



**MercyCare HMO,  
Inc.**

**Three Tier Drug  
Rider**

# TABLE OF CONTENTS

- IMPORTANT INFORMATION ..... 2
  - THREE-TIERED DRUG PLAN ..... 2
  - GENERAL GUIDELINES ..... 2
  - INTERPRETING THIS PRESCRIPTION DRUG RIDER .... 2
  - QUESTIONS? ..... 2
- OBTAINING PRESCRIPTION DRUGS ..... 3
  - OBTAINING A PRESCRIPTION..... 3
  - PAYING FOR YOUR PRESCRIPTION..... 3
    - Participating Pharmacy Benefits: ..... 3
    - Maximum Out-of-Pocket ..... 3
    - Non-Participating Pharmacy Benefits: ..... 3
- PRESCRIPTION DRUG BENEFIT PROVISIONS ..... 4
  - COVERED DRUGS ..... 4
  - PRIOR APPROVAL..... 4
  - DRUG QUANTITY ..... 4
  - PAIN MANAGEMENT and NARCOTICS ..... 4
  - SPECIALTY DRUGS ..... 5
  - IMMUNOSUPPRESSANT DRUGS ..... 5
  - OFF LABEL CANCER DRUGS..... 5
  - NON-COVERED DRUGS ..... 6
- PRESCRIPTION DRUG GLOSSARY ..... 7

# IMPORTANT INFORMATION

## **THREE-TIERED DRUG PLAN**

This three-tiered drug plan incorporates three levels of benefits.

- Tier 1 is for preferred generic drugs, preferred tier 1 brand name drugs, and covered over-the-counter (OTC) drugs, and has the lowest co-payment.
- Tier 2 covers our preferred tier 2 brand name drugs and non-preferred generic drugs, and has the second lowest co-payment.
- Tier 3 represents all non-preferred drugs and clinically-appropriate non-covered drugs by approval, and has the highest co-payment.
- Affordable Care Act compliant drugs that are listed on the U.S. Preventive Services Task Force (USPTF) list of recommended preventive services, category A or B, are covered with zero \$ cost share.
- Drugs that are not available through the pharmacy are covered under the medical benefit.

This drug plan is a closed formulary, which means that only those drugs listed in the formulary are available to our members. See the "Non-Covered Drugs" section of this rider. MercyCare determines the placement of drugs within each tier of this formulary. Other changes may occur to this formulary as determined by MercyCare. The formulary is available to all members on the MercyCare website at [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com). You may obtain a copy of the formulary by calling the Customer Service Department at 1-800-895-2421.

## **GENERAL GUIDELINES**

This drug rider outlines the prescription drug coverage that you have under the contract that we have with your Group. Unless otherwise provided by this rider, the terms and conditions of the Certificate you have under that contract govern this prescription drug coverage.

It is important that you understand all parts of this Prescription Drug Rider in order to get the most out of the coverage that you have.

Some of the terms that are used in this Prescription Drug Rider have specific meanings. These terms and their meanings can be found in the Glossary section of this Prescription Drug Rider.

To ensure that you take full advantage of this prescription drug plan, you should follow these guidelines:

- Tell your physician about this drug program. Doing so can help him or her in making decisions about the prescriptions being prescribed.
- Use the same pharmacy for all your prescriptions as much as possible. This allows your pharmacist an opportunity to know and learn about your medical conditions, allergies, and drug benefits.
- Ask your pharmacist to talk with your doctor to help make sure you receive the most appropriate drugs for your medical condition.

## **INTERPRETING THIS PRESCRIPTION DRUG RIDER**

If any benefit in this Prescription Drug Rider is subject to a determination of medical necessity, we will make that factual determination. You have the right to appeal an adverse determination for a formulary or non-formulary drug. In addition, you have the right to an Independent External Review of any adverse determination. Please refer to the Independent Review section of your Certificate to find the procedures related to appeals.

## **QUESTIONS?**

If after you read this Prescription Drug Rider you have questions, please call the Customer Service Department at: **1-800-895-2421**

**For information on your medical benefits, please refer to your Certificate of Coverage.**

# OBTAINING PRESCRIPTION DRUGS

Please see provider directory for listing of participating pharmacies or please contact the Customer Service Department at:  
**1-800-895-2421**

## OBTAINING A PRESCRIPTION

To fill a prescription, your pharmacist will need:

- Your prescription written from your in network physician or a non-network provider for emergency treatment or from non-network provider that has been previously approved.
- Your member identification card.

Once the information from your member card is entered into the pharmacist's computer, the pharmacist will be able to:

- Verify that you are eligible to receive drugs under the prescription drug plan.
- Check to see if the prescription you have requested is a covered drug.
- See the listing price of the prescription and the amount you will be expected to pay.

## PAYING FOR YOUR PRESCRIPTION

### Participating Pharmacy Benefits:

Tier 1: Preferred Generic, Preferred Tier 1 Brand Name, and Preferred OTC Drugs

- [\$0 - \$50] co-pay per prescription drug order
- [0 - 50%] co-insurance per prescription drug order

Tier 2: Preferred Tier 2 Brand Name Drugs

- [10% - 50%] co-insurance with minimum co-pay of [\$15 - \$50] and a maximum co-pay of [\$20 - \$100] per prescription drug order

Tier 3: Non-Preferred Drugs and Clinically-Appropriate Non-Covered Drugs (with prior approval)

- [20% - 70%] co-insurance with minimum co-pay of [\$20 - \$100] and a maximum co-pay of [\$25 - \$150] per prescription drug order

- [\$0 - \$750] deductible per single per contract year, [\$0 - \$1500] deductible per family per contract year, all tiers combined, thereafter covered at [60 - 100]% per prescription order.

Affordable Care Act compliant \$0 Copay drugs listed as preventive services on USPTF. These drugs are described in the formulary.

If the price of your prescription drug is less than the above amounts, you will only be required to pay the amount of the prescription drug.

### Maximum Out-of-Pocket

The maximum out-of-pocket amount for your drug coverage from participating pharmacies is integrated with the medical benefit maximum out-of-pocket amount. Refer to the medical benefit Schedule of Benefits to see what the combined pharmacy + medical benefit maximum out-of-pocket is for your plan. Once the maximum out-of-pocket amount is met across the pharmacy + medical benefit, your prescription drug claims will be covered without cost sharing.

### Non-Participating Pharmacy Benefits:

- Coverage at 50% of usual and customary charges.
- Co-insurance does not count toward the maximum out-of-pocket.
- [\$0 - \$750] deductible per single, [\$0 - \$1,500] deductible per family, thereafter covered at [60 - 100]% per prescription order.
- [No benefit].

Most of the time, you will be required to pay the member portion at the time you purchase your prescription drugs. However, you may be required to pay for the entire amount of the prescription if for example; you go to a non-participating pharmacy. When you are required to pay in full for the prescription, you can be reimbursed for the amount that you are entitled to by filling out a Prescription Drug Claim Form. You may request this form by calling the Customer Service Department at 1-800-895-2421, or you can download the form from our website at [mercycarehealthplans.com](http://mercycarehealthplans.com). If the drug you purchased is reimbursable, you should receive a check promptly.

If you have any questions about obtaining prescription drugs, please contact the Customer Service Department at:  
**1-800-895-2421**

# PRESCRIPTION DRUG BENEFIT PROVISIONS

**Prescription drug benefits are available for covered drugs prescribed by your physician.**

## **COVERED DRUGS**

This prescription drug program provides coverage for drugs that satisfy the following criteria:

1. Any prescription drug or insulin in the MercyCare Three Tier Drug Plan, prescribed by an in network provider or a non-network provider for emergency treatment or from non-network provider that has been previously approved.
2. Over the Counter (OTC) contraceptive methods, such as spermicides and sponges, are covered only if the method is Federal Food and Drug Administration (FDA)-approved and prescribed for a woman by her health care provider.
3. Biological Drugs.
4. Fertility Drugs.
5. Growth Hormone Therapy.
6. Prescription Inhalants.

And also must be:

1. Medically necessary for your medical condition and appropriate given your medical history; and
2. Prescribed in a manner consistent with its FDA approval and manufacturer recommendations; and
3. Prescribed in its most cost-effective dosing regimen; and
4. Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.

## **PRIOR APPROVAL**

**Standard Request.** Certain formulary drugs and clinically-appropriate drugs that are not shown in the Drug Formulary require prior approval from MercyCare before coverage is provided. This ensures that these drugs are used in a manner consistent with all of the criteria cited in the section marked COVERED DRUGS.

Medications included in this program are subject to change and other medications for other conditions may be added to the program. Your physician will need to send a prior approval form and documentation to MercyCare for our review. We will notify you (and your designee or prescriber) of our decision no later than 72 hours after we receive your request for prior approval.

**Expedited Request.** In exigent circumstances, you (or your designee or prescriber) may request an expedited review of your request for prior approval. An exigent circumstance exists if you are suffering from a health condition that may seriously jeopardize your life, health or ability to gain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug. we will notify you (and your designee or prescriber) of our decision no later than 24 hours after we receive your request for prior approval.

**Independent Review:** If we deny your request for prior approval of a clinically appropriate formulary or non-formulary drug, you may request an Independent External Review of our decision.

If a request for approval of a clinically appropriate formulary or non-formulary drug is granted, either through the standard or expedited process or through the Independent External Review (IER) process, the drug will be covered for the length of the prescription, including refills. In addition, the approved drug coverage will be treated as an essential health benefit. Please refer to the External Review section of your Certificate to see instructions and definitions regarding the IER process.

## **DRUG QUANTITY**

The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days. You may receive a prescription of a non-specialty covered drug up to 90 days if prescribed by your physician; but you will be required to pay 3 co-pays at the time of purchase.

## **PAIN MANAGEMENT and NARCOTICS**

If you are prescribed narcotics for chronic pain you are at risk of becoming addicted. One of the important ways for us to help you avoid this complication is to encourage you to obtain prescriptions for narcotics only from the physician who is managing your pain. The use of long-acting narcotics or large quantities of short-acting narcotics for chronic pain is limited to those prescribed by MercyCare pain specialists or pre-approved non-MercyCare pain specialists. In cases in which the Plan becomes aware of patients who have chronic pain and are on narcotics, the Plan has the right to limit the coverage of narcotics prescription to the one physician who has the primary responsibility for managing your condition.

# PRESCRIPTION DRUG BENEFIT PROVISIONS

## **SPECIALTY DRUGS**

The treatment of many health conditions involves drugs that require special delivery and instructions. These specialty drugs are designated as such in the MercyCare Drug Formulary. To ensure that you receive the service you need, these specialty drugs are covered only when you obtain them from the specialty pharmacy designated in the most current provider directory. These medications will be limited to the day supply that was approved in the prior authorization.

## **IMMUNOSUPPRESSANT DRUGS**

When a prescribing Participating Physician has indicated on a prescription "may not substitute" for immunosuppressant drugs, the Plan will not require the interchange of another immunosuppressant drug or formulation without notification and the documented consent of the prescribing Participating Physician and the Member, or the parent or guardian if the Member is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.

Should the Plan make a formulary change that would alter coverage for a Member receiving immunosuppressant drugs, the Plan shall notify the prescribing Participating Physician and the Member, or the parent or guardian if the patient is a child, or the spouse of the Member who is authorized to consent to the treatment of the patient at least 60 days prior to such change. The notification shall be in writing and shall disclose the formulary change, indicate that the prescribing Participating Physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the policy or plan sponsor's appeal process.

## **OFF LABEL CANCER DRUGS**

If MercyCare provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer MercyCare shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

1. The American Hospital Formulary Service Drug Information
2. National Comprehensive Cancer Network's Drugs & Biologics Compendium;
3. Thomson Micromedex's Drug Dex
4. Elsevier Gold Standard's Clinical Pharmacology

5. Authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services; or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain. Any coverage required by this Section shall also include those medically necessary services associated with the administration of a drug. Despite the provisions of this Section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. This Section shall apply only to cancer drugs. Nothing in this Section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

# PRESCRIPTION DRUG BENEFIT PROVISIONS

## **NON-COVERED DRUGS**

Prescription drug benefits are not available for the following:

- Replacement of any lost, stolen, or destroyed medications.
- Therapeutic devices or appliances, including hypodermic needles or syringes (except for diabetic supplies)
- Any drug or medicine that is administered or delivered by the health care provider to you.
- A brand name drug when it is available as a generic.
- A generic or brand name drug when it is covered as OTC.
- A specialty drug that is not obtained from the designated specialty pharmacy.
- Any drug or medicine which is taken by or administered to you while you are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution.
- Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording having similar intent, experimental drugs, FDA approved drugs used for non-FDA approved uses, or FDA approved drugs used in non-FDA approved regimens, even though a charge is made to you, except that coverage shall be provided for any prescription drug which meets the following criteria:
  - a. Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; AND
  - b. Is approved by the Federal Food and Drug Administration, including phase-3 investigational drugs; AND
  - c. If the drug is an investigational new drug, is prescribed and administered in accordance with the treatment protocol approved by the Federal Food and Drug Administration for the investigational new drugs.
- Anabolic steroids.
- Brand name anti-obesity and anorexients.
- Any prescription drug for a non-medically necessary condition
- Any prescription drug for a non-covered procedure or the treatment of a complication from a non-covered procedure/service.
- Any prescription drug for a sickness or bodily injury not covered by the Plan.
- Medication other than prescription drugs or preferred OTC drugs with or without a prescription order.
- Prescription drugs, which the eligible person is entitled to receive without charge under any Worker's Compensation laws or any municipal state or federal program.
- Nutritional supplements.
- Any prescription drugs dispensed to a member prior to the member's effective date of coverage under the plan or after the member's termination date.
- Any drug when used for cosmetic treatment
- Any drug when used for treatment of hair loss.
- Any medication used to obtain, treat, or enhance sexual performance and/or function, even if the problem is caused by organic diseases or mental health condition, unless the medication is listed in the formulary.
- Any prescription drugs administered by injection except for insulin injections and injections approved by the Plan's Pharmacy and Therapeutics Committee to be covered under the Pharmacy Benefit.
- Homeopathic Medications.
- Special formulations of covered drugs such as sustained release intended primarily for convenience of the patient are not covered.
- Special packaging of covered drugs intended primarily for convenience of the patient are not covered.
- Any drug used to treat hyperhidrosis.

# PRESCRIPTION DRUG GLOSSARY

## **CO-INSURANCE**

Co-insurance means the member's portion, expressed as a percentage of the fee for covered services that the member is required to pay for certain covered drugs.

## **CO-PAYMENT**

Co-payment means the portion, expressed as a fixed dollar amount, that the member is required to pay for certain covered drugs.

## **DEDUCTIBLE**

Deductible means a pre-determined amount of money that an individual member may have to pay before benefits are payable by MercyCare. The single deductible applies to each member each contract year, and the family deductible amount is the most that the employee and his or her dependents must pay each contract year.

## **GENERIC**

A generic equivalent means a prescription drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name prescription drug prescribed to you.

## **MAXIMUM OUT OF POCKET**

Maximum out-of-pocket means the portion of covered charges for which the member is responsible because of applicable co-insurance, co-payment and/or deductible provisions.

## **MERCYCARE DRUG FORMULARY**

MercyCare Drug Formulary means the comprehensive listing of prescription medications available to you as a member.

## **NON-PARTICIPATING PHARMACY**

Non-participating pharmacy means any pharmacy that does not have a contractual relationship with MercyCare for the provision of pharmacy services or supplies to members.

## **OTC (Over the Counter)**

Over the counter (OTC) drugs on the preferred drug list are covered only with a prescription.

## **NON-PREFERRED DRUG**

All drugs not on MercyCare's preferred drug list.

## **PARTICIPATING PHARMACY**

Participating pharmacy means any pharmacy that has contracted with MercyCare to provide pharmacy services or supplies to members.

## **PREFERRED DRUG**

Name brand, generic or OTC drugs in our preferred drug list as determined by MercyCare.

## **PRESCRIPTION DRUG**

Prescription drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription."

## **USUAL AND CUSTOMARY CHARGE**

Usual and customary charge is the dollar amount for a treatment, service or supply provided by a health care provider that is reasonable, as determined by the Plan, when taking into consideration, among other factors determined by MercyCare, amounts charged by health care providers for similar treatment, services and supplies when provided in the same general geographic area under similar or comparable circumstances.