



Health Net®

Health Net Health Plan of Oregon, Inc. Prescription Benefits

WA Supplemental Benefit Schedule WNM15-35-60/11 (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. Coverage includes "off-label" (the prescribed use of a drug which is other than that stated in its FDA approved labeling) indications when use is supported by standard reference compendia, the majority of relevant peer-reviewed medical literature, or by the Federal Secretary of Health and Human Services. **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 Copayments and other amounts you pay for prescription drugs do not apply toward your plan's medical 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	\$15	\$30
Tier 2	\$35	\$70
Tier 3	\$60	\$120

This pharmacy plan provides creditable coverage for Medicare Part D.

- 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, 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.
- 3.13 Drugs and medicines used for diagnostic purposes.

This pharmacy plan provides creditable coverage for Medicare Part D.