HealthTrust

MEDICOMP THREE
MEDICARE SUPPLEMENTAL PLAN

MEDICOMP THREE FEATURES

Comprehensive Coverage
An important part of HealthTrust's Medicomp Three plan is its supplemental medical coverage. This portion of the plan pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care. Medicomp Three also provides Major Medical Benefits that may help pay for additional services that Medicare does not customarily pay.

Coverage No Matter Where You Are
With HealthTrust's Medicomp Three plan, there is no need to worry about traveling in the United States. You can choose to use a provider who accepts Medicare assignment and receive the maximum benefits, but you're covered even if you see a provider who doesn't.

Administered by Anthem Blue Cross and Blue Shield
Your Medicomp Three medical coverage is administered by Anthem Blue Cross and Blue Shield (Anthem), one of the most respected names in the business.

This brochure helps to explain how Medicomp Three coverage works by providing an overview of covered services. While this brochure is intended to describe your benefits as accurately as possible, the specific terms and conditions of eligibility and benefits are set forth in and governed by your Medicomp Three Subscriber Certificate, Prescription Benefit Program summary (if you have elected prescription drug coverage) and any other separate documents relating to features of the plan.

In the event of any discrepancy between this brochure and those documents, the terms of the Subscriber Certificate or Prescription Benefit Program summary will govern. This brochure does not constitute a contract, or any offer to form a contract, and is not binding on any party. The benefits described in this brochure may be changed at any time without prior notice.

STRENGTHENING YOUR HEALTHCARE PLAN

Affordable, comprehensive healthcare is important to everyone—and it becomes even more important at retirement. That's why HealthTrust offers the Medicomp Three supplemental medical plan.

Medicare Parts A and B provide valuable healthcare coverage to retirees. But this coverage is not complete. To help protect you from additional out-of-pocket costs, Medicomp Three pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care.

Medicomp Three consists of two parts:

- ***Medicare Complementary Benefits***, which picks up where Medicare leaves off, paying required deductibles and coinsurance for Medicare-approved services, and
- ***Major Medical Benefits,*** which may cover services that Medicare does not. Major Medical Benefits are provided in addition to Medicare Complementary Benefits. Major Medical coverage is determined by HealthTrust and Anthem as set forth in the *Medicomp Three Subscriber Certificate*.

This brochure highlights how Medicare Complementary and Major Medical Benefits work with Medicare to provide you with a comprehensive healthcare plan.

Questions about Medicare Coverage? If you have questions about Medicare, call 800.MEDICARE (800.633.4227); TTY, call 877.486.2048. Representatives are available 24 hours a day, seven days a week. Be sure to have your Medicare identification (ID) card on hand when you call. You can also learn more by reviewing the current *Medicare & You* booklet, available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov*.

UNDERSTANDING MEDICARE

Before we look at how Medicomp Three works, it's important that you understand the basics of Medicare. Medicare is a national health insurance program for people age 65 and older, as well as for those with qualifying disabilities. It consists of multiple parts:

- ***Part A—Hospital Insurance.*** Part A provides limited coverage for inpatient care in hospitals, critical access hospitals and skilled nursing facilities. Part A also covers hospice care and some home healthcare. You do incur out-of-pocket costs, including deductibles and coinsurance.
- ***Part B—Medical Insurance.*** Part B provides coverage for doctor visits, laboratory tests, emergency room and urgent care, durable medical equipment, outpatient hospital care, vaccinations (including flu, pneumonia and hepatitis B shots), mammograms, prostate cancer screenings and pap tests. It also covers other services that Part A does not, such as some occupational and physical therapy costs. As with Part A, you are subject to out-of-pocket costs, including deductibles and coinsurance.

To be eligible for Medicomp Three, you must be enrolled in both Medicare Parts A and B. While there is no premium for Medicare Part A, you do need to pay Medicare a monthly premium for Part B coverage. Check your Medicare ID card to see if you have Part A and/or Part B coverage.

> ***Important Note*** – Medicare's required deductibles and coinsurance amounts may change each calendar year. For the most up-to-date deductible and coinsurance figures, review the current *Medicare & You* booklet available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov*, or call 800.MEDICARE (800.633.4227).

Medicare Part D

Medicare offers prescription drug coverage known as Medicare Part D. This coverage is available to everyone with Medicare by enrolling in a Medicare Part D plan and paying a monthly premium. All Medicare Part D plans provide at least a standard level of prescription drug coverage set by Medicare.

If you are enrolled in a HealthTrust Medicomp Three with Prescription Drug Coverage Plan (MCRX), you do not need to also enroll in a Medicare Part D Plan. This is because the MCRX plan is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Please see the last page of this brochure for additional information regarding your prescription drug coverage.

HOW MEDICOMP THREE WORKS

Medicomp Three provides certain protections to help you get the highest level of benefits available. For example, your coverage cannot be denied or delayed due to any pre-existing condition. Also if your care is not covered by Medicare in whole or in part, you may submit a Major Medical claim. If your Major Medical claim is denied, you are responsible for paying 100 percent of the cost. For more information, see the *Major Medical Benefits* section on page 5.

Medicomp Three consists of two parts—Medicare Complementary Benefits and Major Medical Benefits. Now, let's look at each part.

Medicare Complementary Benefits

Medicare Parts A and B pay benefits after you have met certain deductibles and/or coinsurance. This means, if your only coverage is through Medicare, you will likely have to pay for some of your care.

However, the Medicomp Three Medicare Complementary Benefits cover 100 percent of Medicare Parts A and B required deductibles and coinsurance amounts. This means your out-of-pocket cost for care is lowered or eliminated.

The following pages look at how Medicare Complementary Benefits supplement your Medicare benefits.

Inpatient Hospital Stays

Medicare Part A provides limited coverage for inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. Part A also covers hospice care and some home healthcare.

Inpatient hospital coverage includes:

- A semiprivate room,
- Meals,
- General nursing care,
- Other hospital services and supplies,
- Care you receive at a critical access hospital, and
- Inpatient behavioral healthcare.

Coverage does not include:

- Private duty nursing,
- A television or telephone in your room, or
- A private room, unless medically necessary.

Medicare Part A requires payment of an annual deductible as well as coinsurance for some Part A services. But, Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover inpatient hospital care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Inpatient Hospital Benefits			
First 60 days	100% after calendar year Medicare Part A deductible	Medicare Part A deductible per calendar year	$0
Days 61 through 90	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	$0
Days 91 through 150**	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	$0
After 150 days of continuous confinement	$0	90% of covered services, up to a lifetime maximum of 365 days	10% of covered services, up to a lifetime maximum of 365 days Then 100% of charges. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	$0

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.
*** Note that Days 91 through 150 are one-time lifetime reserve days.*

Skilled Nursing Home Benefits

Skilled nursing home coverage includes:

- A semiprivate room,
- Meals,
- Skilled nursing and rehabilitative services, and
- Other services and supplies, generally after a related three-day inpatient hospital stay. Limited to up to 100 days per benefit period.

Please note that custodial care is not covered.

Medicare Part A covers 100 percent of Medicare-eligible expenses received in a semiprivate room in a skilled nursing facility during the first 20 days.

But, Part A requires payment of coinsurance from Days 21 through 100. Medicomp Three Complementary Benefits cover 100 percent of this cost.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover skilled nursing home care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Skilled Nursing Home Benefits**			
First 20 days	100%	$0	$0
Days 21 through 100	100% after calendar year Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	$0
After 100 days of continuous confinement	$0	$0	100% of charges. You may submit these charges for consideration for payment under Major Medical

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.

*** Before you receive skilled nursing home care, you are strongly advised to confirm that the facility qualifies for Medicare benefits.* Skilled nursing home confinement must follow a hospitalization and be medically necessary. Custodial care is not covered.

Medical Service Benefits

Medicare Part B covers Medicare-eligible expenses for services rendered by physicians and other Medicare-approved providers, including independent laboratories, ambulance services and independent physical therapists.

Some outpatient hospital services are also covered under Medicare Part B.

Medicare Part B requires payment of an annual deductible as well as coinsurance for certain services. Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part B and Medicomp Three Complementary Benefits cover medical services.

	Medicare Part B Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Medical Service Benefits			
Physician services, hospital outpatient services, prosthetic devices, durable medical equipment, immunosuppressive drugs	80% of Medicare-approved charges after annual Medicare Part B deductible per calendar year	Remaining 20% of Medicare-approved charges and annual Medicare Part B deductible per calendar year	$0 for Medicare-eligible expenses 100% of non- Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	$0
Non-inpatient psychiatric services (psychiatric maximums and exceptions may apply)**	80% of Medicare eligible expenses after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare-eligible expenses	$0 for Medicare-eligible expenses 100% of non-Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3 through 5 of the* Medicomp Three Subscriber Certificate.

*** For psychiatric maximums and exceptions, refer to the Medicare & You handbook available from your local Medicare office by calling 800.633.4227 or at www.medicare.gov.*

MAJOR MEDICAL BENEFITS

Major Medical Benefits are an important component of your Medicomp Three plan.

Please Note: Major Medical Benefits are in addition to your Medicare Complementary Benefits. Major Medical Benefits do not duplicate coverage that is available under Medicare Part A, Medicare Part B or Medicare Complementary Benefits.

If you receive care or services that Medicare does not cover, or if Medicare covers some but not all of your care, you may submit these charges not covered by Medicare to be considered for coverage under Major Medical.

How Major Medical Benefits Are Paid

HealthTrust's Medicomp Three plan pays 100 percent of the cost of eligible Major Medical covered services; *you pay nothing out-of-pocket.*

Please note that Major Medical covers approved care at 100 percent of the *maximum allowable benefit.* The *maximum allowable benefit* is the amount the plan allows for a particular service in your geographical area. Amounts that exceed the *maximum allowable benefit* are not eligible for payment and are considered out-of-pocket expenses to you.

With Major Medical, covered medical services are reimbursable regardless of your choice of physician or hospital.

Maximum Lifetime Benefit

Major Medical carries a lifetime benefit maximum of $1 million. You are responsible for 100 percent of any costs in excess of this maximum.

Any Major Medical Benefits count toward this maximum, as do any benefits previously paid by Anthem while you were covered by any Anthem and/or HealthTrust-sponsored Anthem plan.

Eligible Services

While there is no guarantee that the services listed below will always be accepted for Major Medical payment, we encourage you to submit claims for:

- Ambulance services,
- Chiropractic care received from a participating provider,
- Diabetes management programs,
- Emergency care, which is defined as care required to prevent serious jeopardy to your health, impairment of bodily functions or dysfunction of a bodily organ or part. This includes heart attacks, broken bones, stroke, uncontrolled bleeding and unconsciousness,
- Hospice care received from a participating provider,
- Immunizations, and
- Laboratory and x-ray tests.

For a list of services eligible for submission under Major Medical—as well as a list of limitations and exclusions—see your *Medicomp Three Subscriber Certificate,* available in the HealthTrust Secure Enrollee Portal or "SEP". You can always request a paper copy of your plan materials, by contacting HealthTrust Enrollee Services at 800.527.5001 or enrolleeservices@healthtrustnh.org.

Determining Claims

When determining whether your claim qualifies for Major Medical Benefits, Anthem considers the following:

1. Were the services and supplies medically necessary?
2. Were the services and supplies ordered, performed, prescribed, or supervised by a qualifying physician?
3. Are the charges consistent with the maximum allowable benefit determination?
4. If the claim is in connection with a hospital stay, are the charges within the hospital's semiprivate room rate?

Anthem will notify you if your Major Medical claim is approved or denied. *If coverage is denied, you are responsible for paying 100 percent of any remaining balance.*

In addition, benefits are subject to any applicable deductible, coinsurance, benefit period restrictions, and lifetime maximums that may apply.

PRESCRIPTION DRUG BENEFITS

With a Medicomp Three with Prescription Drug Coverage Plan (MCRX), you receive comprehensive prescription drug benefits administered by CVS Caremark® – as soon as your coverage becomes effective with HealthTrust. Please refer to your CVS Caremark "Your Personal Prescription Benefit Program" summary for information regarding your prescription drug coverage.

HealthTrust's MCRX coverage is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Being enrolled in a creditable coverage plan also allows you to avoid late-enrollment fees if you later switch to a Medicare Part D plan. However, you will not be able to enroll in a Medicare Part D plan until your prescription drug coverage with MCRX ends.

If your employer offers a HealthTrust Medicomp Three without Prescription Drug Coverage Plan (MCNRX) and you elect the MCNRX coverage, you will need to enroll in a Medicare Part D plan for your prescription drug coverage.

CONTACT INFORMATION

Organization	Services
HealthTrust 800.527.5001 *www.healthtrustnh.org*	Provides answers to questions about your enrollment plan materials and the Slice of Life wellness program
Medicare 800.MEDICARE (800.633.4227) *www.medicare.gov*	Provides answers to questions about Part A, Part B, and Part D coverage, and other Medicare programs
Anthem Blue Cross and Blue Shield 800.225.2666 *www.healthtrustnh.org*	Provides answers about your benefits, covered services, plan materials, Subscriber Certificate and participating providers
LifeResources—Employee Assistance Program 800.759.8122 *www.healthtrustnh.org*	Provides counseling and resources for a variety of health-impacting life stressors
CVS Caremark 888.726.1631 *www.healthtrustnh.org*	Provides answers about your prescription drug program benefits and services

HealthTrust

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HealthTrust

Prescription Benefit Summary for CVS Caremark® Prescription Coverage

Your Prescription Benefits Plan Summary

The HealthTrust Prescription Benefits Plan provides comprehensive benefits through CVS Caremark® for you and your covered family members ensuring access to high-quality, cost-effective medications.

For short-term acute medications you may use any of the more than 68,000 retail pharmacies nationwide that make up the participating pharmacy network for CVS Caremark; you are not required to solely utilize CVS pharmacies for short-term acute medications.

For long-term medications you take regularly (also known as maintenance medications) you may use the CVS Caremark Mail Service Pharmacy® or you can pick up your maintenance medications at any CVS Pharmacy® retail location (including Target locations), North Country Healthcare Pharmacy or Walgreens, in Colebrook, NH or Shaw's Osco Pharmacy in Littleton, NH.

For specialty medications used to treat complex conditions, such as cancer, rheumatoid arthritis, or multiple sclerosis, CVS Caremark has a designated specialty pharmacy for all covered specialty prescriptions. While the CVS Specialty® Pharmacy isn't a neighborhood pharmacy you can walk into, CVS Specialty can have your specialty medications available for pickup at any CVS Pharmacy retail location, or you can have your medications delivered to your home or location of your choice.

To ensure you understand your benefits and how to make the program work best for you, please take the time to review this summary before using your prescription benefit plan.

To get the most out of your prescription benefits and other benefits that may be available through HealthTrust, we encourage you to take the time to create a Secure Enrollee Portal (SEP) account and log in often! HealthTrust's SEP is the doorway to all your benefit resources including coverage documents, ID cards, a secure Message Center, single sign-on buttons to Anthem, CVS Caremark, Delta Dental, Slice of Life, LifeResources and other vendor partner websites, and countless other resources. Covered family members age 18 and older can each create an SEP account. **(For easy how-to steps, see the brief video on HealthTrust's home page at *www.healthtrustnh.org*.)**

Additionally, we encourage you to download the **CVS Caremark mobile app** by searching for "CVS Caremark" wherever you download apps. The CVS Caremark mobile app lets you manage your prescription benefits on the go. You can check drug coverage and costs, request new prescriptions or renewals, refill prescriptions, track order status, view prescription history, and more! Simply download the CVS Caremark mobile app and get the access you need, anywhere and anytime.

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Understanding your benefits

Your cost for prescriptions

The amount you pay for your covered medications—also known as your copayment—depends on several factors:

- Whether your prescription is filled with a generic, preferred brand-name, non-preferred brand-name or specialty medication
- Where your prescription is filled (at a participating retail pharmacy, at an out-of-network retail pharmacy, through the CVS Caremark Mail Service Pharmacy, or through the CVS Specialty Pharmacy)

Please see the following chart that outlines your copayments for medications under your HealthTrust prescription benefit plan.

HealthTrust Benefit Code RX10/20/45(LCY)	RETAIL PHARMACY	MAINTENANCE CHOICE (MAIL SERVICE OR CVS PHARMACY)
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication** • **$20** for each preferred brand-name medication*** • **$45** for each non-preferred brand-name medication***	• **$10** for each generic medication** • **$20** for each preferred brand-name medication*** • **$45** for each non-preferred brand-name medication***
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
OUT-OF-POCKET LIMIT	**$1,600** per individual. Includes out-of-pocket costs for prescription expenses during a calendar year.	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS Caremark at 1.888.726.1631 or log on to your secure account at *www.healthtrustnh.org* for the most up-to-date plan information.

**Select high cost generic medications may be subject to the non-preferred copayment.

***When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and the generic.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the most you could pay in combined out-of-pocket costs for prescription and medical expenses under your HealthTrust prescription and medical benefit plans during your designated plan year as set by your employer (January Plan Year: January 1 – December 31; July Plan Year: July 1 – June 30). It does not include your annual cost of prescription coverage, amounts over the Maximum Allowed Amount, penalties, or charges for non-covered services. Once the

combined Out-of-Pocket Limit is satisfied you will not have to pay additional deductibles, coinsurance, or copayments for the rest of the plan year for covered prescription medications.

Please note: The Out-of-Pocket Limit for the HealthTrust Medicomp medical plans with prescription coverage is accumulated on a calendar year basis and includes only prescription expenses.

Covered services

A covered medication is a medically necessary prescription drug, maintenance prescription drug or certain preventative medication, which under federal or state law, require a prescription and are designated as part of the plan design outlined below. They also must be approved by the Food and Drug Administration (FDA).

Benefits are available for the following prescriptions

- Prescription drugs or biologic products which are dispensed pursuant to a prescription order, under federal law or state law. Controlled substances must be prescribed by a licensed provider with an active DEA license.

- Self-administered injectable drugs. These are drugs that do not need administration or monitoring by a provider in an office or facility.

- Self-injectable insulin supplies and equipment used to administer insulin and prescribed oral diabetes medications.

- Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

- Self-administered contraceptive drugs and devices, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, diaphragms, cervical caps and contraceptive rings. Benefits are available for the emergency oral contraceptives for women.

  As required by law, generic and single-source brand contraceptives for women are preventive care services and are covered in full when furnished by a participating pharmacy. Brand-name drugs and devices will be covered as a preventive care benefit only if your provider determines that a brand contraceptive is medically necessary and writes, "Dispense as Written" or “Do not Substitute” on your prescription. As required by law, over-the-counter contraceptive products for women are preventive care services and are covered in full when purchased at a participating pharmacy with a prescription from your provider.

- Vitamins and supplements that require a prescription by law.

- Flu shots (including administration) required by the preventive care benefit.

- Immunizations required by the preventive care benefit.
- Prescription drugs that help you stop smoking or reduce your dependence on tobacco products. FDA-approved smoking cessation products for tobacco cessation for adults age 18 or older, including over-the-counter nicotine replacement products, when obtained with a prescription. These products will be covered in full under the preventive care benefit when furnished by a participating pharmacy.
- Compound drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Specialty medications used to treat rare conditions and advanced diseases as prescribed by your provider.
- Fertility hormones and fertility drugs.
- Drugs used for the treatment of impotency and sexual dysfunction.

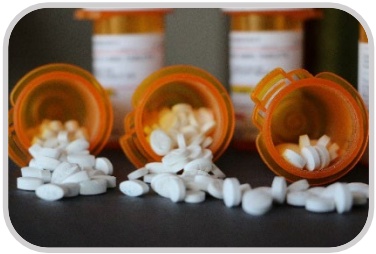
Exclusions

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- Non-Federal Legend Drugs.
- Therapeutic devices or appliances, or software programs (prescription digital therapeutics).
- Topical medical devices.
- Over-the-Counter (OTC) drugs and products unless otherwise specified.
- Unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act.
- Vision enhancement agents (prescription ophthalmic products used to improve field of vision e.g. presbyopia, blepharoptosis, contact lenses, etc.).
- Drugs which are primarily used to promote or stimulate hair growth or for cosmetic purposes only.
- Allergy Sera.

- Compound Drugs – unless all of the ingredients are FDA-approved and do not include OTC drugs or products.
- Drugs labeled "Caution-limited by Federal Law to investigational use", or experimental drugs, even if a charge is made to the covered individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency or medication furnished by any other Drug or Medical Service for which no charge is made to the covered individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while a patient is in a licensed healthcare facility, which operates on its premises or allows to be operated.
- On its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

Managed Prescription Drug Formulary



A prescription drug formulary is a list of preferred drugs established to encourage the use of safe, effective generic and brand-name medications while helping to control prescription drug costs.

CVS Caremark's formulary development process is conducted through its Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an external advisory body consisting of independent healthcare professionals, all of whom have broad clinical backgrounds and/or academic expertise. Regular voting members are not CVS Caremark employees. The P&T Committee meets quarterly (or more frequently as necessary) to review drug coverage, formulary placement, clinical appropriateness coverage criteria, treatment protocols, and all other clinical parameters of drug lists. The P&T Committee reviews both new and existing medications. The formulary will be reviewed quarterly and is amended from time to time.

A prescription drug may not be covered through the formulary if:

- The prescription drug has a generic version;
- The prescription drug is considered less effective than other similar prescription drugs; or
- The prescription drug is as effective as other, similar drugs but costs much more.

If there are documented medical reasons why you must take a medication that is not on the formulary (for example, you are allergic to an ingredient in the generic version), your provider can request a coverage review by calling 1.855.240.0536.

Filling your prescriptions

There are several ways to fill your prescriptions depending on your needs:

For medications taken for a short time

For medications you take for a short time, such as antibiotics for strep throat or pain relievers for an injury, filling your prescription at a participating retail pharmacy is optimal. Simply present your CVS Caremark prescription ID card to your pharmacist and pay your copayment for up to a 34-day supply.

For medications you take regularly

For prescription medications you take regularly to treat ongoing conditions (such as medications used to treat high blood pressure or diabetes), you may fill up to a 90-day supply for the best value and convenience. With your prescription drug coverage, you and your covered family members have the choice of obtaining long-term prescriptions (up to a 90-day supply) through the CVS Caremark Mail Service Pharmacy or to pick up your maintenance medications at any CVS Pharmacy retail location, including those inside Target stores, Walgreens Pharmacy or North Country Healthcare Pharmacy, in Colebrook, NH or Shaw's Osco Pharmacy in Littleton, NH.

Important note: You may obtain one initial fill plus two refills for maintenance or long-term medications at any participating retail pharmacies. It will then be necessary for you to utilize the CVS Caremark Mail Service Pharmacy or any CVS Pharmacy retail location, including those listed above, for additional refills. Otherwise, you will be responsible for 100% of the cost of the medication when filled at a retail pharmacy. The refill limit for maintenance or long-term medications does not apply to covered individuals residing in a licensed nursing home facility.

There are medications, such as controlled substances, that by law have lower day-supply dispensing limitations and can only be dispensed through a retail pharmacy. In these cases, the applicable copayment will be applied each time the medication is dispensed.

CVS Caremark Mail Service Pharmacy

Filling your prescriptions through the CVS Caremark Mail Service Pharmacy offers you the most convenient way to get your medications, which will be delivered safely and conveniently to your home or location of your choice. **Please note:** By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your provider, up to the 90-day supply limit.

When you use the CVS Caremark Mail Service Pharmacy, you can count on:

- Up to a 90-day supply of your medications plus three refills for up to one year when clinically appropriate.
- No-cost standard shipping in a plain, weather-resistant package.
- Convenient delivery to the location of your choice.

- Flexible payment options and, if you elect, automatic refills.
- Refill orders placed at your convenience, by telephone or electronically.
- Access to a registered pharmacist any time, 24/7.

For new prescriptions, please allow approximately 10 to 14 days from the day the CVS Caremark Mail Service Pharmacy receives your request. Refills are generally delivered within seven days following receipt of your refill request. It is important to note that you must use 75% of your medication before you can request a refill through mail service.

Getting started with mail service

You can begin using the CVS Caremark Mail Service Pharmacy for home delivery of your medications, using one of the following options:

- **CVS Caremark Mobile App**
  The CVS Caremark mobile app lets you manage your prescription benefits on the go. You can check drug coverage and costs, request new prescriptions or renewals, refill prescriptions, track order status, view prescription history and more. Simply download the CVS Caremark mobile app and get the access you need.

- **Electronically**
  Log in to your Secure Enrollee Portal (SEP) account and click on the CVS Caremark button for access to the CVS Caremark website to begin managing your prescriptions online.
- **By mail**
  Ask your provider to provide you with a written prescription for your medications. Log in to your secure HealthTrust account at ***www.healthtrustnh.org*** to download and print a mail service form. Mail the prescription(s) along with a completed order form to the address below:

  CVS Caremark
  P.O. Box 94467
  Palatine, IL 60094-4467

  Please note: To avoid delays in filling your prescription, be sure to include the required copayment with your order. Please do not send correspondence to this address.
- **By phone or electronic submission from your provider**
  Your provider may call in your prescription for up to a 90-day supply, plus the appropriate number of refills (maximum one-year supply), through the toll-free FastStart physician number at **1.800.378.5697** or may send the prescription electronically. Most prescriptions are sent electronically. CVS Caremark also accepts faxes, and your provider's office will have the appropriate fax number. Faxes must be sent from your provider's office only. Faxes from other locations, such as your home or workplace, are not acceptable.

CVS Specialty Pharmacy

Medications taken for complex conditions (specialty medications)

For specialty medications used to treat complex conditions, such as cancer, rheumatoid arthritis, or multiple sclerosis, CVS Specialty Pharmacy can help. CVS Caremark has a designated specialty pharmacy for all covered specialty prescriptions. While the CVS Specialty Pharmacy isn't a neighborhood pharmacy you can walk into, CVS Specialty can have your specialty medications available for pickup at any CVS Pharmacy retail location, or you can have your medications delivered to your home or location of your choice.

Getting started

To get started, call a CVS Specialty representative at **1.800.237.2767** or register online at ***CVSspecialty.com***. **Please note:** You must register separately on ***CVSspecialty.com*** even if you have a HealthTrust Secure Enrollee Portal (SEP) account. You may also request that CVS Specialty contact your provider for you, then call you to arrange for delivery of your medication on a day that is convenient for you.

You may refill specialty medications for up to a 90-day supply, if appropriate. It is important to note that some specialty medications have dispensing limitations and may only be filled for a 30-day supply at one time. A copayment will be applied in this case for each 30-day supply dispensed. If your provider prescribes a specialty medication it will be automatically reviewed for any additional requirements (such as prior authorization and dosage limits). Your plan provides coverage for the specialty medications included on the CVS Caremark Advanced Specialty Formulary list as amended from time to time.

24/7 personalized care

CVS Specialty provides 24/7 support from an entire CareTeam of specially trained pharmacists and nurses. Your CareTeam can help you manage your condition by checking dosing and medication schedules, answering your medication questions, helping you manage side effects, helping you set up new medication regimens, and checking that you are taking your medication as prescribed.

Flexible medication pickup or delivery

CVS Specialty lets you stay in control and on track with flexible medication pickup or delivery service. Just pick up your medication at a CVS Pharmacy or have it delivered to your home—the choice is yours.

Convenient online prescription management

Register for a secure, online specialty prescription profile on ***CVSspecialty.com*** and make managing your medication even easier with these online tools.

- Fast refill requests: Most specialty medications and supplies can be filled at the same time with the one-click "Refill All" tool.
- Up-to-date prescription information: View your prescription history, refills remaining, your costs, last fill date, and more.

- Medication pickup or delivery options: Request your refills be sent directly to the location of your choice or pick them up at your local CVS Pharmacy.
- Secure prescription information storage: Keep all your specialty prescription information in one, secure place. Save your favorite CVS Pharmacy location or address for faster ordering and checkout.

Important Plan Details

Generics Preferred Program (automatic generic substitution)

If you want to lower your out-of-pocket costs, ask your provider whether a generic medication is available and right for you. With many generic medications, you get the same high-quality, effective treatment that you get with its brand-name counterpart—without the high cost. FDA approved generic equivalent medications contain the same active ingredients and are subject to the same rigid standards established by the FDA for quality, strength and purity, as their brand-name counterparts. To help manage the cost of prescription benefits, your plan includes an automatic generic substitution feature.

How does the “generics preferred program” work? When your provider prescribes a brand-name medication and a generic substitute is available, you will automatically receive the generic *unless*:

- Your provider writes “dispense as written” (DAW) on the prescription; or
- You request the brand-name medication at the time you fill your prescription.

If you choose generic medications, you get high-quality, effective medication at the lowest cost. Your copayment for the generic medication may be less than the copayment for the brand-name medication. At times, select high cost generic medications may be considered non-preferred, resulting in a higher copayment.

Please Note: If a generic is available, but you request the brand-name medication, you will pay the generic copayment PLUS the full difference in cost between the brand-name medication and the generic equivalent. This amount is not counted toward your out-of-pocket limit.

For example: 30-day supply of medication (generic available but you choose the brand-name medication)	
Brand-name medication cost	$120
Generic medication cost	$50
Difference	$70
Copayment	$10
Your total cost	$80
If you chose the generic medication, you would pay $10	

Prior authorization

Prescriptions for certain medications require a prior authorization—also known as a coverage review—to ensure the medication is cost-effective and clinically appropriate. The review uses both formulary and clinical guidelines and other criteria to determine if the plan will pay for certain medications. Your provider will need to provide information on why they are prescribing the medication for you. Depending on the medication, your provider may need to provide your diagnosis, results of lab tests, or other information from your medical record.

The following situations may require prior authorization for your prescription:

- Your provider prescribes a medication not covered by the formulary
- The medication prescribed is subject to age limits
- The medication is only covered for certain conditions

Your plan requires prior authorization for the following prescription drugs:

- Botox and Myobloc
- Compound Medications
- Ivermectin
- Opioids
- Specialty Medications
- Wellbutrin and its generics
- Weight Loss Medications

If your prior authorization is approved, you can fill your prescription. If denied, you will receive a letter and then you can ask your provider if there is another medication covered by your plan that may also work for you. If you choose to fill the denied medication, you will be responsible to pay for the medication yourself or you and your provider can submit an appeal by following the steps in your denial letter and outlined in the How to File an Appeal Request section of this document.

Quantity Limits

Quantity limits help to ensure you receive your medications in amounts to safely and effectively treat your condition(s). They also help to prevent potential for abuse and misuse. Your plan includes quantity limits for certain medications such as erectile dysfunction medications and covers a limited quantity within a specific time period (8 per 34-day supply and 24 per 90-day supply).

Special Exceptions

There are circumstances when a special exception to the maximum supply limit may be appropriate, for example extended vacations, or lost or damaged medications. If you need an additional supply of your medication, contact CVS Caremark Customer Care at **1.888.726.1631** for assistance. You can also ask your pharmacist to call the Pharmacy Help Line at **1.800.634.6331** to request a vacation override or other supply limit exceptions. This may allow you to obtain your next refill early.

Using an out-of-network pharmacy

Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file a claim when you use a pharmacy in the CVS Caremark retail network. If you use a pharmacy outside the CVS Caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price and you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses up to the Maximum Allowed Amount (MAA) within one year of the covered drug being dispensed. You will be responsible for any amount that exceeds the MAA.

Coordination of Benefits

If you or any covered family members have prescription drug coverage through another employer-sponsored plan or Medicare, reimbursement of deductibles, copayments, or coinsurance expenses are not eligible to submit through your HealthTrust prescription benefit plan.

Claims inquiry

If you believe your claim was incorrectly denied or you have questions about a processed claim, please call CVS Caremark Customer Care at **1.888.726.1631**.

How to file an appeal request

If you are notified that a claim is denied in whole or in part, you have the right to appeal. There are two types of internal appeals that may be submitted through a first or second level appeal request:

- Administrative – These are benefit coverage decisions that are strictly based on the plan's benefit design. These appeals do not require additional information to be obtained from the prescribing provider, but may require additional information from you.
- Clinical (Prior Authorization) – These are benefit coverage decisions that are based on the plan's prior authorization requirement and require additional information to be obtained from the prescribing provider, such as clinical records or medical history information.

Appeal requests must be received within 180 calendar days after you receive the notice of denial. Appeals must be submitted in writing. Acceptable submission methods include fax or mail directly to CVS Caremark; appeals cannot be submitted electronically. All administrative and clinical appeals are reviewed in accordance with your plan design. A decision will be mailed within 15 business days of receipt of a written request by CVS Caremark for pre-service claims and within 30 days for post-service claims. CVS Caremark will determine urgent pre-service claims within 72 hours from the receipt of the appeal by CVS Caremark. If you require an urgent review, please call CVS Caremark Customer Care at **1.888.726.1631** for instructions.

Please note: Not all appeal requests are eligible for the urgent review process. All appeals will be reviewed in accordance with your plan design, and a decision will be sent to you and your provider. You have a right to receive, upon written request and at no charge, the information relied upon to review your request. After receiving the determination from CVS Caremark, you or your representative may file a second level appeal request. Appeal requests (first and second level) should be sent to:

CVS Caremark Appeals Department MC109
P.O. Box 52084
Phoenix, AZ, 85072-2084
Fax: 1.866.689.3092

Please include:

- Your name and member ID number
- Provider's name and telephone number
- Name of the medication
- Information relevant to your appeal

You have the right to an Independent (External) Review Appeal of an "Adverse Benefit Determination". An "Adverse Benefit Determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a plan benefit, and may apply to both clinical and non-clinical determinations. To request an Independent (External) Review Appeal, you must have exhausted CVS Caremark's Internal Review Appeal process described above.

CVS Caremark contracts with Independent Review Organizations (IRO) that have a network of medical experts who will review your external appeal request. The request may be made by you or your authorized representative by submitting supporting documentation, such as clinical records or medical history information. You must submit your request within 120 days after receiving your first and/or second level appeal request determination. The IRO will provide you and CVS Caremark (on behalf of the plan) with written notice of its final external review decision within 45 days after the IRO receives the request. You may also request an expedited Independent (External) Review, which will be decided within 72 hours from the receipt of the inquiry.

A benefit determination made pursuant to the Independent (External) Review Appeal is binding on both the plan and you, except to the extent that other remedies may be available to you under either state or federal law. For instance, if your claim is denied following the Independent (External) Review Appeal, you may still be able to bring a claim in court to contest that decision.

Privacy

Your HealthTrust Benefit Plan meets the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HealthTrust and CVS Health are committed to protecting your privacy.

Resources at-a-glance

Online

To get the most out of your plan, take a minute to create your own secure online account at ***www.healthtrustnh.org*** to access all of your HealthTrust benefits including prescription drug coverage. Your HealthTrust Secure Enrollee Portal (SEP) account will provide quick access to help you manage your health and medication options.

- Check prescription pricing and coverage
- Order refills and track the status of your prescriptions
- Locate participating retail pharmacies
- Access to your digital prescription ID cards
- Obtain health information and much more!

CVS Caremark Mobile App – easy, convenient, accessible

The CVS Caremark mobile app lets you manage your prescription benefits on the go. You can check drug coverage and costs, request new prescriptions or renewals, refill prescriptions, track order status, view prescription history and more! Simply download the CVS Caremark mobile app and get the access you need, anywhere and anytime.

CVS Caremark Telephone Numbers

Call **1.888.726.1631** to speak with a CVS Caremark Customer Care representative to:

- Ask questions about your prescription benefits
- Find the nearest participating retail pharmacy
- Speak with a registered pharmacist
- Order refills or check the status
- Request CVS Caremark Mail Service Pharmacy home delivery order forms or envelopes
- Request claim forms for prescriptions filled at out-of-network pharmacies

All CVS Caremark services listed above are available 24 hours a day, 7 days a week**.**

- CVS Caremark Customer Care: **1.888.726.1631**
- Telecommunication Device Assistance: **1.800.863.5488**
- CVS Specialty: **1.800.237.2767**

HealthTrust Enrollee Services

HealthTrust Enrollee Services Representatives are available to answer questions or help with issues regarding enrollment, eligibility, and any other prescription benefit-related inquiry. To contact HealthTrust, please call the toll-free number, **1.800.527.5001,** between the hours of 8:30 a.m. and 4:30 p.m. Monday through Friday, send an email to ***enrolleeservices@healthtrustnh.org***, or log in to your Secure Enrollee Portal (SEP) account and click on Message Center to send questions or information securely.