



Health Net Health Plan of Oregon, Inc.
Prescription Benefits
SUPPLEMENTAL BENEFIT SCHEDULE
NMSL10-50-75-2000/15 (No MAC S)

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

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 and/or Coinsurance.

Benefits

Coverage includes all Medically Necessary prescription drugs, compounded medications of which at least one ingredient is a prescription drug, orally administered anticancer medications, preventive pharmacy medications, tobacco cessation medications, women’s contraception methods supported by the Health Resources and Services Administration (HRSA) guidelines, and 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 also includes prescription medications associated with an Emergency Medical Condition, including those purchased in a foreign country.

Coverage is subject to the qualifications, limitations and exclusions below:

- 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.
- All drugs, including insulin and diabetic supplies, must be prescribed by a Participating Provider or by a Physician under Referral and must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area. The requirement that drugs must be prescribed by a Participating Provider or by a Physician under Referral does not apply under a Triple Option, PPO, or Flex Net Plan.
- Copayments and/or Coinsurance shall be as follows for each prescription or refill. Prescription Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for prescription drugs do not apply toward your plan’s medical Deductibles, Copayment, Out-of-Pocket Maximums, or stop loss amounts, whichever is applicable under this Agreement.

Annual Out-of-Pocket Maximum for Prescription Benefits per person per Calendar Year: \$2,000

Annual Out-of-Pocket Maximum for Prescription Benefits per family per Calendar Year: \$4,000

	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

This pharmacy plan provides creditable coverage for Medicare Part D.

Specialty Pharmacy	10% to a maximum of \$150	Mail order not available
Orally administered anticancer medications	10% to a maximum of \$150	Mail order not available
Preventive Pharmacy and Tobacco cessation medications and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived.

- Specialty Pharmacy: Certain drugs identified on the formulary (drug list) are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.
- Preventive Pharmacy. Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations. A listing of these medications may be identified at the following USPSTF website: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

Compounded medications and prescriptions or refills dispensed by a Nonparticipating Provider pharmacy are not covered.

- Women's contraception methods. Generic class Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. FDA approved, over-the-counter contraceptive methods for women require a prescription from your Participating Provider. No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

Abortifacient drugs, compounded medications and prescriptions or refills dispensed by a Nonparticipating Provider pharmacy are not covered.

- Tobacco cessation medications. Food and Drug Administration (FDA) approved prescription drugs classified as smoking cessation medications are covered when dispensed by a Participating Provider pharmacy. FDA approved, over-the-counter tobacco cessation medications require a prescription from your Participating Provider. No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.
- Growth Hormone Drugs: Growth hormone drugs are covered if determined to be Medically Necessary and if our medical/pharmacy policy criteria are met for the following conditions: growth hormone deficiency in children and adolescents; chronic renal insufficiency in pre-transplantation children with growth failure; SHOX (short stature homeobox-containing gene) deficiency in children; Central nervous system tumor treated with radiation; Prader Willi Syndrome/Turner Syndrome; therapy of infantile Hypoglycemia; growth hormone deficiency in adults, for Short-Bowel Syndrome and AIDS Wasting Syndrome. Prior Authorization is required.
- The level of benefit you receive is based on the status of the drug at the time your prescription is filled. The drug list 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 drug list will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment and/or Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment and/or Coinsurance as soon as a generic becomes available.
- Reimbursement (minus the Copayment and/or Coinsurance) 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.

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- Reimbursement (minus the Copayment and/or Coinsurance) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For these purposes, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.
- Upon request, Health Net will synchronize refill dates of prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. To request synchronization please call the Customer Contact Center at the number listed at the back of your Agreement.

Exclusions

The following items are excluded from coverage:

- Drugs and medicines prescribed or dispensed other than as described in this Schedule.
- Early refills other than for changes in directions (all medications), or for eye drops used in the treatment of glaucoma.
- Over-the-counter drugs other than insulin and preventive pharmacy medications, tobacco cessation medications or contraceptive methods and devices as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.
- 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.
- Injectable medications other than those listed on the drug list.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than prescription prenatal vitamins, prescription vitamins with fluoride, and supplements or vitamins which are prescribed for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations as described in the "Preventive Pharmacy" section above.
- Drugs for the treatment of onychomycosis (nail fungus); infertility; drugs used for weight loss; sexual dysfunction, sexual enhancement, or sexual performance improvement; growth hormone therapy except as noted above.
- Prescription refills due to loss or theft.
- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

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