3-Tier Outpatient
Group Prescription Drug Benefit Rider
Covered Drug Options

Benefit Tiers

Tier I: Preferred Generic Covered Drugs

Member pays:
$7 Copayment per Designated Plan Pharmacy Therapeutic Supply
$14 Copayment per Mail Order Plan Pharmacy Maintenance Supply

Tier II: Preferred Brand Name Covered Drugs without a Generic Covered Drug Equivalent

Member pays:
$15 Copayment per Designated Plan Pharmacy Therapeutic Supply
$30 Copayment per Mail Order Plan Pharmacy Maintenance Supply

Tier III: Non-Preferred Generic or Brand Name Covered Drugs without a Generic Covered Drug Equivalent

Member pays:
$40 Copayment per Designated Plan Pharmacy Therapeutic Supply

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group's election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Evidence of Coverage (EOC) and Attachment A Benefit Schedule issued by Health Plan of Nevada, Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and herein.

SECTION 1. Obtaining Covered Drugs

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 herein.

- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable Tier I, II or III benefit level. For the purpose of this Rider, benefits for such Specialty Covered Drugs are considered as though they are on the Preferred List.
- If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom we have an arrangement to provide those Covered Drugs.

1.1 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Member obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement:

(a). **Tier I applies when:**
- a Preferred Generic Covered Drug is dispensed;

(b). **Tier II applies when:**
- a Preferred Brand Name Covered Drug is dispensed which has no Generic Covered Drug equivalent;

(c). **Tier III applies when either of the following is dispensed:**
- a Non-Preferred Generic Covered Drug; or
- a Non-Preferred Brand Name Covered Drug which has no Generic Covered Drug equivalent.

(d). **Mandatory Generic benefit provision applies when:**
- a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Member will pay the Tier I Covered Copayment plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply.

(e). When a Maintenance Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I or Tier II Mail Order Plan Pharmacy benefit tier will apply per Maintenance Supply.

1.2 Emergency or Urgently Needed Services Prescription Drugs

(a). **Dispensed by a Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the applicable Copayment amount subject to (a), (b), (c), or (d) in Section 1.1.

(b). **Dispensed by a Non-Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to Section 1.3 below.

1.3 Non-Plan Pharmacy Benefit Payments

(a). In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy be eligible for benefit payment, the Member must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to HPN or its designee.

(b). Benefit payments are subject to the limitations and exclusions set forth in the HPN EOC and this Rider as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and the Tier I, II or III Copayment amount. The Member is responsible for any amounts exceeding HPN's benefit payment.

2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's EME of the Generic Covered Drug less the Tier I Copayment. The Member is responsible for any amounts exceeding HPN's benefit payment.

3. No benefits are payable if HPN's EME of the Covered Drug is less than the applicable Copayment.

1.4 Mail Order Plan Pharmacy Benefit Payments

(a). Benefits for a Maintenance Supply of Maintenance Drugs are available when dispensed by an HPN Mail Order Plan Pharmacy subject to the

applicable Tier I or Tier II Mail Order benefit tier.

(b). Information on how to obtain Mail Order Maintenance Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

Section 2. Limitations.

2.1 Prior Authorization or Step Therapy may be required for certain Covered Drugs.

2.2 Mail Order benefits only apply to Maintenance Drugs as defined herein.

2.3 Benefits for certain Covered Drugs are limited to a specific number of Therapeutic Supplies during a Dispensing Period as defined herein. If the applicable number of Therapeutic Supplies is exceeded prior to the expiration of the Dispensing Period, no benefits are payable until the commencement of any following Dispensing Period.

2.4 Mail Order benefits are payable for a 90-day Maintenance Supply only after three (3) consecutive 30-day Therapeutic Supplies of a newly prescribed Maintenance Drug are filled at the Designated Plan Pharmacy. This requirement is in place to ensure the prescribed dose of the Maintenance Drug is appropriate.

2.5 A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.

2.6 Benefits for prescriptions for Mail Order Maintenance Drugs submitted following HPN's receipt of notice of individual's termination will be limited to the appropriate Maintenance Supply from the date such notice of termination is received to the Effective Date of termination of the individual.

2.7 Benefits for Prior Authorized and Medically Necessary Compounds as defined herein are payable according to the applicable Non-Preferred benefit level.

2.8 Benefits are not payable if you are directed to a Designated Plan Pharmacy and you choose not to obtain your Covered Drug from that Designated Plan Pharmacy.

2.9 If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Plan Pharmacies may be limited. If this happens, HPN may require you to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single Plan Pharmacy. If you do not make a selection within thirty-one (31) days of the date you are notified, then HPN will select a single Plan Pharmacy for you.

SECTION 3. Exclusions

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

3.1 Any drug, supply or device which can be purchased without a prescription, including those prescribed by a licensed Provider;

3.2 Drugs which are available without charge under local, state, or federal programs, including Workers' Compensation programs, or approved clinical trial or study;

3.3 Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices;

3.4 Anorexic agents (weight reducing drugs), drugs prescribed for cosmetic purposes, hair growth, nicotine suppressants, infertility drugs, erectile or sexual dysfunction drugs;

3.5 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs;

3.6 Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN EOC;

3.7 Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members;

3.8 Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after Member's termination date of coverage under the Plan;

3.9 Prescription Drugs, including Covered Drugs dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.

3.10 Over-the-counter drugs, multivitamins and nutritional supplements;

3.11 Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Rider;

3.12 Any refill in excess of the amount specified by the prescription order;

3.13 Any refill dispensed; 1) more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed; 2) as a result of a lost or stolen prescription; or 3) as a result of abuse, misapplication or breakage, whether accidental or intentional;

3.14 Medical supplies unless listed on the PDL or Prior Authorized by HPN;

3.15 Prescriptions for Covered Drugs that exceed the applicable number of Therapeutic Supplies in a given Dispensing Period as determined by HPN;

3.16 Any drug that has been approved by the FDA for less than six (6) months unless Prior Authorized by HPN;

3.17 Compounds that are determined not to be Medically Necessary unless Prior Authorized by HPN;

3.18 Any class of Prescription Drugs for which an over-the-counter Therapeutic Equivalent is available;

3.19 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained;

3.20 Drugs and medicines approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan;

3.21 A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan;

3.22 Prescription Drugs dispensed outside the United States, except as required for emergency treatment;

3.23 Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission; and

3.24 Covered Drugs that are not FDA approved for a specific diagnosis.

SECTION 4. Glossary

4.1 **"Brand Name Drug"** is a Prescription Drug which is marketed under or protected by:

- a registered trademark;
- or a registered trade name;
- or a registered patent.

4.2 **"Compound"** means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician's specifications to meet an individual patient's need.

4.3 **"Copayment"** is the predetermined amount shown in this Rider that the Member is responsible for paying directly to the Plan Pharmacy for each Therapeutic Supply of a Covered Drug at the time the prescription is dispensed. Copayments or any amounts paid in addition to the Copayment do not apply to the annual out-of-pocket Copayment Maximum set forth in the Attachment A Benefit Schedule, if any.

4.4 **"Covered Drug"** is a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:

- can only be obtained with a prescription;
- has been approved by the Food and Drug Administration ("FDA") for general marketing, subject to 3.16 herein;
- is dispensed by a licensed pharmacist;
- is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
- is not specifically excluded herein.

4.5 **"Designated Plan Pharmacy"** means a pharmacy that has entered into an agreement with HPN to provide specific Covered Drugs and/or supplies to Members. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit Rider, please refer to the HPN PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.

4.6 **"Dispensing Period"** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

4.7 **"Eligible Medical Expense (EME)"** for purposes of this Rider, means the Plan Pharmacy's contracted cost of the Covered Drug to HPN but not more than the actual charge to the Member.

4.8 **"Generic Drug"** is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

4.9 **"Mail Order Plan Pharmacy"** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Preferred Maintenance Drugs to Members by mail.

4.10 **"Maintenance Drug"** is a Preferred Covered Drug prescribed to treat certain chronic or life-threatening long-term conditions as determined by HPN, such as the following: Diabetes, Arthritis, Heart Disease and High Blood Pressure. For purposes of this Rider, Maintenance Drugs do not include Specialty Covered Drugs.

4.11 **"Maintenance Supply"** is the quantity, as determined by HPN, of a Preferred Maintenance Drug for which Mail Order benefits are available for a specified number of Drug Fees or Coinsurance amount, and may be less than but shall not exceed a 90-day supply.

4.12 **"Non-Plan Pharmacy"** is a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.

4.13 **"Non-Preferred"** for purposes of this Rider, means those Covered Drugs not included on the Preferred Drug List.

4.14 **"Plan Pharmacy"** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.

4.15 **"Preferred" or "Preferred Drug List (PDL)"** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.

4.16 **"Prescription Drug"** is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

4.17 **"Specialty Drugs"** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

4.18 **"Step Therapy"** is a program for Members who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Member receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Brand Name Covered Drug that may have initially been prescribed, the Member try a lower cost first-step Covered Drug. If the prescribing Physician has documented with HPN why the Member's condition cannot be stabilized with the first-step Covered Drug, HPN will review a request for Prior Authorization to move the Member to a second-step drug, and so on, until it is determined by HPN that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.

4.19 **"Therapeutic Equivalent"** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

4.20 **"Therapeutic Supply"** is the maximum quantity of a Covered Drug for which benefits are available for a single applicable Drug Fee or the applicable Coinsurance amount and may be less than but shall not exceed a 30-day supply.

Important Notice regarding the Preferred Drug List (PDL)

The Preferred Drug List (PDL) is a list of FDA-approved Generic and Brand Name Prescription Drugs, including Specialty Drugs, and their corresponding Prior Authorization and Step Therapy requirements, if applicable, that is established and maintained by HPN. The PDL is developed and maintained by the HPN Pharmacy and Therapeutics (P&T) Committee, which is

comprised of Primary Care and Specialty Physicians, pharmacists and other healthcare Providers.

The Committee meets at least annually and as needed throughout the year to evaluate the PDL and review new and existing categories of drugs. Drugs and drug classes are evaluated based upon FDA-approved indications, effectiveness, adverse effect profile, patient monitoring requirements, patient dosage and administration guidelines, impact on total healthcare costs, and comparison to other drugs on the PDL. Cost becomes a determining factor when minimal or no differences exist when comparing effectiveness with other drug specific parameters.

The Committee uses medical and clinical literature, relevant patient utilization and experience, current therapeutic guidelines, economic data, and Provider recommendations in its decision-making process.

HPN's PDL is subject to change during the year based on P&T Committee decisions and recommendations.

Questions about HPN's PDL should be directed to the Member Services Department at (702) 242-7300 or 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at http://www.uhcnevada.com/ which leads to HPN's portal www.healthplanofnevada.com.