SMITHRX MEMBER EDUCATION

Glossary: Common Healthcare Benefits Terms for Members

Please refer to this glossary to help you better understand your pharmacy benefits, especially as you're discussing your coverage with healthcare providers and insurers. If you're interested in a specific topic, scroll to the bottom to view the index or search ffor keywords by typing CTRL+F or CTRL+Command.

Accumulators
A running total of money you've paid towards your deductible or out-of-pocket maximum for covered services. This includes any copays, coinsurance, and other health care costs, but not your monthly premium payments.

Appeal
In the healthcare and Pharmacy Benefit Management (PBM) industries, an appeal is a formal request to review and reconsider a decision made regarding coverage or reimbursement for services and medications.

Buy-and-Bill
A process where physician offices purchase medications for in-office dispensing or administration. The 'buy' aspect refers to providers purchasing the medication from a wholesaler or drug manufacturer, while the 'bill' has to do with getting reimbursements from insurance companies or third-party payers.

Cash Price
Paying cash for your prescriptions means that you are paying for your medications without using any insurance. The cost associated with this price includes the cost for the pharmacy to acquire the medication at a wholesaler, pharmacy dispensing fees, and a mark-up for the pharmacy to be profitable.

Coinsurance
Your share of the costs of a health care service. It's usually a percentage of the total charge for the service. This is often required for things like doctor visits and prescription drugs. If you have a deductible plan, you would start paying coinsurance after the deductible is met.

- **Example:** if your health insurance plan has a coinsurance rate of 20%, and the cost of a covered medical procedure is $1,000, you would pay 20% of the cost ($200), and your insurance would cover the remaining 80% ($800). This sharing continues until you reach your out-of-pocket maximum.

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Coordination of Benefits (COB)
The process insurance companies use to determine how to cover your medical expenses when you're covered by more than one health insurance plan. It clarifies who pays what by determining which plan is the primary payer and which is the secondary payer. It also ensures proper claim processing and helps avoid overpayment or duplicate payments.

Co-payment (Co-pay)
A fixed amount you pay for a health care service, usually when you receive the service. This is often required for things like doctor visits and prescription drugs. If you have a deductible plan, you would start paying a copay after the deductible is met.

Deductible
A deductible is the amount of money that an insured person must pay out of their own pocket for medical services before their health insurance plan starts to pay. Think of it as the initial amount you pay each year before your insurance covers the costs of your treatments.

Key Points About Deductibles:

1. **Annual Basis:** The deductible amount is typically reset every year. For example, if your plan has a $1,000 deductible, you'll need to spend $1,000 on eligible healthcare services each year before your insurance begins to share in the costs.
2. **Only for Covered Services:** Deductibles apply to services covered under your health plan. Non-covered services must be paid entirely out of pocket and do not count towards the deductible.
3. **Plan Variations:** Different health insurance plans have different deductible amounts. Plans with higher deductibles usually have lower monthly premiums, and vice versa.
4. **Family vs. Individual Deductibles:** If you have a family health insurance plan, there may be both individual deductibles (which apply to each person) and a family deductible (which applies to the total expenses of all family members).
    a. Please refer to either the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD) documents for detailed information regarding your specific plan."

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5. **After Deductible:** Once you have paid your deductible, your insurance typically covers a significant portion of additional medical costs, though you may still be responsible for copayments or coinsurance until you reach your out-of-pocket maximum.

Understanding your deductible is crucial for budgeting your healthcare expenses and deciding on the right health insurance plan based on your typical healthcare needs.

Deductible Options
Embedded and Aggregate deductible plans differ in how the deductible level is reached.

- **Embedded** deductible feature means each person on the plane has to meet their individual Deductible for their benefits to start paying.

- **Non-embedded (Aggregate)** deductible feature means the entire family Deductible must be paid out of pocket before their benefits start paying.

Dispense as Written (DAW)
In the pharmacy industry, "Dispense as Written" (DAW) is a notation used by physicians on a prescription to provide instructions to a dispensing pharmacy for the prescription.

Codes: In the United States, there are specific DAW codes that can be used on prescriptions to indicate the reason for the brand-specific request. For example:

- **DAW 0**: No product selection indicated.
- **DAW 1**: Substitution not allowed by prescriber.
- **DAW 2**: Substitution allowed - patient requested product dispensed.

Implications for Cost: Dispensing as written can affect the cost of the medication. Brand-name drugs are typically more expensive than their generic counterparts, and insurance coverage may differ between brand-name and generic drugs, potentially leading to higher out-of-pocket expenses for the patient.

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Dispense as Written Penalty
Based on the benefit plan design, members may be required to pay a penalty charge if they request a brand medication when a lower cost generic is available. The DAW 2 Penalty is the additional cost difference between the brand and generic.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Eligibility Files
Member eligibility file means a data file containing demographic information for each individual member eligible for medical or rx benefits, for one or more days of coverage at any time during the reporting month. These files are transmitted to PBM from the TPA or Medical Carrier on a recurring basis, often daily, listing the names and other pertinent information necessary for PBM to enroll Plan Members, terminate enrollment/coverage, or to make changes to existing Plan Member records.

Explanation of Benefits (EOB)
A statement from your health insurance company detailing what costs it will cover for medical care or products you've received.

Formulary
A formulary is a list of prescription drugs that are approved for coverage under a specific health insurance policy or plan. The formulary is developed, managed, and periodically updated by a PBM or a health plan's pharmacy and therapeutics committee, which consists of pharmacists and healthcare providers.

In-Network Provider
A provider who has a contract with your health insurer to provide services at a discount.

Letter of Medical Necessity (LMN)
The written explanation from the treating physician describing the medical need for services, equipment, or supplies to assist the claimant in the treatment, care, or relief of their accepted work-related illness(es).

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Mail Order Pharmacy
A “mail-order” dispensing method means that you don't have to pick up your medication from a pharmacy; instead, it is delivered to your doorstep. Mail order pharmacies are often used for long-term maintenance medications and, for certain drugs, may be able to provide longer day supply.

- **Cost Savings:** Often, mail-order pharmacies offer lower copays and longer prescription supplies (e.g., 90-day refills for the price of 30 days at retail). ...
- **Convenience:** Refill and manage prescriptions online or by phone, eliminating the need for in-person visits.

Medicaid
A joint federal/state government program that provides health insurance for adults and children with limited income and resources.

Medical Claim
A request for payment that you or your health care provider submits to your health insurer when you get items or services you believe are covered.

Medicare
A federal health insurance program in the United States for people aged 65 or older and younger people with disabilities, including those with end stage renal disease and amyotrophic lateral sclerosis.

Non Formulary
A list of prescription drugs that are not covered by the plan and member/patient must switch to alternate therapy.

Out-of-Network Provider
A provider who does not have a contract with your health plan. Services from out-of-network providers may cost you more.

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Out-of-Pocket Maximum (OOP Max)
The OOP Max in health insurance applies to both medical and pharmacy benefits, and it serves as a critical financial safeguard for policyholders. This cap ensures that once you spend a certain amount of money on eligible healthcare services within a plan year, including prescription medications, your health plan will pay 100% of the costs of covered benefits for the rest of that year.
The OOP Max typically includes all deductibles, copayments, and coinsurance you pay for covered healthcare services and prescription drugs. It's designed to prevent excessive out-of-pocket spending on both medical services (like doctor's visits, hospital stays, surgeries) and pharmacy benefits (prescription medications).

Example: If your health plan's OOP Max is $6,000 and includes both medical and pharmacy benefits, and you incur $4,000 in medical expenses and $2,000 in pharmacy costs in a year, you would reach your OOP Max. After reaching this threshold, your insurance would cover 100% of your additional covered medical and pharmacy costs for the remainder of the plan year.

Over-the-Counter (OTC)
Medicines sold directly to a consumer without a requirement for a prescription from a healthcare professional, as opposed to prescription drugs, which may be supplied only to consumers possessing a valid prescription. Such as prenatal vitamins or antihistamines (allergy spray).

Pharmacy Claim
A request for payment that the pharmacy submits to your pharmacy benefits manager (PBM), to process your claim. The pharmacy will see instantly if the claim is processed successfully or denied along with any cost responsibility for the patient.

Premium
The amount of money individuals pay, usually monthly, to have health insurance. This payment ensures that the insurance plan remains active, and it covers the insured individual for a specific period.

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Prior Authorization (PA)
The process from your health plan in order to be approved to obtain certain prescription drugs. The prior authorization process is used to monitor certain medications to ensure they are safe, medically necessary, and clinically appropriate. Approval from a health plan may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Provider
A physician, hospital, health care professional, or health care facility licensed, certified, or accredited as required by state law, that delivers medical services or care to patients.

Quantity Limit
The maximum number of pills or total dosage of a medication that a patient can receive in a defined period (e.g., monthly)that will be covered, determined by the plan design. These limits are put in place to promote safe and cost-effective use of medications and services, prevent medication abuse, and manage healthcare costs.

Refill too Soon
Refers to a situation in the pharmacy where a patient attempts to refill a prescription medication before a certain minimum usage has occurred since the last refill, usually 75-80%. This interval is often regulated by clinical practice and also subject to the plan design. This helps prevent drug over-supply and over-use.

Retail Pharmacy
The term “retail community pharmacy” means an independent pharmacy, or chain pharmacy, that is licensed as a pharmacy by the State and dispenses medications to the general public at retail prices. These pharmacies are typically located all over the community for ease of access.

Specialty Drugs
Higher-cost medications that treat rare, complex, and chronic health conditions and may require special treatment. These drugs are usually prescribed by a physician specialist (‘ology’), such as Oncology or Gastroenterology. The drugs themselves may require special handling in the storage and or shipping process, and patients who

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use them may need to work closely with doctors, pharmacists, and other health care providers who can monitor their progress. Most specialty drugs will require a prior authorization.

Step Therapy
If a health plan uses step therapy for certain drugs, it means that a patient is required to try a clinically effective, lower cost prescription drug that treats a given condition before “stepping up” to a similar-acting, but more expensive drug. The health plan won’t cover the more expensive drug unless it can be established that the clinically effective, lower-cost medication cannot treat the patient’s condition. Other names for step therapy are “step protocol” and “fail first requirements.”

Third Party Administrator (TPA)
A third-party administrator is a company that provides operational services such as claims processing and employee benefits management under contract to another company. Insurance companies and self-insured companies often outsource their claims processing to a TPA.

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Common Terms: SmithRx Connect 360 Programs

Connect 360 Programs
Our suite of Connect 360 programs designed to help identify the lowest net cost for drugs and assist members in navigating various cost saving programs.
**Reference materials available*

Connect Advocates/Specialists
Manage the patient flow, by coordinating with members, drug manufacturers, providers, and pharmacies to help navigate the process.

Connect Enrollment Process
Once the SmithRx Connect specialist engages with the member, they will explain the program details, assist with enrollment, and coordinate with their provider and pharmacy if needed.

Connect Identification Process
SmithRx identifies members taking eligible medications by reviewing paid claims and are part of our Connect 360 Programs and will initiate member outreach.

Connect Member Outreach
Once members with eligible drugs are identified, our Specialists will reach out via text message, email, and phone call to assist members enrolling into the Connect 360 programs.

Copay Coupon Cards
Manufacturer-sponsored programs that help commercially insured patients afford expensive prescription drugs by covering part or all of their out of pocket costs for certain medications.

SmithRx Pharmacy Network
Members will have access to our pharmacy network, which includes a broad retail network, specialty mail order, limited drug distribution, and other options, depending on the benefit design, type of medication, and Connect program enrollment. This could include:

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- **Mail Order Pharmacies**
  Amazon Pharmacy, Walmart Home Delivery, and Mark Cuban Cost Plus Drug Company (MCCPD)
- **Specialty Pharmacies**
  Costco Specialty and Senderra Specialty
- **Retail Pharmacies**
  Over 65,000 retail pharmacies across the nation including the major national chains, regional chains, and independent pharmacies. Including CVS, Rite Aid, Walgreens, Walmart, and Costco, just to name a few.

Helpful Link: Pharmacy Benefits FAQ for Members
Helpful Link: All Pharmacies Overview for Members

Members can log in to www.smithrx.com/portal for resources.

Patient (Member) Support
Chat: On our website
www.smithrx.com also available in the Member Portal
member.mysmithrx.com
Support: 844-454-5201
Email: help@smithrx.com

Connect Patient Support
Chat: On our website
www.smithrx.com also available in the Member Portal
member.mysmithrx.com
Connect: 844-385-7612
Email: connect@smithrx.com

The SmithRx Member Services team is available from 6am to 7pm Monday - Friday and Saturday 9am to 2pm Mountain Time.

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