your 90-day prescription drug Copayments are:

- Tier 1 drug Copayment: \$30
- Tier 2 drug Copayment: \$90
- Tier 3 drug Copayment: \$195

MAIL SERVICE PRESCRIPTION DRUG PROGRAM

We provide a Mail Service Prescription Drug Program if you prefer the convenience and savings of receiving prescriptions for maintenance medications through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Prescription Drug Program. In addition to saving a trip to the pharmacy, your plan provides lower Copayments for drugs purchased through the Mail Service program.

Although most maintenance medications are available from the Mail Service Program, we may exclude drugs from the program for clinical reasons or to prevent potential waste. Drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

Please see your Member ID card, as well as this brochure, for your Mail Service Prescription Drug Copayments. The Mail Service Prescription Drug Copayments listed in this brochure and on your Member ID card apply only to the Mail Service Prescription Drug Program.

For more information about the Mail Service Prescription Drug program, please call **1-877-347-3216** (TTY **1-877-517-9301**) or visit **www.harvardpilgrim.org**.

Your mail service prescription drug Copayments are:

- Tier 1 drug Copayment: \$25
- Tier 2 drug Copayment: \$75
- Tier 3 drug Copayment: \$165

WHAT IS NOT COVERED OR HAS LIMITED COVERAGE

There are a number of prescription drugs that are either not covered, are subject to quantity limits or require prior authorization.

We cover only drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy. Drugs that are not covered include, but are not limited to, drugs primarily used for cosmetic purposes and weight loss.

We also limit the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on the quantity of certain drugs we cover.

We may require prior authorization to evaluate whether certain drugs are Medically Necessary. Prior authorization is based on clinical criteria and may include: (1) an evaluation of whether a drug is clinically appropriate for the medical condition for which it has been prescribed; or (2) whether "step therapy" will be required. Drugs subject to step therapy are only covered if a Member has either tried another drug to treat a specific condition or obtained prior authorization to be exempted from that requirement. Members or their practitioners may obtain a copy of

our clinical review criteria for a drug for which coverage is requested by calling **1-888-888-4742 ext. 31786**.

Drugs that are excluded from coverage, subject to quantity limits, or require prior authorization are listed in the Premium Three-Tier Prescription Drug List. You may view this list online at www.harvardpilgrim.org by clicking **Pharmacy Program** or by calling the Member Services Department at **1-888-333-4742**.

Exclusions from Coverage

No coverage is provided under this prescription drug brochure for the following:

- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs that we specifically exclude, including, but not limited to, drugs primarily used for cosmetic purposes and weight loss
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.)
- Non-prescription items, other than those specifically listed under "What is Covered."
- Drugs that have not been approved by the FDA.
- Drugs prescribed as part of a course of treatment that we do not cover.
- Drugs provided to you anywhere other than an outpatient pharmacy. (See your Benefit Handbook for an explanation of the limited coverage available for medications received from physicians and other non-pharmacy providers.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies. The Specialty Pharmacy Program is described above.
- No benefits are provided for medications prescribed by providers who are not authorized to do so by us or for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.
- Any sales tax or governmental assessment on pharmacy items.
- Compounded prescriptions unless: (1) all of the active ingredients in the compound are FDA approved prescription drugs; and (2) either the patient is under the age of 18 or HPHC has given prior approval for coverage of the compound.

PRIOR APPROVAL

Certain drugs require Prior Approval for coverage under the Plan. These include compounded drugs for Members over the age of 18. Your prescribing provider may request Prior Approval by calling the Pharmacy Services Department at **1-617-509-1786**.

EXCEPTION PROCESS

Your Plan has an exception process you may use to ask us to provide coverage for drugs that are excluded or limited by the Plan. You may use the exception process to ask us to cover a drug that is excluded from the Plan. Drugs are excluded from coverage if they are not listed in the Prescription Drug List. You may also use the exception process to request an exception to a limitation on the coverage of a drug, including a quantity limitation.

We will only grant exceptions for clinical reasons. Your prescribing provider must give us a statement that explains why an exception is Medically Necessary, including why the covered drugs

on the Prescription Drug List are not as effective as the requested drug. We will act on a request for an exception within two business days of receiving your prescribing provider's statement of the reasons an exception is Medically Necessary.

You may request an **expedited exception** when one of the following situations occurs:

- you could seriously jeopardize your life, health or ability to regain maximum function if there is a delay in treatment, or
- you are undergoing a current course of treatment using a non-formulary drug.

We will notify you of a decision no later than 24 hours after receiving your expedited request.

You or your prescribing provider may request an exception by calling the Pharmacy Services Department, toll free, at **1-888-888-4742 ext. 31786**. For a faster decision, please include the medical information from your prescribing provider when you first ask for an exception. Your prescribing provider may send us a statement of Medical Necessity either by fax at **1-617-509-9144** or by email to: pharmacy_services@harvardpilgrim.org.

Your request for an exception will be considered by pharmacists and other appropriate practitioners. If we deny your request, we will tell you the reason for the denial and explain the process for requesting an appeal of our decision.

ABOUT YOUR DRUG BENEFIT

Pharmacy and Therapeutics Committee

Our Pharmacy and Therapeutics (P & T) Committee is an advisory group comprised of our clinical staff and of physician specialists, independent physicians, and pharmacy specialists that work together to promote clinically sound, cost effective pharmaceutical care.

The P&T Committee makes recommendations for tier placement of drugs, and limitations on drug coverage, as well as providing guidance on clinical criteria.

Tier Changes

We regularly review and update the Premium Three-Tier Drug List as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change at any time. In the event that a drug has been reassigned to a higher tier, we will send notice to Members who have received coverage for the drug and product during the 100-day period prior to the notice date. Such notice will be sent 60 days before the tier change takes effect. You can get an updated Premium Three-Tier Drug List online www.harvardpilgrim.org by *clicking Pharmacy Program* or by calling the Member Services Department at **1-888-333-4742**.

Deletions from Coverage

On occasion we may discontinue coverage of a drug or other product covered under this Brochure. In such event, we will send notice to Members who have received coverage for the drug or product during the 12-month period prior to the date of discontinuation. Such notice will be sent at least 60 days before discontinuing coverage for the drug or product unless the FDA has determined the drug or product to be unsafe.

Important Notice

In the event of a Medical Emergency, seek immediate care. You may call **911** or your local emergency number. Please see your Benefit Handbook and Schedules of Benefits for information on your emergency coverage.

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