

# Prescription Drug Coverage

## SELECT 5 TIER

Covered prescription medications are available at participating pharmacies.

	Retail	Mail (up to a 90-day supply)
Tier 1	<b>Up to a 30-day supply:</b> \$10 Copayment per prescription or prescription refill <b>Up to a 90-day supply:</b> \$30 Copayment per prescription or prescription refill	\$20 Copayment per prescription or prescription refill
Tier 2	<b>Up to a 30-day supply:</b> \$25 Copayment per prescription or prescription refill <b>Up to a 90-day supply:</b> \$75 Copayment per prescription or prescription refill	\$50 Copayment per prescription or prescription refill
Tier 3	<b>Up to a 30-day supply:</b> \$45 Copayment per prescription or prescription refill <b>Up to a 90-day supply:</b> \$135 Copayment per prescription or prescription refill	\$90 Copayment per prescription or prescription refill
Tier 4	<b>Up to a 30-day supply:</b> \$70 Copayment per prescription or prescription refill <b>Up to a 90-day supply:</b> \$210 Copayment per prescription or prescription refill	\$140 Copayment per prescription or prescription refill
Tier 5	<b>Up to a 30-day supply:</b> \$140 Copayment per prescription or prescription refill <b>Up to a 90-day supply:</b> \$420 Copayment per prescription or prescription refill	\$280 Copayment per prescription or prescription refill

### Important Notes:

**Opioid Antagonists:** Prescribed, ordered or dispensed opioid antagonists used in the reversal of overdoses caused by opioids are covered by the Plan. These opioid antagonists do not require Prior Approval or a prescription from a health care provider.



Opioid antagonists are covered with no Member Cost Sharing.

**Drugs to Treat Chronic Conditions:** Your coverage also includes generic and brand name drugs used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; (iii) hypertension and iv) chronic ischemic heart disease. As required by law, at least one generic and one brand name drug identified by the Plan to treat these conditions will apply the following Member Cost Sharing:

Generic drugs are covered with no Member Cost Sharing.

Member Cost Sharing for brand name drugs will not exceed \$25 for up to a 30-day supply. (Note: Insulin is the drug used to treat diabetes.)

Your plan has an annual Out-of-Pocket Maximum, which is listed on the Schedule of Benefits. Once you have reached the Out-of-Pocket Maximum (including Deductible, Copayment and Coinsurance amounts), your prescriptions are covered in full for the rest of the year with no other cost sharing required.

Visit [www.harvardpilgrim.org/2026Select5T](http://www.harvardpilgrim.org/2026Select5T) for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.



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# Language Assistance Services

**Arabic (العربية)** انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

**French (Français)** ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

**Greek (Ελληνικά)** ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

**Gujarati (ગુજરાતી)** ध्यान आपो: જો તમે અંગ્રેજી સવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિય આઈડી કાર્ડ પરના નંબર પર કોલ કરો.

**Haitian Creole (Kreyòl Ayisyen)** ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

**Hindi (हिंदी)** ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी कार्ड पर ददए गए नंबर पर कॉल करें।

**Italian (Italiano)** ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

**Khmer (ភាសាខ្មែរ)** ប្រសិនបើអ្នក គនិយាយភាសាបសដេបប្រាំពីភាសាអង់បល: ស បសវាភម្មជំនួ យភាសា ដលៃឥតលិកតុល: លំអាចរកបានសប្បារម្ម ក។ សូ មូហ៍ហ៍កាន់បលឧហ៍បល ID ភាគសាជីករស្មុ ក។

**Korean (한국어)** 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

**Lao (ພາສາລາວ)** ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ ມ່ນພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການບໍລິການພາສາໄ ີ ໂຕຍໍບເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີຮູ້ ຢືນ ບໍລິເວນ ຕິວສະມາຊິກຂອງ ທ່ານ.

**Polish (polski)** UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

**Portuguese (Português)** ATENÇÃO: caso fale outro idioma que não o inglês, são lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

**Russian (Русский)** ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

**Spanish (Español)** ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

**Traditional Chinese (繁體中文)** 注意事項: 如果您講非英語的其他語言, 我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

**Vietnamese (Tiếng Việt)** LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

**ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

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# General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

## HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

### **Point32Health Civil Rights Legal Coordinator**

1 Wellness Way  
Canton, MA 02021-1166

866-750-2074, TTY service: 711

Fax: 617-668-2754

Email: [OCRCoordinator@point32health.org](mailto:OCRCoordinator@point32health.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at

[www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html)