ASPIRUS HEALTH PLAN

Department of Origin: Pharmacy	Date approved: 07/26/2023
Approved by: Chief Medical Officer	**Effective Date:** 07/26/2023
Pharmacy Clinical Policy Document: Coordination of Prescription Drug Benefits	**Replaces Effective Policy Dated:** 08/1/2022
Reference #: PP/C001	**Page:** 1 of 2

PURPOSE:
The intent of this Pharmacy clinical policy is to provide coverage guidelines for coordination of prescription drug benefits when PreferredOne is the *secondary plan*.

Please refer to the member's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member's benefit plan or certificate of coverage, the terms of the member's benefit plan document will govern.

POLICY:
PreferredOne coordinates prescription drug benefits as a *secondary plan* including the allowable cost of the medication and co-pay as defined in the Certificate of Coverage (COC) or Summary Plan Description (SPD).

Benefits must be available for health care services. Healthcare services must be ordered by a provider. Healthcare services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

COVERAGE:

I. Requests for coordination of prescription drug benefits can be initiated by calling the Customer Service department telephone number listed on the member's insurance card.

II. Copayment reimbursement will be considered for coordination of prescription drug benefits when:

   A. The member uses his/her *primary plan* insurance and PreferredOne is the *secondary plan.* A copy of the member's ID card and the original pharmacy receipt are required for processing requests.

   B. The member pays the total cost of the prescription(s) out-of-pocket and PreferredOne is *secondary.* A copy of the member's ID card, a copy of the *Explanation of Benefits (EOB*) from the *primary plan,* as well as the original pharmacy receipt are required for processing requests.

III. If incomplete information is received, written notification will be sent to the member requesting the necessary information and requests will not be processed until the necessary information is obtained.

IV. After the necessary information is received, processing of requests may take up to 3 weeks.

EXCLUSIONS:

I. The requested medication is not covered by the plan.

II. Refer to member's prescription drug benefits.

III. Services provided to a member that has other primary insurance coverage for those services, also, and the member does not provide PreferredOne the necessary information to pursue coordination of benefits.

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DEFINITIONS:

Coordination of Benefits (COB):

Coordination of benefits applies when a member has healthcare coverage under more than one plan. When a plan is *primary,* the primary plan benefits are determined before those of any other plan and without considering any other plan's benefits. When a plan is *secondary,* the secondary plan benefits are determined after those of another plan and may be reduced because of the primary plan's benefits. The *primary plan* that pays first pays without regard to the possibility that another plan may cover some expenses. A *secondary plan* pays after the primary plan and may reduce the benefits it pays so that payments from all groups' plans do not exceed 100% of the total allowable expense.

Explanation of Benefits (EOB):

Explanation of benefits made payable by the Plan, including any member out-of-pocket expenses.

Primary Plan/Secondary Plan:

The order of benefit determination rules (identified in the member's benefit plan) determines whether PreferredOne is a "primary plan" or a "secondary plan" when compared to the other plan covering the member.

REFERENCES

1. Medical Management Process Manual UR015 Use of Medical Policy and Criteria
2. Medical Policy: MP/C009 Coverage Determination Guidelines
3. Pharmacy Policy: PC/F002 Formulary Exceptions
4. Pharmacy Policy: PP/Q003 Quantity Limits
5. Pharmacy Policy: PP/T002 Therapeutic Equivalence
6. NCQA 2021 HP Standards and Guidelines UM 11: Procedures for Pharmaceutical Management

Effective March 20, 2015: This Pharmacy Policy (PP/C001) will resume being on an annual review schedule.
Effective June 30, 2011: This Pharmacy Policy is no longer annually reviewed.

DOCUMENT HISTORY:

Created Date: 04/02
Reviewed Date: 11/15/06, 10/01/07, 08/13/08, 07/16/09, 06/30/11, 03/20/15, 03/18/16, 06/07/16, 06/07/17, 03/07/18, 06/11/18, 06/11/19, 06/10/20, 6/11/2021, 6/10/2022, 6/10/2023
Revised Date: 04/18/04, 11/16/05, 07/15/10, 07/15/15, 09/25/18

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-800-332-6501 (TTY: 711).

Arabic تنبيه :إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً .اتصل بن اعلى رقم الهاتف1-800-332-6501(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: _यान द_: य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_।1-800-332-6501 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-332-6501 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer1-800-332-6501 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-800-332-6501 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-800-332-6501 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請 致電 1-800-332-6501 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-332-6501 (TTY: 711).

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