

3-Tier Outpatient Prescription Drug Rider to the HPN Group Evidence of Coverage

| Plan Retail Prescription Drug Benefits | |
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| Prescription Drug Tier | Tier I HMO Plan Benefit |
| Tier I | Member pays \$10 Copayment per Designated Plan Pharmacy Therapeutic Supply. |
| Tier II | Member pays \$15 Copayment per Designated Plan Pharmacy Therapeutic Supply. |
| Tier III | Member pays \$30 Copayment per Designated Plan Pharmacy Therapeutic Supply. |
| Prescription Drug Products from a Mail Order Network Pharmacy or 90 Day Retail Plan Network Pharmacy⁽¹⁾ | |
| Member pays 2.5 times the applicable Tier Cost-share per Pharmacy Therapeutic Supply. | |
| Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs and for any Covered Drugs requiring Prior Authorization and/or Step Therapy as outlined in the HPN EOC. | |

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, Tier II or Tier III benefit. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN has an arrangement to provide those Covered Drugs.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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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 is the low Cost-share option for Covered Drugs.
- (b). Tier II is the midrange Cost-share option for Covered Drugs.
- (c). Tier III is the high Cost-share option for Covered Drugs.
- (d). Mandatory Generic benefit provision applies when:
 - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying any applicable CYD, the Member will pay the applicable tier Cost-share 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. The difference in the amount between such Brand Name and Generic Covered Drug paid by the Member does not accumulate to any otherwise applicable plan Calendar Year Prescription Drug Deductible, overall plan CYD or annual Out of Pocket Maximum.
- (e). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable CYD and Mail Order Plan Pharmacy Cost-share benefit tier will apply per Therapeutic 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 Copayment amount subject to the applicable Tier I, Tier II or Tier III Cost-share benefit.
- (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 applicable Tier I, II or III Copayment amount. The Member is responsible for any amounts exceeding HPN’s benefit payment.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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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 applicable tier 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 90 Day Retail Plan Network ⁽¹⁾ and Mail Order Plan Pharmacy Benefit Payments

- (a). Benefits for Covered Drugs are available when dispensed by an HPN Retail⁽¹⁾ and Mail Order Plan Pharmacy subject to the applicable Tier I, Tier II, Tier III or Tier IV Cost-share.
- (b). Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

⁽¹⁾ Applies to select retail pharmacies, please consult your Provider directory.

SECTION 2. Limitations

- 2.1 Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- 2.2 Benefits are available for refills of Covered Drugs, including prescription eye drops and opioids, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
- 2.3 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.
- 2.4 Benefits for prescriptions for Mail Order Drugs submitted following HPN's receipt of notice of Member's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Member.
- 2.5 Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- 2.6 If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member's selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.
- 2.7 Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Member will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Member will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Member each time prior to dispensing the fifteen (15) day supply to confirm if the Member is tolerating the Specialty Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the HPN Prescription Drug List (PDL).

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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- 2.8** Medical exceptions, i.e., exclusions or non-formulary products, may require failure of formulary alternatives. If non-formulary medications are approved, the Member is responsible for the highest Tier CYD, copayment and/or coinsurance as applicable. Medical exceptions do not apply to drugs that are considered benefit exclusions, such as drugs for sexual dysfunction, cosmetic products and infertility.

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** Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- 3.2** Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- 3.3** Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices.
- 3.4** Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- 3.5** Any product dispensed for the purpose of appetite suppression or weight loss.
- 3.6** Medications used for cosmetic purposes.
- 3.7** Prescription Drug Products when prescribed to treat infertility.
- 3.8** Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 3.9** Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.
- 3.10** Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN EOC.
- 3.11** Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.
- 3.12** Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after Member's termination date of coverage under the Plan.
- 3.13** Prescription Drugs, including Covered Drugs, dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.
- 3.14** Drugs or supplies available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that HPN has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and HPN may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

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- 3.15** General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.
- 3.16** Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.
- 3.17** Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Rider.
- 3.18** Any refill dispensed 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.
- 3.19** Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- 3.20** Medical supplies unless listed on the PDL or Prior Authorized by HPN.
- 3.21** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- 3.22** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- 3.23** Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier III).
- 3.24** Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.
- 3.25** Experimental or investigational or unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be experimental, investigational or unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.
- 3.26** A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and/or Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.
- 3.27** Prescription Drugs dispensed outside the United States, except as required for emergency treatment.
- 3.28** Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.
- 3.29** Biosimilar Prescription Drugs.
- 3.30** Publicly available software applications and/or monitors that may be available with or without a prescription order or refill.
- 3.31** Covered Drugs that are not FDA approved for a specific diagnosis.
- 3.32** Drugs and medicine approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by HPN.
- 3.33** Unit dose packaging of Prescription Drugs.

SECTION 4. Glossary

- 4.1** “**Biosimilar Prescription Drug**” means a biological Prescription Drug approved based on showing that it is highly similar to a Reference Product, and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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- 4.2** “**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.
- 4.3** “**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.
- 4.4** “**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 3.31 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** “**Copayment**” or “**Cost-share**” means the amount the Member pays when a Covered Service is received.
- 4.6** “**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.
- 4.7** “**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.
- 4.8** “**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.
- 4.9** “**Generic Drug**” is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.
- 4.10** “**Mail Order Plan Pharmacy**” is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members by mail.
- 4.11** “**Non-Plan Pharmacy**” is a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.
- 4.12** “**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.
- 4.13** “**Prescription Drug List (PDL)**” means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.
- 4.14** “**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.
- 4.15** “**Reference Product**” means a biological Prescription Drug.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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- 4.16 “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.
- 4.17 “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 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.
- 4.18 “Therapeutic Equivalent”** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.
- 4.19 “Therapeutic Supply”** is the maximum quantity of a Covered Drug for which benefits are available for the applicable Drug Fee or the applicable Coinsurance amount and may be less than but shall not exceed a 90- day retail or mail order supply.

Coverage Policies and Guidelines

HPN’s Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on HPN’s behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug’s acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug.

Questions about HPN’s PDL should be directed to the Member Services Department at 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at <http://www.uhcnvada.com/> which leads to HPN’s portal www.myhpnonline.com.

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

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- Coupons: HPN may not permit certain coupons or offers from pharmaceutical manufacturers to apply to the Member's annual CYD and/or Out of Pocket Maximum or to reduce the Member's Copayments and/or Coinsurance. Costs defrayed for the Member as a result of pharmaceutical coupons are not Eligible Expenses. Questions regarding which coupons or offers are available can be addressed at <https://www.myuhc.com/> .

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.