2015 Value Formulary

(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN

Health Net Healthy Heart (HMO) *in Alameda, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo Counties*,
Health Net Jade (HMO SNP) i*n Arizona*, Health Net Jade Cardiovascular (HMO SNP),
Health Net Ruby (HMO), Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO),
Health Net Ruby Select (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Violet (PPO),
Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Violet Option 3 (PPO)

HPMS Approved Formulary File Submission ID 15441, Version Number 27

This formulary was updated on 12/01/2015. For more recent information or other questions, please contact Health Net at:

Arizona Plans: 1-800-977-7522

California HMO Plans: 1-800-275-4737
California HMO SNP Plans: 1-800-431-9007
California PPO Plans: 1-800-960-4638

Oregon/Washington Plans: 1-888-445-8913

or, for **TTY users, 711**, 8:00 a.m. - 8:00 p.m., seven days a week (automated telephone service is used on some weekends and holidays), or visit **www.healthnet.com/medicare**.

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Health Net®
MEDICARE PROGRAMS

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means Health Net. When it refers to "plan" or "our plan," it means Health Net Healthy Heart (HMO) *in Alameda, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo Counties*, Health Net Jade (HMO SNP) *in Arizona*, Health Net Jade Cardiovascular (HMO SNP), Health Net Ruby (HMO), Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), Health Net Ruby Select (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Violet (PPO), Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Violet Option 3 (PPO).

This document includes a list of the drugs (formulary) for our plan which is current as of the date on the front and back cover pages. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2016, and from time to time during the year.

What is the Health Net Healthy Heart (HMO) in Alameda, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo Counties, Health Net Jade (HMO SNP) in Arizona, Health Net Jade Cardiovascular (HMO SNP), Health Net Ruby (HMO), Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), Health Net Ruby Select (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Violet (PPO), Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Violet Option 3 (PPO) Value Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Health Net network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2015 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2015 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current

as of the date on the front and back cover pages. To get updated information about the drugs covered by us, please contact us. Our contact information appears on the front and back cover pages.

If we make any other negative formulary changes during the year, you will be notified via mail and the changes will be posted on our website.

How do I use the formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "CARDIOVASCULAR AGENTS - MISC.". If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page Index 1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides two each per day per prescription for *simvastatin 40 mg*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Health Net Healthy Heart (HMO) *in Alameda, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo Counties*, Health Net Jade (HMO SNP) *in Arizona*, Health Net Jade Cardiovascular (HMO SNP), Health Net Ruby (HMO), Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), Health Net Ruby Select (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Violet (PPO), Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Violet Option 3 (PPO) Value Formulary?" on page iv for information about how to request an exception.

What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options

- You can ask Member Services for a list of similar drugs that are covered by us. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Health Net Healthy Heart (HMO) in Alameda, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo Counties, Health Net Jade (HMO SNP) in Arizona, Health Net Jade Cardiovascular (HMO SNP), Health Net Ruby (HMO), Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), Health Net Ruby Select (HMO), Health Net Seniority Plus Ruby (HMO), Health Net Violet (PPO),

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Violet Option 3 (PPO) Value Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy.

After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 102-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Level of care changes

If you experience a change in your level of care, we will cover a transition supply of your drugs. A level of care change occurs when you are discharged from a hospital or moved to or from a long-term care facility.

- If you move home from a long-term care facility or hospital and need a transition supply, we will cover one 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a total of a 30-day supply.
- If you move from home or a hospital to a long-term care facility and need a transition supply, we will cover one 34-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a total of a 34-day supply.

We understand that there are other circumstances when an override may be granted. These situations are managed on a case-by-case basis through communication between the dispensing pharmacy and Health Net.

For more information

For more detailed information about your plan's prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about our plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

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The formulary that begins on page 1 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page Index 1.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., LIPITOR) and generic drugs are listed in lower-case italics (e.g., *atorvastatin calcium*).

The information in the Requirements/ Limits column tells you if our plan has any special requirements for coverage of your drug.

Formulary tier descriptions

To figure out how much you pay for a drug, the abbreviations below appear in the Drug Tier column on the formulary. The copayment or coinsurance level is shown in the Copayment/Coinsurance column. To find out your copayment or coinsurance for each tier, please check your Evidence of Coverage.

Abbreviation	*Copayment/Coinsurance*	*Description*
1	Tier 1 copayment	Preferred generic drugs. These drugs are not eligible for exceptions for payment at a lower tier.
2	Tier 2 copayment	Non-Preferred generic drugs.
3	Tier 3 copayment	Preferred brand drugs and may include some non-preferred generic drugs. Brand drugs in this tier are not eligible for exceptions for payment at a lower tier.
4	Tier 4 copayment	Non-Preferred brand drugs and may include some non-preferred generic drugs.
5 (Specialty)	Tier 5 copayment or coinsurance	High-cost drugs. These drugs are not eligible for exceptions for payment at a lower tier.
6 (Select Care)	$0 copayment	Some brand and generic drugs used to treat specific chronic conditions.
NF	Non-formulary - If an exception request is approved for a non-formulary drug; the Non-Preferred brand tier (Tier 4) copayment applies. You may not ask us to provide the drug at a lower cost-sharing level.	Drugs not covered on Health Net's Medicare Part D formulary. You may request an exception from Health Net to cover these drugs. See the section, "How do I request an exception to the Health Net Medicare Part D Value Formulary?"

Abbreviations

The abbreviations below may appear in the Requirement/Limits column on the formulary.

Abbreviation	*Definition*	*Description*
AL	Age Limit	Some drugs may require prior authorization if your age does not meet manufacturer, FDA, or clinical recommendations.
B/D	Medicare Part B vs. Part D	Some drugs require prior authorization to determine coverage under the Medicare Part B or Part D benefit, according to Medicare guidelines. Your doctor or other prescriber may need to supply additional information to help us make the coverage determination.
GL	Gender Limit	Some drugs are only covered for males or females based on manufacturer, FDA, or clinical recommendations.
LA	Limited Access	Some drugs may be subject to limited access or restricted access. This means that a drug may only be available at one or a limited number of pharmacies. Limited access may be due to the following reasons: • The FDA has restricted distribution of a drug to certain facilities, pharmacies or prescribers, or • Certain drugs require special handling, coordination of care, or patient education that cannot be provided at a retail pharmacy You should talk to your doctor, or other prescriber, or pharmacist for details about getting limited access drugs.
MO	Mail Order	This drug is available at Health Net's mail order pharmacy in addition to other network pharmacies.
PA	Prior Authorization	Health Net requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
QL	Quantity Limit	For certain drugs, Health Net limits the amount of the drug that we will cover. For example, Health Net covers two each per day per prescription for *simvastatin 40 mg*. This may be in addition to a standard one-month or three-month supply limits.

Abbreviation	*Definition*	*Description*
RX/OTC	Prescription and Over-The-Counter	Certain drugs are available both in a prescription form and in an OTC form. Other than some insulins and insulin supplies, only prescription drugs are covered by Health Net Medicare Part D plans.
ST	Step Therapy	In some cases, Health Net requires you to first try certain drugs to treat your medical condition before covering another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
*	Additional Gap Coverage	**Only for Health Net Healthy Heart (HMO) plans in *Los Angeles, Orange, Riverside, and San Bernardino counties* and Health Net Seniority Plus Ruby (HMO) plan in *San Diego County*:** We provide additional coverage of this prescription drug in the coverage gap. Please refer to your *Evidence of Coverage* for more information about this coverage.

This formulary was updated on 12/01/2015.
For more recent information or other questions, please contact Health Net Medicare Part D at:

Arizona Plans: 1-800-977-7522

California HMO Plans: 1-800-275-4737
California HMO SNP Plans: 1-800-431-9007
California PPO Plans: 1-800-960-4638

Oregon/Washington Plans: 1-888-445-8913

or, for **TTY users, 711**, 8:00 a.m. - 8:00 p.m., seven days a week (automated telephone service is used on some weekends and holidays), or visit **www.healthnet.com/medicare**.

This information is available for free in other languages. Please call Member Services at the phone number listed above.

Esta información está disponible en forma gratuita en otros idiomas. Por favor llame a nuestro número de servicio al cliente al número de teléfono que aparece arriba.

本資訊備有其他語言版本，可免費提供。請撥打本冊子開頭所列的免付費電話，聯絡我們的客戶服務部。

Health Net has a contract with Medicare to offer HMO, PPO and HMO SNP plans.
Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.