Members Health Plan NJ - Summary of Material Modifications

To the Revised July 1, 2019 Summary Plan Description of Members Health Plan NJ Effective January 1, 2021 for all Enrolled Groups:

Members Health Plan NJ is changing pharmacy management services to Aetna and is therefore revising the Summary Plan Description for all groups effective January 1, 2021.

The following Summary of Material Modification (SMM) outlines the material changes being made. It is important to review the new Summary Plan Description (SPD) as this SMM may not include all changes.

For a copy of the new SPD please go to **www.membershealthplannj.com** or contact us directly at 1-833-MEWANOW.

Effective January 1, 2021 for all groups:

I. **The Plan is changing pharmacy management services from Express Scripts to Aetna, utilizing Aetna's pharmacy network and formulary.**

II. **Glucometers are covered at 100% for diabetics enrolled in the prescription plan. You can order a Glucometer by calling the toll-free Member Services number on Your member ID card.**

III. **Section titled "Defined Terms," beginning on page 96, is amended to include the following new terms:**

Non-Preferred drug
A Prescription Drug or device that may have a higher out-of-pocket cost than a Preferred Drug.
Preferred Drug is a Prescription Drug or device that may have a lower out-of-pocket cost than a Non-Preferred Drug.

Preferred Drug Guide is a list of Prescription Drugs and devices established by Aetna or an affiliate. It does not include all Prescription Preferred Drug Guide Drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the Preferred Drug Guide is available Preferred Drug Guide at Your request. Or You can find it on the Aetna website at www.aetna.com/formulary.

Specialty Pharmacy
This is a Pharmacy designated by Aetna as a Network Pharmacy to fill Prescriptions for Specialty Prescription Drugs.

Specialty Prescription Drugs
These are Prescription Drugs that include typically high-cost Drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

IV. Section titled "Defined Terms," beginning on page 96, is amended to replace the Preferred Drug term with the following:

Preferred Drug is a Prescription Drug or device that may have a lower out-of-pocket cost than a Non-Preferred Drug.

V. The Plan has implemented a copay assistance program called PrudentRX Copay Program. Refer to attached revised Prescription Summary for details.

VI. The Plan has updated its maintenance network and members can now fill maintenance medications through Aetna RX Home Delivery or CVS Pharmacy. Refer to attached revised Prescription Summary for details.

VII. The Plan has added a new tier for specialty medication as follows:

The new Specialty Drug copayments/coinsurance are as follows:

	RX 1		RX 2		RX 3		RX 4		RX 5	
	Retail	Mail	Retail	Mail	Retail	Mail	Retail	Mail	Retail	Mail
Specialty (90-day max supply):	30%	30%	30%	30%	50%	50%	Ded, then 30%	Ded, then 30%	Ded, then 50%	Ded, then 50%

Refer to attached revised Prescription Summary for details.

VIII. Section titled "Plan Exclusions" subsection "Prescription Drugs", beginning on page 53, of the Summary Plan Description is replaced with the following:

Prescription Drugs. The following Prescription Drugs are not covered under the Plan:

1. Abortion Drugs
2. Allergy sera and extracts administered via injection
3. Any services related to the dispensing, injection or application of a Drug
4. Biological sera
5. Cosmetic Drugs- Medications or preparations used for cosmetic purposes.
6. Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) -Including compounded bioidentical hormones
7. Devices, products and appliances, except those that are specially covered
8. Dietary supplements including medical foods
9. Drugs or medications
   - Administered or entirely consumed at the time and place it is prescribed or dispensed
   - Which do not, by federal or state law, require a Prescription order (i.e. over-the-counter (OTC) Drugs), even if a Prescription is written except as specifically provided in the Prescription Drug Benefits section
   - That includes the same active ingredient or a modified version of an active ingredient as a covered Prescription Drug (unless a medical exception is approved)
   - That is therapeutically equivalent or therapeutically alternative to a covered Prescription Drug including biosimilars (unless a medical exception is approved)
   - That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
   - Not approved by the FDA or not proven safe and effective
   - Provided under Your medical plan while an inpatient of a healthcare facility
   - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
   - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
   - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
   - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications.
   - That are Drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our Precertification and clinical policies
10. Duplicative Drug therapy (e.g. two antihistamine Drugs)
11. Geneticcare - Any treatment, device, Drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.
12. Immunizations related to travel or work
13. Immunization or immunological agents except as specifically provided in the Summary of Covered Services and Supplies section.
14. Implantable drugs and associated devices except as specifically provided in the Prescription Drug Benefits section.
15. Injectables:

- Any charges for the administration or injection of Prescription Drugs or injectable insulin and other injectable Drugs covered by Aetna
- Needles and syringes, except for those used for self-administration of an injectable Drug
- Any Drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified Provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

16. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the Summary of Covered Services and Supplies – Diabetic Services, Supplies and Training section.
17. Prescription Drugs:
    - Dispensed by other than a Network retail, mail order and specialty Pharmacies except as specifically provided in the Prescription Drug Benefits section.
    - Dispensed by a mail order Pharmacy that is an out-of-network Pharmacy, except in a medical Emergency or urgent care situation except as specifically provided in the How to get an Emergency Prescription filled section.
    - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a Prescription is written.
    - Packaged in unit dose form.
    - Filled prior to the effective date or after the termination date of coverage under this Plan.
    - Dispensed by a mail order Pharmacy that include Prescription Drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
    - That includes an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another Drug and is not clinically superior to that Drug as determined by the Plan.
    - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or Prescription Drugs for the treatment of a dental condition.
    - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Preferred Drug Guide or formulary.
    - That are Non-Preferred Drugs, unless Non-Preferred Drugs are specifically covered as described in Formulary list. However, a Non-Preferred Drug will be covered if in the judgment of the Prescriber there is no equivalent Prescription Drug on the Preferred Drug Guide or the product on the Preferred Drug Guide is ineffective in treating Your disease or condition or has caused or is likely to cause an adverse reaction or harm You.
    - That are being used or abused in a manner that is determined to be furthering an addiction to a habit- forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and Drugs obtained for use by anyone other than the member identified on the ID card.
18. Refills- Refills dispensed more than one year from the date the latest Prescription order was written.
19. Replacement of lost or stolen Prescriptions
20. Specialty Prescription Drugs
    - Specialty Prescription Drugs and medicines provided by Your Employer or through a third party vendor contract with your Employer.
    - Drugs that are included on the list of Specialty Prescription Drugs as Covered under Your outpatient Prescription Drug plan.
21. Test agents except diabetic test agents
22. We reserve the right to exclude:
    A manufacturer's product when a same or similar Drug (that is, a Drug with the same active ingredient or same therapeutic effect), supply or equipment is on the Preferred Drug Guide. Any dosage or form of a Drug when the same Drug (that is, a Drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on Aetna Preferred Drug Guide.

Members HealthPlan NJ

Prescription Benefit Plan Summary

Members Health Plan NJ Offers Its Members Comprehensive Pharmacy Coverage Through Aetna

The following Prescription Drug Benefit Section applies for all Plans that have elected Prescription Coverage. Please contact your Employer or refer to your ID Card to see which Rx Option you are enrolled in.

PRESCRIPTION PLAN OPTIONS
RX Plan 1 - Only available with Medical Plans (Plans A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30 day supply): $15 - Generic, $35 - Preferred Brand, $50 - Non Preferred Brand Maintenance and Home Delivery (90 day supply): $35 - Generic, $82.50 - Preferred Brand, $120 - Non Preferred Brand Specialty (90 day max supply): Member pays 30% per prescription
RX Plan 2 - Only available with Medical Plans (Plans A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30 day supply): $30 - Generic, $50 - Preferred Brand, $80 - Non Preferred Brand Maintenance and Home Delivery (90 day supply): $70 - Generic, $120 - Preferred Brand, $195 - Non Preferred Brand Specialty (90 day max supply): Member pays 30% per prescription
RX Plan 3 - Only available with Medical Plans (Plans A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30 day supply): Generic: - $15 copay, Brand - 50% copay (Min of $25 /Max of $500) *(50% copay applies to the contracted rate)* Maintenance and Home Delivery (90 day supply): Generic: - $37.50 copay, Brand - 50% copay (Min of $62.50 /Max of $1,250) *(50% copay applies to the contracted rate)* Specialty (90 day max supply): Member pays 50% per prescription
RX Plan 4 - ONLY Available with Plans N, R, S, W **(This RX plan would be considered an IRS/HSA compatible RX plan.)**
MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES Retail (30 day supply): $15 - Generic, $35 - Preferred Brand, $50 - Non Preferred Brand Maintenance and Home Delivery (90 day supply): $35 - Generic, $82.50 - Preferred Brand, $120 - Non Preferred Brand Specialty (90 day max supply): Member pays 30% per Prescription after Deductible (No Min or Max applies)
RX Plan 5 - ONLY Available with Plans N, R, S, W **(This RX plan would be considered an IRS/HSA compatible RX plan.)**
MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES Retail (30-day supply): Generic: - $15 Copay after Deductible / Brand - 50% Copay after Deductible (Min of $25 /Max of $500) (50% Copay applies to the contracted rate) Maintenance and Home Delivery (90-day supply): Generic: - $37.50 Copay after Deductible / Brand - 50% Copay after Deductible (Min of $62.50 /Max of $1,250) (50% Copay applies to the contracted rate) Specialty (90 day max supply): Member pays 50% per Prescription after Deductible (No Min or Max applies)
RX Plan 6 - Only available with Medical Plans (Plans A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z) **(if No RX is selected, medical rates will increase 3%)**
No RX Coverage

You can select one (1) or more Rx Options per each Medical Plan Option you select

All MHPNJ Prescription Programs have cost saving measures in place to ensure that both our Members and our Plan save the most on covered prescriptions.

- Aetna RX Home Delivery - Mail order will save members significantly for the long-term. Once members get started, they can request refills easily by mail, online, or over the phone.
- Maintenance Medications - All enrollees will be required to use the Aetna Home Delivery Pharmacy or CVS Pharmacies to fill Prescriptions for maintenance medications. Enrollees will be permitted to fill Prescriptions for maintenance medications up to two (2) times prior to being required to switch to Aetna RX Home Delivery mail-order Pharmacy or CVS Pharmacy retail locations.
- Save by using Generics. The Plan has a program in place to automatically fill the enrollee's Prescription with the low cost generic alternative to save dollars for the enrollee and the Plan.
- Dispense as written - If You request a brand-name medication when a generic equivalent is available, You will pay the applicable Copayment, plus the difference in cost between the brand and the generic.
- PrudentRx Copay Program for Specialty Medications-The Plan has contracted with PrudentRX to offer the PrudentRX Copay program, a specialty Pharmacy Copayment assistance program. Members will have a $0 copay for specialty medications on the Plan's Exclusive Specialty Drug List dispensed by CVS Specialty®, as long as they enroll in the PrudentRX program. Certain specialty Pharmacy Drugs are considered non-essential health benefits under the Plan and the cost of such Drugs will not be applied toward satisfying the participant's Maximum Out-of-Pocket; although the cost of the Program Drugs will not be applied towards satisfying a participant's Maximum Out-of-Pocket, the cost of the Program Drugs will be reimbursed by the manufacturer at no cost to the participant. The program currently targets specialty Drugs in therapy classes: hepatitis c, autoimmune, oncology, and multiple sclerosis. If you currently take one or more medications included in the Plan's Exclusive Specialty Drug List, You will receive a welcome letter and phone call from PrudentRx that provides information about the program as it pertains to Your medication. All eligible members will be automatically enrolled in The PrudentRx Copay Program, but You can choose to opt out of the program by calling 1-800-578-4403. To enroll, simply call PrudentRx at 1-800-578-4403 and to address any questions regarding the PrudentRx Copay Program. If You choose not to participate or do not affirmatively enroll, You will be responsible for the full amount of the 30% or 50% Coinsurance responsibility on eligible specialty medications. Keep in mind that the Coinsurance will not count towards Your Deductible or Maximum Out-of-Pocket as your out of pocket costs will be $0. This program does not apply to anyone enrolled in the Plan's HSA compatible plans, RX Plan 4 & RX Plan 5.