**SECTION 4 – MEDICAL NECESSITY, REFERRAL, AND PREAUTHORIZATION REQUIREMENTS**  
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* This section addresses the medical necessity, referral and preauthorization requirements. You will find the requirement to use a network provider and any exceptions to this in the Who Provides The Care section in your Policy.

**Prescription Drugs/Medications**  
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* What You Need To Know About Your Outpatient Prescription Drug Covered Benefits Read this section carefully so that you know:
  + How to access network pharmacies
  + Eligible health services under your Policy
  + Other services
  + How you get an emergency prescription filled
  + Where your Schedule of Benefits fits in
  + What preauthorization requirements apply
  + How can I request a medical exception request
  + Prescribing units

**Eligible Health Services Under Your Policy**  
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* We base your prescription drug plan on drugs listed in the drug guide. We exclude prescription drugs not in the drug guide unless we approve a medical exception request. Any prescription drug approved or covered under the plan for a medical condition or mental illness and has been removed from the drug guide before your plan renewal will be covered at the contracted benefit level until the plan’s renewal date. Our Pharmacy & Therapeutics (P&T) Committee meets no less than quarterly to review existing therapeutic classes as well as new drugs to the market. The P&T Committee’s clinical decisions are based on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines, and other sources of appropriate information. If it is medically necessary for you to use a prescription drug that is not on this drug guide, you or your provider must request a medical exception. See the Requesting A Medical Exception section for more information.

**Specialty Pharmacy**  
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* If You redeem a coupon or other offer for Brand Name Drugs that do not have a Generic equivalent or drugs obtained through Prior Authorization, Step Therapy or an exceptions and appeals process covered under this Policy, we will allow the dollar value of the coupon, or other offer to reduce any applicable deductibles, maximum out-of-pocket limit, copayment or coinsurance.

**The following are not covered under this benefit:**  
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* Drugs or medications:
  + Which do not, by applicable law, require a prescription order (i.e., over-the-counter (OTC) drugs), even if a prescription is written, except where stated above
  + That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a prescription drug exception is approved
* Injectables:
  + Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
  + Needles and syringes, except those used for insulin administration.
  + For 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.

**How To Request A Medical Exception**  
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* Sometimes you or your provider may ask for a medical exception for drugs that are not covered. You, someone who represents you, or your provider can contact us. You will need to provide us with the required clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision. For directions on how you can submit a request for a review:
  + Call us or contact us through our website. For details, see the Contact Us For Help section in your Policy. The UM department will verify your eligibility
  + Contact the UM department at 1-626-8100 Option 1
  + You, someone who represents you, or your provider may seek a quicker medical exception when the situation is urgent. It is an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug. A formulary exception request for a drug that is not listed in the drug guide is an adverse determination and you can have the adverse determination reviewed as an appeal of an adverse determination including an expedited appeal. See the attached Health Care Insurer Appeals Process.

**SECTION 6 – GENERAL EXCLUSIONS**  
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* We already told you about the many health care services and supplies that are eligible for coverage under your Policy in the Coverages section. In that section, we also told you that some health care services and supplies have exceptions and some are not covered at all (exclusions). For example, physician care is an eligible health service but physician care for cosmetic surgery is not covered. This is an exclusion.

**Network Providers**  
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* For you to receive the benefits, you must use network providers for eligible health services. There are some exceptions:
  + Emergency services – refer to the description of emergency services and urgent care in the Coverages section.
  + Urgent care – refer to the description of emergency services and urgent care in the Coverages section and to the Schedule of Benefits.
  + Network provider not reasonably available – You can get eligible health services under your Policy that are provided by an out-of-network provider if an appropriate network provider is not reasonably available. You must ask to use the out-of-network provider in advance and we must agree. See the How To Contact Us For Help section for assistance. We will make a decision as soon as your medical condition requires but no later than 5 working days after we receive all of the information we need from your provider. We may decide not to approve your request. Before we deny the request, a specialist of the same or similar specialty as the provider you are requesting to see will review your request. If access is approved, we will pay the out-of-network provider at our usual and customary charge or at an agreed rate. We will work with the provider so that all you pay is the appropriate network level copayment. See the How To Contact Us For Help section for assistance.
  + Transplants – see the description of transplant services in the Coverages section

**Your PCP**  
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* If you have a chronic, disabling or life-threatening illness, you can request to use a network specialist as your PCP. Your network specialist must let us know that the network specialist agrees to act as your PCP. You can contact Member Services at the toll-free number on your ID card for information as to how to apply for this exception. Designation of your network specialist as your PCP will not be retroactive. If your request is denied, you may appeal the decision. See the attached Health Care Insurer Appeals Process and the When You Disagree - Complaint Decisions And Appeal Procedures section.