Core ME Five-Tier

Prescription Drug Brochure

This brochure is a legal document that explains the prescription drug benefits provided by Harvard Pilgrim Health Care, Inc. (HPHC) to Members with plans that include outpatient pharmacy coverage.

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Prescription Drug Brochure

I. 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 outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

• Our prescription drug benefit	• Where to buy your prescriptions
• General Member Cost Sharing	• Our Mail Service Prescription Drug Program
• Covered and non-covered drugs	• 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.

Your benefits are administered on a Calendar Year basis.

A. FIVE-TIER PRESCRIPTION DRUG BENEFIT

We place all covered drugs into one of five levels or "tiers." Each tier has its own Member Cost Sharing, which is listed on your identification (ID) card. Medications listed in tier 1 will always have the lowest Member Cost Sharing. Medications in Tier 5 will always have the highest Member Cost Sharing.

Please Note: There are a limited number of medical drugs/supplies identified on the Prescription Drug List with the status **Medical-Covered** (i.e. spacer for asthma treatment). These are covered under your medical benefits and may be obtained at a retail pharmacy. Information on medical drugs may be found online in the Prescription Drug List. If the drug is covered, it will have a status of "Medical-Covered."

B. THE PRESCRIPTION DRUG LIST

The Prescription Drug List identifies all outpatient prescription drugs covered by the Plan. To get a copy of the Core ME Five-Tier Prescription Drug List, visit **www.harvardpilgrim.org** and log into **your secure online account** or call Member Services at **1-888-333-4742**.

C. MEMBER COST SHARING

This section describes Member Cost Sharing under your outpatient prescription drug benefit.

Your Member Cost Sharing may include a combination of Copayments, Coinsurance or a Deductible. Please see your ID card for Cost Sharing information.

Discount Rate

In this brochure, we refer to the term "Discount Rate." The Discount Rate is a 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. Our cost for covered drugs is generally lower than the Discount Rate.

How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price. The retail price is what pharmacies charge for drugs. If a participating pharmacy's retail price is less than the Discount rate, your Member Cost Sharing will be the lower amount.

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. Copayment amounts usually differ by drug tier.

What You Pay

Copayments are based on whether you use a participating or non-participating pharmacy:

Participating Pharmacy
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.
Non-Participating Pharmacy
If you buy your prescriptions at a non-participating pharmacy, you pay the lower of the Copayment or the pharmacy's retail price for the drug.

Please see "Buying Prescriptions" for more information.

What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill. Limits may apply. If your physician prescribes less than a 30-day supply of a medication, your Copayment still applies. 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. Coinsurance is a percentage you pay for a drug, instead of a fixed dollar amount.

What You Pay

Coinsurance varies, depending on whether you use a participating or non-participating pharmacy.

Participating Pharmacy
If you buy your prescriptions at a participating pharmacy, your Coinsurance payment is calculated using the lower of the Discount Rate or the pharmacy's retail price for the drug.
Non-Participating Pharmacy
If you buy your prescriptions at a non-participating pharmacy, your Coinsurance payment is calculated using the pharmacy's retail price for the drug.

Your out-of-pocket Coinsurance percentage is based on the Discount Rate or the pharmacy's retail price, whichever is lower. Coinsurance is calculated the day the pharmacy fills the prescription and 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.

If your Plan includes a per prescription maximum Coinsurance amount, your per prescription Coinsurance payment is limited to that maximum.

Deductibles

Your Plan may include a Deductible.

A Deductible is a specific dollar amount that you pay each Calendar Year for certain covered services. If a Deductible applies to your prescription coverage, you must first pay the Deductible amount before any coverage for drugs begins for the Calendar Year.

Please see your ID card to see if a Deductible applies to your Plan. If you have a combined medical and prescription Deductible, it will be stated on your Schedule of Benefits. If you have a separate Deductible for prescription drugs, the amount will be listed in your Summary of Benefits and Coverage.

What You Pay

Participating Pharmacy
When you use a participating pharmacy, you pay the lower of the Discount Rate or the pharmacy's retail price for prescriptions until the Deductible is met.
Non-Participating Pharmacy
When you use a non-participating pharmacy, you pay the pharmacy's retail price for prescriptions until the Deductible is met.

If the Discount Rate or retail price for a prescription, 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. Your Member Cost Sharing will never be more than 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. Once you have met your Deductible for the Calendar Year, drugs are covered for the rest of the Calendar Year. Applicable Copayment or Coinsurance applies.

✔ 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.

Preventive Medications with a High Deductible Health Plan

If you have a High Deductible Health Plan, 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 to prevent illness in people who have developed risk factors. In others it may be to prevent the recurrence of an illness from which the Member has recovered. Please see your Prescription Drug Coverage flyer to determine if you have this coverage.

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, you will not be responsible for your In-Network Deductible for these drugs.

The Plan may change the listing of designated preventive medications from time to time. To find out if your medication is on the list, visit **www.harvardpilgrim.org** and log into **your secure online account.**

The preventive medications described above are separate from the preventive care services listed in your Schedule of Benefits, for which no Member Cost Sharing applies as required by the Affordable Care Act.

Out-of-Pocket Maximum

Your Plan provides 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.

If you have a combined medical and prescription Out-of-Pocket Maximum it will be stated on your Schedule of Benefits.

If you have a separate Out-of-Pocket Maximum for prescription drugs, the amount will be listed in your Summary of Benefits and Coverage.

Participating pharmacies will not charge you Member Cost Sharing once you have reached your Out-of-Pocket Maximum.

II. WHAT IS COVERED

Your prescription drug benefit covers select Medically Necessary drugs. These drugs require a prescription by law. Some drugs may be limited or excluded.

Please Note: As required by law, a pharmacist may dispense an emergency supply of a chronic maintenance drug to a patient without a prescription if the pharmacist is unable to obtain authorization to refill the prescription from a health care provider and the pharmacist has a record of the prescription in the name of the patient, including the amount of the drug dispensed in the most recent prescription or the standard unit of dispensing the drug, and that record does not indicate that no emergency supply is permitted.

Your benefit also covers the non-prescription items listed below when you have a prescription. All covered drugs are subject to the applicable Member Cost Sharing.

Your Plan covers the following prescription and non-prescription items:

Covered Prescription Drugs (when listed on the Prescription Drug List)	**Covered Non-Prescription Items (when listed on the Prescription Drug List)**
• FDA approved prescription drugs prescribed by a physician and listed as covered in the Prescription Drug List • Oral agents for controlling blood sugar • Needles and syringes needed to administer covered drugs • Insulin, insulin delivery devices or medical supplies • FDA approved contraceptive drugs and devices* • Prenatal vitamins • FDA approved hormone replacement therapy (HRT)	• Insulin, insulin delivery devices or medical supplies • Lancets • Blood glucose testing strips • Urine diabetic testing strips • Ketone diabetic testing strips • Certain over-the-counter drugs that are an alternative to a prescription drug when listed as covered in the Prescription Drug List **Please Note:** If you are a Medicare member, the items listed above may be covered by your Medicare Part B coverage.

• Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS when recognized by established research documentation • Compounded prescriptions are covered if: (1) the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and cost $500 or less (3) and one or more agents within the compound is FDA approved and requires a prescription	

Please Note: No Member Cost Sharing applies to certain preventive care services, including but not limited to FDA approved contraceptive drugs and devices, oral fluoride for children through age sixteen, iron supplements for children up to age 12 months, certain HIV prevention drugs, and folic acid for women planning or capable of pregnancy. A Member may receive a 12 month supply of an FDA approved prescription contraceptive per Calendar Year in accordance with state law. Please go to **www.harvardpilgrim.org** to see a complete list of covered preventive services.

*A qualified religious employer may exclude coverage for contraceptive drugs and devices. Please see your Schedule of Benefits to determine whether these items are excluded under your Plan.

If a statewide State of Emergency is declared by Maine's acting Governor, and you have a valid prescription, you may receive up to a 180 day supply of most covered prescription drugs. Please note that contraceptives and opioids are excluded from this extended supply coverage.

III. BUYING PRESCRIPTIONS

A. PARTICIPATING PHARMACIES

If you use a participating pharmacy, you only have to show your ID card and pay the applicable Member Cost Sharing. 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 68,000 participating pharmacies in the United States, including:

• CVS/pharmacy	• Target Pharmacy
• Kmart Pharmacy	• Walgreens
• Rite Aid	• Walmart
• Stop & Shop	• Many independent drug stores

More information on participating pharmacies is available on our website at **www.harvardpilgrim.org/rx** or by calling Member Services at **1-888-333-4742.**

B. THE SPECIALTY PHARMACY PROGRAM

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions. These pharmacies are staffed with clinicians to provide support services for Members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Specialty pharmacies can dispense up to a 30-day supply of medication at one time and the medication is mailed directly to the Member’s home. This is NOT part of the Mail Service Prescription Drug Program. Extended day supplies and Copayment savings do not apply to these specialty drugs unless specified on the formulary. Some medications may be required to be dispensed for a 60-Day supply. In these circumstances, Members have the option to

decline the 60-Day supply and obtain a 30-Day supply of the medication by contacting Member Services at the number on your Member ID card.

To find out if your medication needs to be obtained at a specialty pharmacy, visit **www.harvardpilgrim.org** and log into **your secure online account.**

The specialty pharmacies are not part of the Mail Service Prescription Drug Program.

C. 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. You will be reimbursed minus your applicable Member Cost Sharing. Reimbursement information can be found in your Benefit Handbook. Payment will be limited to the Allowed Amount for the drug.

Except in the event of unforeseen illness or injury, prescriptions obtained at a non-participating pharmacy are not covered for HMO plans.

D. LIMITED DISTRIBUTION DRUGS

Limited distribution drugs treat complex conditions. They are only available through certain pharmacies. Select limited distribution drugs will be limited to a 30-day supply. The Prescription Drug List will indicate when a limited distribution drug is limited to a 30-day supply.

E. 90-DAY PRESCRIPTION DRUG BENEFIT AT A PHARMACY

You may purchase up to a 90–day supply of maintenance medications from certain Maine retail pharmacies. When you obtain a 90–day prescription from one of these Maine retail pharmacies, you will pay the Mail Service Prescription Drug Program Member Cost Sharing. Although most maintenance medications are available for a 90–day supply, we may limit drugs for clinical reasons or to prevent potential waste. Specialty drugs, discussed above, are not available for a 90–day supply.

F. 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.

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, specialty drugs, discussed above, are not available through the Mail Service Program.

Please see your Summary of Benefits and Coverage for your mail service prescription drug cost sharing.

For more information about the Plan's Mail Service Prescription Drug Program, please call **1-855-258-1561 (TTY 711).**

G. MEDICATION SYNCHRONIZATION PROGRAM

The Medication Synchronization Program allows multiple prescriptions to be aligned for refill to the same date. This program applies only to medications for chronic conditions. Medications may be dispensed in split fills with less than a month's supply of the medication filled at a time.

In these instances, you will be responsible for paying a pro-rated Member Cost Sharing amount instead of the Member Cost Sharing normally paid for full 1-30 day supply. The Medication Synchronization Program applies a prorated daily cost sharing rate to covered maintenance prescription drugs that are:

- dispensed by a participating pharmacy;
- in a quantity less than a thirty (30) days' supply; and
- used for the management or treatment of a chronic, long-term condition.

Medication synchronization is limited to one per Plan Year or Calendar Year per maintenance drug. Prescription drugs excluded from this program include, but are not limited to:

- controlled substances
- pain medications
- antibiotics

You can get more information on this program on our website at **www.harvardpilgrim.org/rx** or by calling Member Services at **1-888-333-4742**.

IV. WHAT IS NOT COVERED OR HAS LIMITED COVERAGE

Some 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 drugs that are not listed in the Prescription Drug List or are listed as non-formulary. If your doctor feels that one of the non-formulary drugs is needed, your doctor can submit a request for coverage under the exception process. See section *V.B. Exception Process*.

We 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 require Prior Authorization to evaluate whether certain drugs are Medically Necessary. Prior Authorization is based on Medical Necessity Guidelines 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:

1. tried another drug to treat a specific condition or
2. obtained Prior Authorization to be exempted from that requirement.

Members or their practitioners may obtain a copy of our Medical Necessity Guidelines for a drug for which coverage is requested by calling **1-888-333-4742.**

Drugs that are covered, subject to quantity limits, or require Prior Authorization are listed in the Prescription Drug List. We may add to the list of drugs at any time. You may view the most current copy of this list by visiting **www.harvardpilgrim.org** and logging into your secure online account. You may also request a copy of this list by calling Member Services at **1-888-333-4742.**

Please Note: Several drugs used for medication-assisted treatment for opioid use disorder are available in each therapeutic class of medication without Prior Authorization. Prior Authorization is not required for any drugs used for medication-assisted treatment for opioid use disorder for pregnant women.

Exclusions from Coverage

No coverage is provided under this prescription drug brochure for the following:

- Drugs not listed in the Prescription Drug List.
- Drugs listed as non-formulary in the Prescription Drug List except when approved through the Exception Process.
- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- 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.)
- Drugs that by law do not require a prescription (unless listed as covered under "What is Covered" or listed on the Prescription Drug List as covered).
- Non-prescription items, other than those specifically listed under "What is Covered." Drugs packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the Prescription Drug List as covered.
- Drugs that have not been approved by the FDA. (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation.)
- Drugs that, even if approved for lawful marketing by the U.S. Food and Drug Administration, do not have reliable scientific evidence to support that the treatment is effective in improving health outcomes or that appropriate patient selection has been determined.
- Any drug product used exclusively for cosmetic purposes.
- Experimental or investigational drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Drugs prescribed as part of a course of treatment that we do not cover.
- Drugs provided to you anywhere other than an outpatient pharmacy. Certain drugs may be covered as a non-pharmacy benefit, e.g. infused or injected drugs, which are covered under your medical benefits. (See your Benefit Handbook for an explanation of the limited coverage available for medications received from physicians and other non-pharmacy providers.)
- 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) the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and cost $500 or less, (3) one or more agents within the compound is FDA approved and requires a prescription.
- Prescription and over-the-counter homeopathic drugs.
- Fluoride supplements for adults.

- Vitamins and dietary supplements (except those listed as covered on the Prescription Drug List).
- Drugs for the treatment of idiopathic short stature.
- Non-drug products, such as therapeutic or other prosthetic devices, appliances, supports or other non-medical products. These may be covered under the medical benefit.
- Prescription drugs filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy.
- Prescription drugs that become available over the counter because the same active ingredient or a modified version/therapeutic equivalent of the active ingredient has become available over the counter. In this case, the specific medication may not be covered and the entire class of prescription drugs may also not be covered.
- Prescription drugs when co-packaged with non-prescription products.
- Immunization agents: Select vaccines may be accessible at the pharmacy at No Member Cost Sharing and covered under the medical benefit.
- Digital therapeutics and prescription digital therapeutics (PDTs), unless indicated otherwise.
- Drugs prescribed for weight loss.

Please Note: Members may request reimbursement for coverage of fluoride supplements purchased through a pharmacy that are Medically Necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay prior to beginning cancer treatment, including chemotherapy, biological therapy or radiation therapy treatment in accordance with state law.

V. PRIOR AUTHORIZATION AND EXCEPTION PROCESS

A. PRIOR AUTHORIZATION

Certain drugs require Prior Authorization. These include compounded drugs for:
- Members over the age of 18, and
- Members under the age of 18 when the active ingredients are not listed in the Prescription Drug List and cost $500 or more.

Your prescribing provider may request Prior Authorization by completing the form found online at **www.harvardpilgrim.org/pharmacycriteria** and faxing it to **1-617-673-0988.** Providers can also electronically submit their Prior Authorization request. If you have any questions regarding this process, please contact Member Services at **1-888-333-4742,**

HPHC will honor the prior carrier's authorization for up to 6 months if the Member's Provider requests Prior Authorization to be continued.

As required by state law, Prior Authorization requests for drugs used to treat serious mental illness will be approved. For these drugs, step therapy is not required. Under 24-A MRSA 4320 serious mental illness means an illness that must result in serious functional impairment that substantially interferes with or limits one or more major life activities.

B. EXCEPTION PROCESS

Your Plan has an exception process. You may use this to request coverage for:

- New-to-Market drugs
- non-formulary drugs
- drugs that are excluded
- drugs with quantity limitations

Drugs not listed in the Prescription Drug List or drugs listed as non-formulary are not covered. Medically Necessary exceptions are described under the exception process.

If you have a High Deductible Health Plan where the Deductible does not apply to certain medications for preventive care, drugs not identified by HPHC as preventive may be eligible for an exception to have the Deductible waived. Please see your Prescription Drug Coverage flyer to determine if you have this coverage. Please see the section titled, "Deductibles", above, for more information on the preventive drug benefit.

Medical providers may request an exception on behalf of a Member for coverage of any drug that is non–formulary or limited (or a preventive care drug subject to the Deductible). They should provide a statement that explains why an exception is Medically Necessary. This should include the reason(s) why the covered drugs on the Prescription Drug List are not as effective as the requested drug. Exceptions may be granted only for clinical reasons. Expedited exception requests can be made for the following reasons:

- you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function or
- when you are undergoing a current course of treatment using a non-formulary drug.

Providers may complete the form found online at **www.harvardpilgrim.org/pharmacycriteria** and fax it to **1-617-673-0988.** If you have any questions regarding this process, please contact Member Services at **1-888-333-4742.**

Requests for an exception will be reviewed within 48 hours of receipt. Your prescribing provider should include the reasons an exception is Medically Necessary. If you request an exception for a Medically Necessary prescription drug that is non–formulary or limited by the Plan and we do not respond to your request within 48 hours after receiving the clinical rationale from your prescribing provider, your request will be approved. We will notify you of a decision no later than 24 hours after receiving an expedited exception request.

If a standard or expedited exception request is denied, you may request that the original exception request and denial are reviewed by an independent review organization. A determination will be made within one business day of receipt of the complete information for standard and expedited requests.

VI. ABOUT YOUR DRUG BENEFIT

A. PHARMACY AND THERAPEUTICS COMMITTEE

Our Pharmacy and Therapeutics (P&T) Committee is an advisory group. It is comprised of physician specialists, independent physicians, and pharmacists. They work together to promote clinically sound, cost effective pharmaceutical care.

The P&T Committee reviews and approves tier placement of drugs, and limitations on drug coverage. They also provide guidance on Medical Necessity Guidelines.

B. TIER CHANGES

We regularly review and update the Prescription Drug List as new drugs or drug information becomes available. 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 60 days' written advance notice of an adverse change to the formulary to impacted Members unless a drug is being removed from the formulary due to safety concerns. An adverse change to the formulary includes the removal of a prescription drug from the formulary. It also includes moving the prescription drug to a higher tier

when such decision is not a result of the introduction of a generic equivalent of that prescription drug. You can get an updated Prescription Drug List online at **www.harvardpilgrim.org** by logging into **your secure online account**, or by calling Member Services at **1-888-333-4742.**

C. DELETIONS FROM COVERAGE

We may discontinue coverage of a drug identified on the Prescription Drug List or covered under this Brochure. Generally, such changes will take place annually but may occur throughout the year. In such event, we will send notice to impacted Members at least 60 days before discontinuing coverage for the drug or product unless the FDA has determined the drug or product to be unsafe.

D. NEW-TO-MARKET DRUGS

New-to-Market drugs are reviewed for safety and clinical effectiveness by the Point32Health Pharmacy & Therapeutics Committee. We then make a coverage decision based on the Committee's recommendation. A new drug will not be covered until this process is completed. This is usually done within 6 months of the drug product's availability. If the New-to-Market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

E. 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.

F. INCORPORATION WITH BENEFIT HANDBOOK

This Prescription Drug Brochure incorporates the terms and conditions provided in your plan's Benefit Handbook. This includes, but is not limited to, appeals and grievance processes, utilization review procedures and coordination of benefits and subrogation policies.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللُّغة العربية ، خَدَمات المُساعَدة اللُّغوية مُتَوفرة لك مَجانا ً **إتصل على 1 888-333-4742 (TTY: 711)**

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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