Health Net

Health Net Health Plan of Oregon, Inc.
Prescription Benefits
Supplemental Benefit Schedule NMSS10-20-40/09 (No MAC S)

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, orally administered anticancer medications, 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 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. 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 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.

2.3 Copayments shall be as follows for each prescription or refill. Prescription deductibles (if any), Copayments and other amounts you pay for prescription drugs do not apply toward your plan's other deductibles, Copayment or out-of-pocket maximums, or stop loss amounts.

	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	$20	$40
Tier 3	$40	$80
Specialty Pharmacy	20% to a maximum of $200	Mail order not available
Orally administered anticancer medications	No Copayment	Mail order not available

2.4 Specialty Pharmacy: Certain drugs identified on the PDL are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs must be obtained from a designated Specialty Pharmacy Provider. Specialty Pharmacy drugs include, but are not limited to, injectable medications other than insulin that the majority of patients or a caregiver can administer at home after receiving adequate training from a medical professional.

2.5 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

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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.

2.6 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.

2.7 Reimbursement (minus the Copayment) 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 the purposes of this 2.6, "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.

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 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.

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 Over-the-counter contraceptive devices and supplies..

3.12 Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.

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