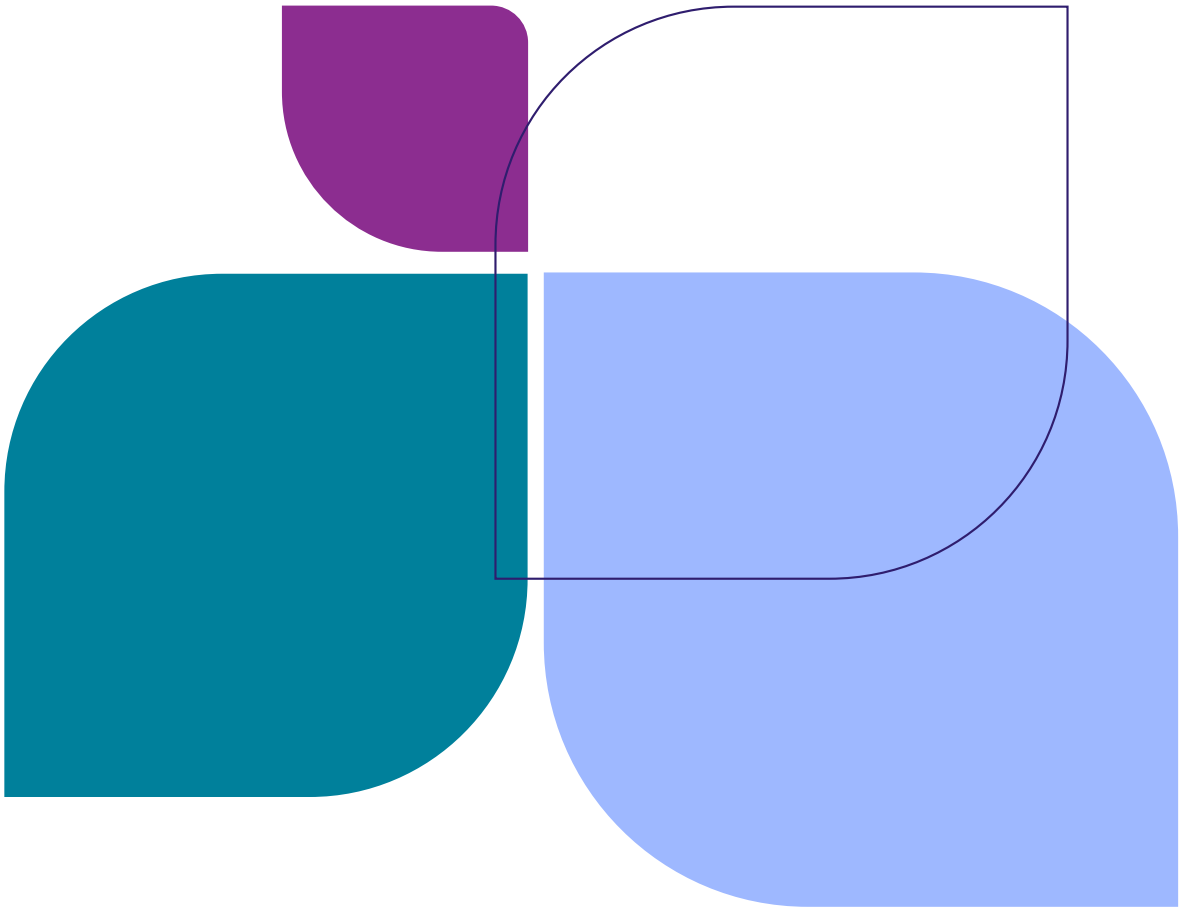
Prime THERAPEUTICS™

Reimagine pharmacy management

Your Phoebe-Devitt Homes pharmacy benefits with Prime Therapeutics



Welcome to Prime Therapeutics

Prime Therapeutics (Prime) is your pharmacy benefit manager. We want you to have the best and simplest experience, and we're focused on getting you the meds you need when and how you need them.

Please show your member ID card and prescription at any network pharmacy to get your drugs. We offer a large network of major chains, regional pharmacies and independent stores. Download the PrimeCentral™ app to access your digital ID card and compare the cost of medicines at in-network pharmacies.

Reaching Prime

If you or your provider have questions about your pharmacy benefits, please call the customer service number on your member ID card **(TTY 711)**. We are open 24 hours a day, 7 days a week. You can also visit our website at **PrimeTherapeutics.com** to learn more about us.

In the event you need a quick refill or if a natural disaster occurs, please contact customer service. We can work with a local pharmacy to help you with an urgent request.

Making the most of your benefits

The choices you make play a key role in how well your pharmacy benefits work. Here are a few helpful tips:

- **Ask for generics:** When generic drugs are a choice, they can help you save money. Generic drugs often cost less and work as well as brand-name drugs.
- **Take your drugs as directed:** Taking drugs as prescribed is one of the best things you can do to stay healthy and avoid medical problems. Missing doses, stopping drugs early or swapping drugs with other people can lead to problems that can impact your health.
- **Get over-the-counter (OTC) products:** Some drugs that used to be offered only by prescription (e.g., Claritin, Prilosec and Zyrtec) are now offered OTC. Ask your doctor if an OTC drug is right for you.

PrimeCentral™, your easy-to-use pharmacy app

Use the app to access your digital ID card, receive savings alerts, compare pricing, stay informed and:

- View real-time prescription pricing
- Shop for lower-cost options
- Switch medicines and pharmacies with a tap
- Review pharmacy claims history
- Search for in-network pharmacies

Scan to download on the Apple Store or Google Play Store!

You can also access helpful tools using our online member portal, **Prescription Hub**, at **PrimeTherapeutics.com/Member**.

Prescription summary — Phoebe-Devitt Homes

Copay/Coinsurance

Tier	Retail (1-to-30-day supply)	Phoebe Pharmacy (1-to-30-day supply)	Phoebe Pharmacy (31-to-90-day supply)	
Preferred generics	$10	$10	$25	Plan pays 100% for generic preventive drugs on the Magellan Rx Preventive Medication List. All 90 days supply retail must go through Phoebe Pharmacy only.
Nonpreferred generics	$10	$10	$25	
Preferred brands	$50	$50	$100	Brand medications on the Prime Preventive Medication List will bypass the deductible and pay at the applicable coinsurance. All 90 days supply retail must go through Phoebe Pharmacy only. If a generic drug is available and you choose the brand, you will pay the cost of the difference between the generic and brand-name drug, plus the applicable coinsurance.
Nonpreferred brands	$70	$70	$145	
Specialty	$0	N/A	N/A	For specialty medications please contact the Optimed Health Partners contact center at **877.884.0998**.

Deductible/Out-of-pocket maximum

	Individual	Family	
Deductible	$125	N/A	**NOTE: Deductible is waived at Phoebe-Devitt pharmacy.** These deductibles DO apply to the pharmacy portion of your benefits. You must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Out-of-pocket maximum	$9,200	$18,400	The out-of-pocket maximum is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket maximum must be met in order for covered prescription drugs to be covered at 100%. Amounts paid for penalties, premiums and over-the-counter medications do not count toward the out-of-pocket maximum. This is a combined out-of-pocket including both medical and pharmacy.

Optimed Medication Program

This policy states the provisions in which coverage, and reimbursement for prescribed medications is allowable for Members. The Optimed Medication Program provides Members with a higher tier of support to promote an understanding of the program, and the level of care they receive to ensure they obtain medication safely, use it effectively, and it is reimbursed within the plan's selected, or preferred procurement avenue.

Prescription medications, including Specialty Medications may be covered, and reimbursed through a Member's medical or pharmacy benefit. For the purpose of this policy, Specialty Medications shall mean treatments detailed within a specific Specialty Medication Drug List that includes self-administered mediations, as well as those that are administered by a healthcare professional.

Additionally, many prescription medications have requirements regarding handling, administration, and/or clinical oversight programs (including adverse reaction monitoring and interventions) to provide safe administration and impactful health outcomes.

Examples of treatment-specific requirements include:

- Medications that are available through the medical benefit typically require close medical supervision and may be limited to certain settings such as a medical office, infusion center, outpatient, or in the home.
- Medications that are available through the pharmacy benefit are typically self-administered injectables, or oral medications and are less likely to require a specific healthcare setting.
- Network Providers, and/or Members are required to obtain prior approval for certain medications unless it is an emergent, loss of life circumstance.

Once approval is obtained, several options may be made available to Network Providers, and Members, to bill, procure, and/or administer the approved medication(s). When the prior authorization is initiated a care coordinator will reach out to the member to assist with navigating the approved procurement channel.

For any member(s) who meet required, individual qualifications for external assistance through variable program benefits for prescribed treatment(s), the plan will require the use of such programs. Additionally, the plan has the ability to require the use of a particular, preferred, or mandated program(s) to provide services to members. When utilizing the plan's preferred procurement avenue, or the directly contracted service provider, the Member's financial liability may be variable, reduced, or eliminated as determined by the availability of external programs and the individual members qualifications to meet these requirements. Therefore, any whole or partial benefit for which a member individually qualifies is not a covered benefit under the plan and such amounts are not applied towards member cost shares such as deductible or out of pocket maximums.

In cases where a medication(s) and any administrative services are pre-authorized to be performed in a hospital owned facility, the associated medication(s) must be procured or billed through approved channels and may require the utilization of a specific medication provider.

Charges submitted for reimbursement on the associated medication(s) administered in a healthcare setting will not be covered when billed through the hospital's ancillary services, or the plan's medical benefits, unless specifically pre-authorized during the approval process.

Formulary information

The formulary, or drug list, is a tool that helps guide you and your doctor in choosing the drugs that allow the most effective and affordable use of your prescription drug benefit.

Assigning prescription drugs to the formulary

The Prime Pharmacy and Therapeutics (P&T) Committee makes the final approval for prescription drug tier placement. In its evaluation of each prescription drug, the P&T Committee considers several factors, including but not limited to, clinical and economic factors.

Clinical factors may include:

- Evaluations of the place in therapy
- Relative safety and efficacy
- Whether supply limits or notification requirements should apply

Economic factors may include:

- Acquisition cost of the prescription drug
- Available rebates and assessments on the cost effectiveness of the prescription drug

When considering a prescription drug for tier placement, the P&T Committee reviews clinical and economic factors regarding covered persons as a general population. Whether a prescription drug is appropriate for an individual covered person is a determination that is made by the covered person and the prescribing doctor.

The P&T Committee may periodically change the placement of a prescription drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to you.

If a brand-name drug becomes available as a generic

If a brand-name prescription drug becomes available as a generic drug, its tier placement may change. As a result, your copay or participation amount may change. You will pay the amount applicable for the tier to which the prescription drug is assigned.

Find your formulary

Visit **PrimeTherapeutics.com/Member/Documents** to view formulary documents. You are using the NetResults™ formulary. Download the PrimeCentral app to see if a drug is covered on your formulary and what alternatives may be available.

Prior authorization

A prior authorization (PA) is required when your health plan needs to review a drug you've been prescribed to make sure it's right for you. PAs help ensure the drug is used correctly, and they can help reduce risks and costs. Drugs used to treat pain, cancer, viral infections and obesity may require a PA.

Visit **PrimeTherapeutics.com/Member/Documents** to see if your drug requires a PA.

How it works

Bring or mail your prescription to your pharmacy. If a PA is needed, your provider can call **800.424.0472**. Your PA can be approved or denied based on the info your provider sends.

If your PA is approved, we'll let you know so you can get your medicine right away. If your PA is denied, we'll send a letter to you and your doctor with next steps.

Step therapy

Step therapy is when your health plan asks you to try a cheaper but equally effective drug before "stepping up" to a drug that costs more. This process helps control the risk of side effects and costs. For example, you might try an over-the-counter drug first. If it doesn't help you, you may then try a more expensive generic or brand-name drug.

Visit **PrimeTherapeutics.com/Member/Documents** to see if your drug requires step therapy.

How it works

Bring or mail your prescription to your pharmacy. If step therapy is needed, your pharmacist will get an alert, and they will review your options. If there is a low-cost drug in your claims history, you can fill the higher-cost drug. If the lower-cost drug options don't work for you, your pharmacist or provider can call **800.424.0472**, and we'll work through next steps.

If your drug is approved, we'll let you know so you can get your medicine right away. If your drug is denied, we'll send a letter to you and your doctor with next steps.

Supply limits

Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, either visit **PrimeTherapeutics.com/Member/Documents** or call Prime customer service at **800.424.0472** with any questions about your prescription benefit. Whether or not a prescription drug has a supply limit is subject to Prime's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the plan and Prime have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

Appeals procedures

Requests for coverage determination or appeals relating to the pharmacy benefit should be sent to Prime in writing along with any other pertinent information you would like Prime to review in conjunction with your appeal. Send all information to:

Prime Therapeutics Management, LLC
Attn: CP – 4001
P.O. Box 64811
St. Paul, MN 55164-0811

If your appeal is denied, Prime will provide written notification to you or your authorized representative. Written notification will include the specific reason(s) for the denial and reference to the specific plan provision on which the adverse benefit determination was based.

Covered prescription drug expenses

There are certain prescription drugs and related expenses that are covered under your plan. The items listed below are considered covered prescription drug expenses. Out-of-network claims are not covered on the prescription drug benefit.

Prescription products. The plan will cover prescription products that are necessary for the care and treatment of an illness or injury and are prescribed by a duly licensed medical professional. These products can be obtained only by prescription and are dispensed in a container labeled "Rx only." They include the following products prescribed by a duly licensed medical professional:

- Compound drugs of which at least one ingredient is an FDA prescription drug
- Any other drugs that, due to state law, may be dispensed only when prescribed by a duly licensed medical professional
- Products are prescribed in an amount not to exceed the day's supply outlined in the prescription summary above

Prescription drugs lost as a direct result of a natural disaster. Covered persons will be given the opportunity to prove that prescription drugs, otherwise considered covered expenses under this plan, were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (e.g., homeowner's property).

Home delivery prescriptions. The plan will pay for covered expenses incurred by a covered person for prescription products dispensed through the home delivery pharmacy identified by Prime. Prescription products may be ordered by mail with a copay from the covered person for each prescription or refill. The copay is shown in the prescription summary above. By law, prescription products may not be mailed to a covered person outside the United States.

Diabetic supplies. The plan will cover diabetic supplies, including blood sugar diagnostics, insulin, insulin syringes, lancets and urine test strips. Standard tier copays apply.

Affordable Care Act requirements. As part of the Patient Protection and Affordable Care Act, nongrandfathered plans are required to cover select FDA-approved drug products related to preventive health services for adults and children, without a member having to pay a copay or coinsurance or meet a deductible.

Exclusions

The items listed below are NOT considered covered prescription drug expenses.

- Alcohol swabs
- Anabolic steroids
- Digital therapeutics
- Respiratory devices
- Vitamins (not prenatal)
- Allergy extracts
- Compound drugs
- Infertility
- Vaccine network
- Weight loss agents

Questions?

Visit **PrimeTherapeutics.com/Member** or call customer service at **800.424.0472** with any questions about your pharmacy benefits. Help is available 24 hours a day, 7 days a week.