This brochure is a legal document that explains the prescription drug benefits provided by HPHC Insurance Company, Inc. (HPHC) to Members with plans that include outpatient pharmacy coverage.
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. This benefit covers most outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you’ll find information about:

- Our four-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.

FOUR-TIER PRESCRIPTION DRUG BENEFIT

We place all covered drugs into one of four levels or “tiers.” Each tier has its own Member Cost Sharing, which is listed on your identification (ID) card. The four tiers are described below.

Tier 1:

Tier 1 is made up of lower cost generic drugs that have been selected by Harvard Pilgrim. These drugs contain the same active ingredients as their brand-name counterparts. You pay the lowest Copayment or Coinsurance amount for Tier 1 drugs.

Tier 2:

Tier 2 is primarily made up of higher-cost generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 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.

Tier 3:

Tier 3 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 3 may also include generic drugs that we have determined to be more costly than their brand name alternatives.

Tier 4:

Tier 4 is made up of drugs that we have not included in Tiers 1-3. You pay the highest Member Cost Sharing for Tier 4 drugs.

Please see your ID card for your applicable Member Cost Sharing amounts.

Getting a Copy of the Drug List

You can get a copy of the Four-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.
MEMBER COST SHARING
This section describes how we administer the different types of Member Cost Sharing under your outpatient prescription drug benefit.

Similar to your medical coverage, Members are required to share the cost of the benefits provided under the Plan. Your Member Cost Sharing may include a combination of Copayments, Coinsurance or a Deductible. For the Member Cost Sharing amounts that apply to your Plan, please see your ID card.

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

Note: The Discount Rate is not a fixed discount. It may be modified as market conditions change.

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.

Note: Our cost for covered drugs is generally lower than the Discount Rate.

Copayments
Some plans provide prescription drug coverage with 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 usually apply to each of the four drug tiers. Your Copayment amounts are listed on your ID card.

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

<table>
<thead>
<tr>
<th>Participating Pharmacy</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<th>Non-Participating Pharmacy</th>
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<tr>
<td>If you buy your prescriptions at a non-participating pharmacy, the Discount Rate does not apply. You pay the lower of the Copayment or the pharmacy’s retail price for the drug.</td>
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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.

Coinsurance
Some plans provide prescription drug coverage with Coinsurance. With Coinsurance, you pay percentage payments for a drug, instead of fixed dollar amounts. If your coverage requires the payment of Coinsurance, the applicable Coinsurance percentages are listed on your ID card.
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The Coinsurance percentage is multiplied by the Discount Rate or the pharmacy’s retail price, as applicable, to arrive at your out-of-pocket Coinsurance payment. Coinsurance is calculated the day the pharmacy fills the prescription and the Coinsurance is paid to the pharmacy at the time of purchase.

⚠️ FOR EXAMPLE: If the participating pharmacy’s retail price is $150 but the Discount Rate is $100, your Coinsurance amount is based on the Discount Rate of $100. If your Coinsurance is 20%, your Member Cost Sharing will be $20.

Some Plans include a minimum or maximum Coinsurance amount, or both. If your Plan includes a per prescription minimum Coinsurance amount, you always pay at least that minimum, unless the Discount Rate or the pharmacy’s retail price for the drug is less than the minimum. In that case, at a participating pharmacy you pay the lower of (1) the minimum Coinsurance amount, (2) the Discount Rate or (3) the pharmacy’s retail price for the drug. At a non-participating pharmacy you pay the lower of (1) the minimum Coinsurance amount or (2) the pharmacy’s retail price for the drug. If your Plan includes a per prescription maximum amount, your per prescription Coinsurance payment is limited to that maximum.

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

Deductibles

Your Plan may include a Deductible.

A Deductible is a specific dollar amount that you pay each calendar year for certain covered services before any coverage is available for those services. If a Deductible applies to your coverage, you must first pay the Deductible amount for the purchase of prescription drugs before any coverage for drugs begins for the calendar year.

Please see your ID card to see if a Deductible applies to your Plan.

What You Pay

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If the Discount Rate or retail price for a prescription, as applicable, exceeds the balance remaining on the Deductible for the calendar year, you are required to pay the balance of the Deductible and the applicable Copayment. If Coinsurance applies, you are required to pay the applicable Coinsurance percentage on any amount exceeding the Deductible. You are never obligated to pay any combination of Copayments,
Coinsurance or Deductible amounts that exceed the lower of the Discount Rate or the pharmacy’s retail price for the drug.

The Deductible amount is applied the day the pharmacy fills the prescription and is paid to the pharmacy at the time of purchase.

**Where the Deductible Applies**

The Deductible may apply to drugs in any Tier. Please see your ID card for the amount of your Deductible and the tiers to which it applies. Once you have met your Deductible for the calendar year, drugs are covered for the rest of the calendar year, subject to the applicable Copayment or Coinsurance.

![FOR EXAMPLE:](image)

FOR EXAMPLE: If your Plan has a $100 Deductible and you have a claim with a discount rate of $200, you will be responsible for the first $100 to satisfy your Deductible requirement before we begin to pay benefits.

Your Deductible may not apply to certain medications used for preventive care. These medications have been selected by the Plan because they are often used to lower the risk of illness. In some cases these medications are prescribed for people who have developed risk factors for an illness that has not yet manifested itself. In others it may be to prevent the recurrence of an illness from which the patient has recovered. Please see your ID card to determine if you have this coverage. Your ID card will include the words “Preventive Drug Benefit” if you have this coverage.

The preventive medications described above are separate from the preventive care services, including drugs, listed in your Schedule of Benefits, for which no Member Cost Sharing applies.

If your Plan exempts preventive drugs from the Deductible and your health care provider prescribes one of the designated preventive medications, the Deductible will not apply to that prescription. However, you will be required to pay the applicable Copayment or Coinsurance amount for the drug. Since no deductible applies to preventive medications, expenses you incur for such drugs do not apply to your In-Network Deductible.

The Plan may change the listing of designated preventive medications from time to time. For a current list of designated preventive medications, please visit our web site at [www.harvardpilgrim.org](http://www.harvardpilgrim.org).

**Out-of-Pocket Maximum**

Your Plan may provide prescription drug coverage with an Out-of-Pocket Maximum. Your Out-of-Pocket Maximum may apply 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. Please refer to your ID card to see if an Out-of-Pocket Maximum applies to your Plan.

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. All covered drugs are subject to the applicable Member Cost Sharing. Please check your ID card 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

- 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.
- Oral fluoride (only for children up to age 5)
- Folic acid (only for women planning or capable of pregnancy)

Covered Non-Prescription Items

- Insulin
- Oral agents for controlling blood sugar
- Lancets
- Blood glucose testing strips
- Urine diabetic testing strips
- Ketone diabetic testing strips

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, and folic acid for women planning or capable of pregnancy. Please go to www.harvardpilgrim.org to see a complete list of covered preventive services.

*Certain religious employers may exclude coverage for contraceptive drugs and devices. Please see the Exclusions section of your Benefit Handbook to determine whether these items are excluded under your Plan.

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

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.
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 click either Infertility Pharmacy Program or Specialty Pharmacy Program). This information is also available 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. Please see your ID card for the Member Cost Sharing that applies to you. The specialty pharmacies are not part of the Mail Order Prescription Drug Program, to which different Member Cost Sharing rules may apply.

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, and 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 your applicable Member Cost Sharing. Payment will be limited to the Allowed Amount for the drug.

In the case of HMO coverage plans, no benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

Mail Service Prescription Drug Program

We provide a Mail Service Prescription Drug Program for Members who prefer the convenience of receiving their prescriptions through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Program. In addition to saving a trip to the pharmacy, some plans provide lower Member Cost Sharing amounts 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. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

Please see your ID card for your Mail Service Member Cost Sharing. The Mail Service Member Cost Sharing amounts listed on your ID card apply only to the Mail Service Program.

For more information about the Plan’s Mail Service Prescription Drug Program, please call 1-877-347-3216 (TTY 1-877-517-9301).

What is Not Covered or has Limited Coverage

There are a number of prescription drugs that are 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 Four-Tier Prescription Drug List. You may view this list online at [www.harvardpilgrim.org](http://www.harvardpilgrim.org) by clicking Pharmacy Program or you may request a copy of this list 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.
- In the case of HMO coverage plans, 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 and Exception Policy

We may require prior authorization for coverage of certain drugs. We may add to the list of drugs for which prior authorization is required or for which coverage is excluded or limited at any time. Medical providers may request an exception on behalf of a Member for coverage of any drug that is excluded or limited. Exceptions may be granted only for clinical reasons. Providers may request such an exception by calling the Pharmacy Services Department at **1-888-888-4742 ext. 39014**. Providers may also use this number to request prior approval for a compounded drug. We will act on any such request within two working days of receiving the clinical rationale for the request.

We will not grant individual exceptions to waive or reduce the Copayment and Coinsurance amounts for a particular drug. However, medical providers may submit a request to us to review or reconsider coverage of a drug.
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 Four-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 Four-Tier Drug List online at 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.