Sharp Health Plan
Outpatient Prescription Drug Benefit

GENERAL INFORMATION

This supplemental Evidence of Coverage and Disclosure Form is provided in addition to your Member Handbook and Health Plan Benefits and Coverage Matrix to describe your supplemental Outpatient Prescription Drug Benefits. Under this supplemental benefits plan, you are entitled to receive the benefits described below, subject to all the terms, conditions, exclusions, and limitations described in your Member Handbook.

HOW DOES THE PLAN WORK FOR ME?

Except for certain specialty medications, you may obtain covered Outpatient Prescription Drug Benefits from any Plan Pharmacy. Except for Emergency Services and out-of-area urgent care services, outpatient prescription drugs that are not obtained from a Plan Pharmacy are not covered and you will be responsible for payment. Look in your Provider Directory to find a Plan Pharmacy near you.

Always present your Sharp Health Plan Member ID card to the Plan Pharmacy. Ask them to inform you if something is not going to be covered. You pay the Copayments for Covered Benefits as listed in your Health Plan Benefits and Coverage Matrix. If the retail price for your prescription drug is less than your Copayment, you will only pay the retail price. Cost-sharing for covered orally administered anticancer medications will not exceed $200 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a Deductible unless you are enrolled in an HSA-compatible high deductible health plan.

Covered outpatient prescription medications include:

Tier I:	Generic drugs on Tier 1 of the Sharp Health Plan Drug Formulary
Tier II:	Brand name drugs, and inhaler spacers listed on the Sharp Health Plan Drug Formulary
Tier III:	Generic and brand name prescription drugs that are specifically listed as Tier III or that are not listed on the Drug Formulary but are not specifically excluded from coverage

When a generic is available, the pharmacy is required to switch a brand name drug to the generic equivalent unless prior authorization is obtained and the brand name drug is determined to be medically necessary. The Food and Drug Administration (FDA) applies rigorous standards for identity, strength, quality, purity and potency before approving a generic drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents.

SHARP HEALTH PLAN DRUG FORMULARY

The Sharp Health Plan Drug Formulary (Formulary) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Members while maintaining affordable pharmacy benefits.

The Formulary is updated quarterly, based on input from the Sharp Health Plan Pharmacy & Therapeutics (P&T) Committee, which meets regularly. The Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. Voting members are recruited from the Plan's provider network based on experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee.

Updates to the Formulary and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the Formulary current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of Sharp Health Plan's current Drug Formulary, please visit our website at www.sharphealthplan.com or call Sharp Health Plan Customer Service at 1-800-359-2002.

WHAT IS "PRIOR AUTHORIZATION?"

Some Tier I, Tier II and Tier III prescription medications require prior authorization. This means that your doctor must contact Sharp Health Plan in advance to provide the medical reason for prescribing the medication. Sharp Health Plan processes routine requests within 72 hours and urgent request within 24 hours of receipt of the information reasonably necessary to make a determination, including information the Plan has requested to make such a determination, as appropriate and Medically Necessary for the nature of the Member's condition. Urgent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Upon receiving your physician's request for prior authorization, Sharp Health Plan will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

Selected prescription drugs require step therapy. This means that a Member must try an alternative prescription drug first that Sharp Health Plan determines will be clinically effective. There may be a situation where it may be medically necessary for a Member to receive certain medications without first trying an alternative drug. In these instances, your Provider may request prior authorization by calling or faxing Customer Care. The list of prescription drugs subject to step therapy is subject to change by Sharp Health Plan. An updated copy of the list of drugs subject to step therapy is available upon request, and included within the Sharp Health Plan Formulary document which is updated monthly.

The criteria used for prior authorization and step therapy are developed and based on input from the Sharp Health Plan P&T Committee as well as physician specialist experts. Your physician may contact Sharp Health Plan to obtain the usage guidelines for specific medications.

HOW DO I OBTAIN MAINTENANCE DRUGS BY MAIL ORDER?

Mail order is a convenient, cost-effective way to obtain maintenance drugs. A maintenance drug is prescribed to treat or stabilize chronic conditions such as diabetes or hypertension. Certain maintenance drugs are available for up to a 90-day supply through our prescription home delivery service administered by CVS Caremark. To use this service:

1. Your provider may fax a prescription for up to a 90-day supply of your maintenance drug to CVS Caremark Mail Service Pharmacy using the form on https://www.caremark.com/portal/asset/NewRX_Fax_Form_v91.pdf.

2. Your provider may call in your prescription to CVS Caremark at 1-800-930-5190.

3. Your provider may send your prescription electronically through their electronic medical record by choosing:
    - Mail CVS Caremark Service Electronic
    - NCPDP ID 322028 9501
    - East Shea Blvd
    - Scottsdale, AZ 85260

4. You may call CVS Caremark at 1-800-930-5190 to enroll and to provide your payment information.

Certain medications, such as antibiotics, narcotics and central nervous system stimulants, are not available through mail order. Please use the Drug List tool at www.sharphealthplan.com to determine if your medication is available through CVS Caremark, or call Customer Care.

HOW DO I OBTAIN SPECIALTY MEDICATIONS?

Certain specialty medications are generally provided exclusively by Diplomat Specialty Pharmacy via mandatory mail order. Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often for chronic conditions and involve complex care issues that need to be managed. Examples include Xeloda, Temodar, Sensipar, and Zortress.

Sharp Health Plan has partnered with Diplomat Specialty Pharmacy to supply specialty medications for our Members. Diplomat Specialty Pharmacy's dedicated team of pharmacists, nurses, specialty technicians and patient care coordinators are available to answer all of your therapy and medication support needs. The Diplomat Specialty team works in cooperation with your doctors to coordinate your care for optimal outcomes. Specialty drugs are dispensed through a mandatory mail order program, using free, discreet, next-day delivery to your home, office or other location. Specialty drugs are available for a maximum of a 30-day supply. The 30-day Copayments for Outpatient Prescription Drugs listed in your Health Plan Benefits and Coverage Matrix apply to specialty drugs.

Diplomat Specialty Pharmacy will contact you each month to arrange for delivery of your refills. Diplomat will confirm that you are still taking your specialty medication. They will also confirm the date and location of your delivery, as well as your payment information. Diplomat will deliver your refill one week before your 30-day supply runs out. During this call you will be asked questions to determine whether or not you are experiencing medication side effects or are taking any new medications that may interact with your specialty medication.

If your condition requires immediate access to a specialty medication or if a drug is not delivered timely, Sharp Health Plan may authorize an exception to the mandatory mail order requirement. This exception will enable you to obtain your prescription through a retail pharmacy for one fill. Such an exception may be requested by calling Sharp Health Plan Customer Care at 1-800-359-2002. The Plan will review the exception request and issue a determination in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours for routine requests and within 24 hours for urgent requests. If the Plan authorizes the exception, the prescription will be limited to a 30 day supply or less. Less than a 30 day supply may be authorized, for example, when your medication has already been mailed to you but you have not received it. The Plan may authorize a quantity sufficient to supply you with medication until your prescription arrives. You will not be charged an additional copayment for the emergency supply of medication.

All Specialty medications require Prior Authorization from Sharp Health Plan. To use this service:

1. Your doctor will submit a Prior Authorization request to Sharp Health Plan.
2. If approved by Sharp Health Plan, your physician and Diplomat will be notified of the approval.
3. Your physician will fax your prescription to Diplomat Specialty Pharmacy.
4. After Diplomat receives your prescription information, they will contact you to enroll you in their service, obtain payment information and arrange for delivery of your medication.
5. If you have any questions, Diplomat can be reached at (877) 319-6337.

HOW ARE DEDUCTIBLES AND COPAYMENTS APPLIED FOR MY COVERED OUTPATIENT PRESCRIPTION DRUG BENEFITS?

The following copayments apply to prescription drugs prescribed by a Plan Provider and dispensed by a Plan Pharmacy and to prescription drugs prescribed and dispensed for Emergency Services or out-of-area urgent care services. Please see your Health Plan Benefits and Coverage Matrix for the copayment amount for each tier.

A. Retail Pharmacy
    1. For up to a 30-day supply of a Tier I drug listed on the Drug Formulary, you pay **one Tier I Copayment.**
    2. For up to a 30-day supply of a Tier II drug listed on the Drug Formulary, you pay **one Tier II Copayment**.
    3. For up to a 30-day supply of a Tier III drug (if covered), you pay **one Tier III Copayment.**

B. Mail Order Pharmacy
   1. For up to a 90-day supply of a Tier I maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Tier I Copayments.**
   2. For up to a 90-day supply of a Tier II maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Tier II Copayments**.
   3. For up to a 90-day supply of a Tier III maintenance drug that is obtained through the Prescription Home Delivery Service (if covered), you pay **two Tier III Copayments.**

Some benefit plans also have a deductible that applies to any brand name medications covered by Sharp Health Plan. If your benefit plan includes a deductible, you are responsible for paying all costs for covered brand name medications each calendar year, up to the amount of the deductible, before Sharp Health Plan will cover those drugs at the applicable copayment.

Members with a three-tier supplemental benefit plan: Drugs that are not listed on the Sharp Health Plan Drug Formulary are not excluded from coverage, unless the drug is specifically identified below as excluded. Non-listed drugs are available at a (Tier III) copayment and may require prior authorization. If a non-listed drug requiring prior authorization is approved, the member is responsible for the Tier III copayment. Costs for non-listed drugs, except those specifically excluded from coverage, will apply to the deductible.

WHEN CAN I REFILL MY PRESCRIPTION?

Sharp Health Plan allows you to refill your prescription after you have used at least 70% of the prescribed amount. For a 30-day supply, this means you can get a refill 22 days after you last filled the prescription. For a 90-day supply, you can get a refill 64 days after you last filled the prescription. If you try to order a refill at the pharmacy too soon, you will be asked to wait until the allowable refill date. A prescription cannot be refilled if there are no refills left or if the prescription has expired. If that is the case, please speak with your doctor.

Exceptions to filling a medication before the approved refill date can be made in certain circumstances. If your doctor increases your daily dose, the pharmacy or prescribing physician can submit a Prior Authorization form to Sharp Health Plan requesting that the Plan override the "refill too soon" denial. If you need to refill a medication early because you are going on an extended vacation, you can call Sharp Health Plan to request a "vacation override."

If you have any questions regarding when your prescription is eligible to be refilled, please call Sharp Health Plan Customer Care at 1-800-359-2002.

WHAT IS NOT COVERED UNDER MY OUTPATIENT PRESCRIPTION DRUG BENEFITS?

The services and supplies listed below are exclusions and limitations to the benefits described in this brochure and are not covered by Sharp Health Plan:

1. Drugs dispensed by other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency or urgent care condition.
2. Drugs when prescribed by non-contracting providers that are not authorized by the Plan except when coverage is otherwise required in the context of Emergency Services.
3. Over-the-counter medications or supplies, even if written on prescription, except as specifically identified as covered in the Sharp Health Plan Drug Formulary.
4. Vitamins (other than pediatric or prenatal vitamins listed on the Drug Formulary).
5. Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are not excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.)
6. Herbal, nutritional and dietary supplements.
7. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
8. Drugs and supplies prescribed in connection with a service or supply that is not a Covered Benefit unless required to treat a complication that arises as a result of the service or supply.
9. Travel and/or required work related immunizations.
10. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
11. Drugs obtained outside of the United States unless they are furnished in connection with urgent care or an Emergency.
12. Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug.
13. Off-label use of FDA approved prescription drugs unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer reviewed journal.
14. Replacement of lost, stolen, or destroyed medications.
15. Compounded medications, unless prior authorization is obtained and determined to be medically necessary.

Certain services and supplies listed in your Member Handbook are treated as "Covered Benefits" and not supplemental "Outpatient Prescription Drug Benefits." Therefore, the following regular Covered Benefits are not subject to the Copayments, exclusions, or limitations described in this brochure. Please refer to your Member Handbook for specific information about the Copayments, exclusions, and limitations that apply to these Covered Benefits.

1. Medically necessary formulas and special food products prescribed by a Plan physician to treat phenylketonuria (PKU) provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically necessary injectable and non-injectable drugs and supplies that are administered in a physician's office or self-injectable drugs.
3. FDA approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by or under direct supervision of a physician.
4. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, and lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under these Outpatient Prescription Drug Benefits.