CONSUMER DIRECTED HealthSelect℠

Master Benefit Plan Document

Employees Retirement System of Texas Consumer Directed HealthSelect℠ Prescription Drug Program

Effective: September 1, 2025

EXPRESS SCRIPTS®

REVISED 9/1/25

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Participant services, claim inquiries, Prior Authorization, appeals: **(800) 935-7189** (TTY 711) toll-free
- Claims submittal address:
  Express Scripts
  P.O. Box 66577
  St. Louis, MO 63166-6577
- Online assistance: **www.HealthSelectRx.com**

The Consumer Directed HealthSelect℠ Prescription Drug Program (Program) is a self-funded benefit plan offered through the Texas Employees Group Benefits Program (GBP) by the Employees Retirement System of Texas (ERS).

Consumer Directed HealthSelect (CDHS) contains both a High-Deductible Health Plan (HDHP) that has a combined medical and pharmacy Annual Deductible and a Health Savings Account (HSA).

The purpose of this Master Benefit Plan Document (MBPD) is to outline the Covered Drugs, Supplies and Benefits provided to you under the CDHS Program.

The Prescription Drug Program (PDP) is separately administered by Express Scripts. This MBPD describes the Prescription Drug Benefits available to you and your eligible covered Dependents. It includes information regarding:

- who is eligible;
- medications and products that are covered under this Program, called Covered Drugs or Supplies;
- medications and products that are not covered, called Exclusions. Exclusions are described in Section 7, *Exclusions: What the Prescription Drug Program Will Not Cover*;
- how Benefits are paid; and
- your rights and responsibilities under the Program.

This MBPD is designed to meet your information needs. It supersedes any previous printed or electronic MBPD for this Program.

IMPORTANT

A medication or product is only a Covered Drug or Supply if it meets Clinical Criteria. (See definitions of Clinical Criteria and Covered Drugs or Supply in Section 13, *Glossary*.) The fact that a Prescriber has prescribed a medication or product, or the fact that it may be the only available treatment for a Sickness, Injury, condition, disease or its symptoms does not make the product a Covered Drug or Supply under the Program.

ERS intends to continue this Program, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Program at any time, for any reason, and without prior notice, or as directed by the state of Texas. This MBPD is not to be construed as a contract for any purposes or employment benefits.

The GBP, as administered by ERS, is ultimately responsible for paying Benefits described in this MBPD.

Please read this MBPD thoroughly to learn how the CDHS Program works. If you have questions, contact your Benefits Coordinator or HHS Employee Service Center, or call Express Scripts at **(800) 935-7189** (TTY 711) toll-free.

IMPORTANT

All definitions, terms, and provisions recited in the ERS Consumer Directed HealthSelect High-Deductible Health Plan MBPD - are applicable to the Consumer Directed HealthSelect Prescription Drug Program, except those contained in Sections 3 through 7, and 11, which pertain to only to the respective Health Plan. Each applicable definition, term and provision is hereby adopted and shall be construed to apply in like manner and with equal force to this Program; provided that if any such provisions conflict with provisions herein contained the provisions of this Program shall govern any interpretations of rights or obligations accruing under the Plan.

How to Use This MBPD

- Read the entire MBPD and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this MBPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your MBPD and any future Amendments at **www.HealthSelectRx.com** or request printed copies by calling Express Scripts at **(800) 935-7189** (TTY 711) toll-free.
- Capitalized words in the MBPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words “you” and “your” refer to Participants as defined in Section 13, *Glossary*.
- ERS is also referred to as the Plan Administrator.
- If there is a conflict between this MBPD, MBPD Amendments and any benefit summaries provided to you, this MBPD and its Amendments will control.

Express Scripts Civil Rights Coordinator

Express Scripts
Attn: Office of Civil Rights Coordinator
P.O Box 4083
Dublin, Ohio 43016
Phone: (877) 819-6184 (TTY 711)
Email: affordablecareactgrievance@evernorth.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you. You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by mail, email, or phone:

Online:

https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Mail:
Centralized Case Management Operations
U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Email:
OCRComplaint@hhs.gov

Phone:

800-368-1019
800-537-7697 (TTY/TDD)

For more details on how to file a complaint, please visit https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Getting Help in Other Languages or Formats

English Text:

You have the right to get help and information in your language at no cost. To request an interpreter, call Express Scripts at **(800) 935-7189** (TTY 711) toll-free, press 0.

This notice is also available in other formats such as large print. To request the document in another format, please call Express Scripts at **(800) 935-7189** (TTY 711) toll-free, 24 hours, 7 days per week.

Express Scripts Nondiscrimination Notice

Express Scripts, Inc. is a wholly-owned subsidiary of Evernorth. Express Scripts/Evernorth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Express Scripts does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Express Scripts:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

1. Qualified interpreters
2. Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Express Scripts 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 by sending an email to AffordableCareActGrievance@Evernorth.com or by writing to the following address:

Express Scripts / Evernorth
Nondiscrimination Complaint
Coordinator PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please send an email to AffordableCareActGrievance@Evernorth.com or call (800) 935-7189 (TTY 711) which is also the number on the back of your Prescription ID card.

Multi-language Interpreter Services

English: You have the right to get help and information in your language at no cost. To request an interpreter, please call toll-free **(800) 935-7189** (TTY 711), 24 hours a day, 7 days a week.

Spanish: Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711.

Vietnamese: Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711.

Chinese: 您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711。

Korean: 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711.

Arabic:

لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرف العضوية الخاصة بخطتك الصحية، واضغط على 0. 711 TTY.

Urdu:

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ 711 TTY۔

Tagalog: May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711.

French: Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0.ATS 711.

Hindi: आपको अपनी भाषा में िबना िकसी शु या िबना िकसी खचर् के सहायता और जानकारी पर् ा करने का ि अधकार है। दुभाि षया मांगने या उसकी माँग करने क िलए, अपने □ ेमानेवाक पहचान पतर्(आईडी) कीपीछे िदए गए सद□ोके टोल-री नंबर पर कॉल करें और 0 दबाएँ। TTY 711।.

Persian (Farsi):

شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. 711 TTY.

German: Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711.

Gujarati: તમને તમારી ભાષામાં િવનામૂલ્યે અથવા કોઈ ખચર્ વગર મદદ અને માિહતી મેળવવાનો અિધકાર છે. દુભાિષયા માટે િવનંતી કરવા અથવા પૂછવા માટે, તમારા આરોગ્ય યોજનાના ઓળખ (ID) કાડર્ની પાછળ આપેલા સભ્યો માટેના ટોલ-ફ્રી નંબર પર કૉલ કરો અને 0 દબાવો. TTY 711.

Russian: Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711.

Japanese: ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。

Laotian: ທ່ານມີສິດ ທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711.

Navajo: T’áá shikaadéé nihá nílínígíí saad bee áká’ání dóó bína’nitin t’áá hóló̜ holne’ t’áá łá’í íiyisí. Diné Bizaad bee áká’ánígíí ná’iiníł’□□ł nihá, ahééhígíí t’áá íiyisí bee hodiilnihígíí ID bee ak’e’elchíhí (béésh bee hane’) bikáa’gi hóló̜. Bąąh calldooleeł dóó 0 yídaal’□. TTY 711.

SECTION 2 – INTRODUCTION

IMPORTANT

Your enrollment in the CDHS Prescription Drug Program is determined based upon your enrollment in the Consumer Directed HealthSelect Health Plan, administered by Blue Cross and Blue Shield of Texas (BCBSTX. If you are enrolled in the Consumer Directed HealthSelect℠ High-Deductible HealthPlan, you are automatically enrolled in the Consumer Directed HealthSelect Prescription Drug Program through Express Scripts.

For more information regarding:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for selecting coverage for yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan,

See Section 2*, Introduction in the Consumer Directed HealthSelect High-Deductible Health Plan Master Benefit Plan Documents*. To review the Plan documents referenced above, go to **www.healthselectoftexas.com**.

SECTION 3 - HOW THE PROGRAM WORKS

What this section includes:

- Accessing Benefits;
- Network Pharmacies;
- Managing Your Prescription Drug Benefits Online;
- Benefit Levels;
- Maintenance Medications;
- Retail and Mail Order Coverage;
- Annual Prescription Drug Deductible;
- Coinsurance;
- Total Network Out-of-Pocket Maximum;
- Dispense As Written (DAW) Penalty; and
- Assigning Prescription Drugs to the Preferred Drug List (PDL)
- Coverage While Traveling Outside the United States

Accessing Benefits

You can choose to receive Covered Drugs or Supplies at a Network Pharmacy or Non-Network Pharmacy. Generally, when you receive Covered Drugs or Supplies from a Network Pharmacy, you pay less than you would if you receive the same prescriptions from a Non-Network Pharmacy. Therefore, your out-of-pocket expenses may be less if you use a Network Pharmacy.

You must either show your pharmacy ID card to a Network Pharmacy at the time you obtain your Prescription or you must provide the Network Pharmacy identifying information to verify your enrollment in the Program.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the Pharmacy.

You may seek reimbursement as described in Section 8, *Claims Procedures,* under the heading **How to File a Claim**. When you submit a claim in this manner, you may pay more if you failed to verify your eligibility at the time the Prescription Drug was dispensed.

If you receive prescriptions from a Non-Network Pharmacy, the Program pays Benefits at a lower level. You may want to ask the Non-Network Pharmacy about drug costs before you receive your prescription.

Network Benefits apply to Covered Drugs or Supplies that are dispensed by a Network Pharmacy.

Non-Network Benefits apply to Covered Drugs or Supplies that are provided by a Non-Network Retail or Mail Order Pharmacy.

Network Pharmacies

Express Scripts arranges for Pharmacies to participate in the Network. At your request, Express Scripts will send you a directory of Network Pharmacies free of charge. Keep in mind, a Pharmacy's network status may change so the most up-to-date source of Network Pharmacies is the Program's dedicated website. To verify a Pharmacy's status or request a directory or for assistance locating a pharmacy, you can call Express Scripts at (800) 935-7189 (TTY 711) toll-free or go to **www.HealthSelectRx.com**.

Looking for a Participating Pharmacy?

CDHS Prescription Drug Program's dedicated website, **www.HealthSelectRx.com**, has a directory of Network Pharmacies in addition to other helpful information. While Network status may change from time to time, **www.HealthSelectRx.com** has the most current source of Network information. Use **www.HealthSelectRx.com** to search for Pharmacies that participate in the Network.

Managing Your Prescription Drug Benefits Online

Manage your Prescription Drug Benefits quickly and easily by registering for a free account with Express Scripts at **www.HealthSelectRx.com**. After registering, you can:

- view the benefits of your Program, including out-of-pocket costs;
- browse the Preferred Drug List (PDL):
- look up covered medications and estimated pricing;
- view your prescription history;
- initiate a Prior Authorization;
- refill prescriptions using Express Script's Mail Order Pharmacy;
- check mail order status at any time; and
- sign up for text message reminders;

Benefit Levels

Program Benefits are available for those Prescription Drugs that are considered Covered Drugs or Supplies.

All Prescription Drugs covered by the Program are categorized into Tiers as shown on the Preferred Drug List (PDL). A Prescription Drug's Tier status can change periodically, based on the National Pharmacy & Therapeutics Committee's periodic decisions in connection with Tiering. Tier 1 includes all Generic Drugs, while Tier 2 and Tier 3 are Brand-name Drugs.

Negative changes (e.g., when a drug moves to an excluded status, or Prior Authorization, Step Therapy, or a Quantity Limit is added to a Covered Drug or Supply) may occur twice a year (January 1 and July 1) and may result in additional costs to the Participant.

Participants who have recently taken a drug that is impacted by a negative change will be notified by letter no fewer than 30 days prior to the change.
Positive changes (e.g., a drug moves to covered status) may occur more often. As a result of such a change, you may pay less for that Prescription Drug.

For the most up-to-date drug coverage and Tier information, visit **www.HealthSelectRx.com** or call Express Scripts at **(800) 935- 7189** (TTY 711).

Both Brand-name and Generic Drugs are assigned Coinsurance, which is the amount you pay after you have met your Deductible whether you visit a retail Pharmacy or order your medications through Mail Order Pharmacy.

Your Coinsurance amount will also depend on whether you use a Network or Non-Network Pharmacy.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a Non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

See Section 5, *Schedule of Benefits and Coverage*, for further details. Here's how the Tier system works:

- Tier 1 drugs are typically Generic Drugs and therefore may have the lowest out-of-pocket expense. You should consider Generic Drugs if you and your Prescriber

decide they are appropriate for your treatment.

- Tier 2 and Tier 3 represent Brand-name Drugs. Consider a Brand-name Drug if a Generic Drug is not available to treat your condition.

Your cost will also depend on:

- If you have met the deductible.
- If you receive Benefits at a Network or Non-Network Pharmacy.
- If your Medication is considered Maintenance and you fill the medication for less than a 60-day supply.
- If your Medication is a Brand-name Drug when a Generic is available. This is also known as Dispense as Written penalty.

The following sections will give more information on how these situations affect your cost.

Maintenance Medications

Maintenance medications are medications used to treat chronic conditions such as high blood pressure, diabetes and arthritis. These medications might be needed for months, years, or even a lifetime. They are often prescribed with refills and available in 60-90-day supplies.

Retail Coverage - for Up to a 30-Day Supply at Network Pharmacies

Express Scripts has a large Network of participating retail pharmacies, which includes many large drug store chains and several local, independent pharmacies. You can obtain information about Network Pharmacies by contacting Express Scripts toll-free at **(800) 935-7189** (TTY 711) or by visiting **www.HealthSelectRx.com** and selecting *Find a Network Pharmacy*.

To obtain your Prescription Drug from a retail Pharmacy, simply present your pharmacy ID card and pay the Coinsurance. The Program pays benefits for certain covered Prescription Drugs described below:

- As written by a Prescriber.
- Fill up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer’s packaging size or based on Quantity Limits.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the applicable Coinsurance will reflect the number of days dispensed.
- Certain Preventive Care medications (including certain contraceptives) may be covered without Participant cost share depending on Generic availability. In some cases, you will be responsible for payment (for example, if you choose a Brand-name Drug when an equivalent Generic Drug is available you will be responsible for the difference in cost plus the applicable coinsurance.)

Retail Coverage – Extended Days' Supply (EDS) Retail Pharmacies

Covered Maintenance Drugs are available for a 60–90-day supply when you fill your Prescription at a Network EDS Retail Pharmacy. In order to obtain a 60–90-day supply of your medication, your Prescriber must write your Prescription for the appropriate amount. Refer to Table 2 under Network Extended Days' Supply (EDS) Retail Pharmacy in Section 5, *Schedule of Benefits and Coverage*, for supply limits and applicable Coinsurance.

The Program pays benefits for certain covered Prescription Drugs provided at Network EDS Retail Pharmacies, as described below:

- As written by a Prescriber.
- Fill a 60–90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on Quantity Limits.
- Certain Preventive Care medications (including certain contraceptives) may be covered without Participant cost share depending on Generic availability. In some cases, you will be responsible for payment (for example, if you choose a Brand-name Drug when an equivalent Generic Drug is available you will be responsible for the difference in cost plus the applicable coinsurance.)

Visit **www.HealthSelectRx.com** or contact Express Scripts toll-free at **(800) 935-7189** (TTY 711) to find a Network EDS Retail Pharmacy.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Drug or Supply. Pharmacy Benefits do not apply when the medication is considered Experimental or Investigational or for an Unproven Services. You are responsible for paying 100% of the cost if Pharmacy Benefits do not apply.

Mail Order Pharmacy

The Mail Order Pharmacy allows you to purchase a 60–90-day supply of a covered Maintenance Medication through the mail. Maintenance Medications help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

The Program pays mail order Benefits for certain covered Prescription Drugs:

- As written by a Prescriber.
- Fill a 60–90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on Quantity Limits. Certain Preventive Care medications (including certain contraceptives) may be covered without Participant cost share depending on Generic availability. In some cases, you will be responsible for payment (for example, if you choose a Brand-name Drug when an equivalent Generic Drug is available you will be responsible for the difference in cost plus the applicable coinsurance.)

If you need your medication right away, you may need to fill an initial Prescription Drug order through a Network Retail Pharmacy to allow adequate time for delivery of your Mail Order Prescription. Your Prescriber should write one prescription for a 30-day supply to be filled at a local Network Retail Pharmacy, and a second prescription for a 60–90-day supply with three refills to be submitted to a Network Mail Order Pharmacy. This will allow you to obtain a local supply immediately while the Network Mail Order Pharmacy is shipping your 60–90-day supply.

To use the Mail Order Pharmacy, you will need to complete a patient profile. This can be completed using one of the options below:

- Complete the mail service order form online at **www.HealthSelectRx.com**

- Call Express Scripts for assistance completing the mail service order form at **(800) 935-7189** (TTY 711) toll free; or
- Print the mail service order form from **www.HealthSelectRx.com** and fill out the form by hand

Once you have completed the patient profile:

- ask your Prescriber to:

  fax: (888) 327-9791

  call: (800) 211-1456 or

  e-scribe the medication to: ePrescribing@express-scripts.com

- you may mail a paper copy of your Prescription Order to:

  Express Scripts Pharmacy

  P.O. Box 66577
  St. Louis, MO 63166-6577

Your medication, plus instructions for obtaining refills, will arrive about 14 days after your order is received. If you need a mail service order form, or if you have any questions, contact Express Scripts toll- free at **(800) 935-7189** (TTY 711).

If you choose to use a Non-Network Mail Order Pharmacy, you will be required to pay in full and seek reimbursement as described in Section 8, *Claims Procedures,* under the heading **How to File a Claim**. When you submit a claim in this manner, you may pay more than if you used the Network Mail Order Pharmacy.

Note: To maximize your Benefits, ask your Prescriber to write your Prescription Order or Refill for a 60–90-day supply, with refills if appropriate. Be sure your Prescriber writes your Prescription Order or Refill for a 60–90-day supply, not a 30-day supply with three refills.

Don’t Forget Your ID Card

Remember to show your pharmacy ID card every time you fill a prescription for Covered Drugs or Supplies from a Pharmacy. If you do not show your ID card, a Pharmacy has no way of knowing that you are enrolled in the Program.

Network Annual Deductible

The Network Annual Deductible is the amount you must pay each Calendar Year in both Covered Health Expenses and Covered Drugs or Supplies before the CDHS Health Plan and Prescription Drug Program begins to pay. Both medical and pharmacy Eligible Expenses count toward your Annual Deductible, as shown below. The deductible does not apply to certain preventative medications, formulary insulin, or certain diabetic supplies.

Coverage Type	Network Annual Deductible	Non-Network Annual Deductible
Individual Coverage	$2,100	$4,200
Family Coverage	$4,200	$8,400

Coinsurance

Coinsurance is a fixed percentage that you are responsible for paying for Covered Drugs or Supplies received from a Pharmacy. The amount you pay for Coinsurance depends on whether you receive Covered Drugs or Supplies from a Network Pharmacy or a Non-Network Pharmacy. Your Coinsurance amount is determined after you meet your applicable Annual Deductible.

After you pay your Network Annual Deductible, if you receive Covered Drugs or Supplies from a Network Pharmacy, you will be responsible for 20% Coinsurance. If you receive Covered Drugs or Supplies from a Non-Network Pharmacy, you will be responsible for 40% Coinsurance after paying your Non-Network Annual Deductible.

Coinsurance payments apply to your Total Network Out-of-Pocket Maximum as defined in this section.

Total Network Out-of-Pocket Maximum

The Total Network Out-of-Pocket Maximum is your overall combined limit for the amount you will pay each Calendar Year for Network Covered Health Services and Covered Drugs or Supplies. The Total Network Out-of-Pocket Maximum includes Coinsurance and your Annual Deductible, as described below. Once you reach the applicable Total Network Out-of- Pocket Maximum, you will not be required to pay additional out-of-pocket expenses for Network Benefits for the remainder of the Calendar Year. The Plan will pay 100% for those Eligible Expenses for Covered Health Services and Covered Drugs or Supplies for that level of Benefits through the remainder of the Calendar Year, except as noted below.

Note: Non-Network Benefits do not have a Total Out-of-Pocket maximum. See Table 1 below and Table 2 in Section 5, *Schedule of Benefits and Coverage*, for details on those items that apply to the Total Network Out-of-Pocket Maximum.

Table 1 below identifies Program Features and how they apply toward your Total Network Out-of-Pocket Maximum.

TABLE 1

Program Features	Applies to the Calendar Year Total Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible for Covered Drugs or Supplies received from a Network Pharmacy	Yes
Payments toward the Annual Deductible for Covered Drugs or Supplies received from a Non-Network Pharmacy	No
Coinsurance payments for Covered Drugs or Supplies received from a Network Pharmacy	Yes
Coinsurance payments for Covered Drugs or Supplies received from a Non-Network Pharmacy	No
The payment you make for a Brand-name Drug when a Generic, Chemically Equivalent drug, is available (also referred to as the Dispense As Written Penalty)	No
Medications, services or supplies that are for non-Covered Health Services, non-Covered Drugs or Supplies or conditions excluded under the Plan or Program	No
For Covered Drugs or Supplies that require Prior Authorization, the amount you pay if you do not obtain Prior Authorization	No

Program Features	Applies to the Calendar Year Total Network Out-of-Pocket Maximum?
For Covered Drugs or Supplies that are subject to Step Therapy requirements, the amount you pay for a more costly drug if Step Therapy requirements have not been met	No
For Covered Drugs or Supplies that are subject to Quantity Limits, the amount you pay for any quantity of that drug above the quantity covered by the Program	No

Dispense As Written (DAW) Penalty

The Dispense As Written (DAW) Penalty is the amount you pay for a Brand-name Drug when a Generic Drug is available. If you or your Prescriber choose not to substitute a Generic drug for the higher cost Brand-name drug, you will pay the Generic Drug Coinsurance plus the difference in cost to the Program between the cost of the Generic Drug and the Brand-name Drug. If at any time the DAW Penalty is waived due to clinical necessity as determined via the appeal process, the Brand-name Covered Drug or Supply would then be covered at the lesser of the applicable Coinsurance or the cost of the drug to the Program.

Assigning Prescription Drugs to the Preferred Drug List (PDL)/Formulary

The Express Scripts National Pharmacy and Therapeutics Committee manages the list of Covered Drugs and coordinates with ERS for Program approval. This Committee makes the final classification of an FDA- approved Prescription Drug or other pharmaceutical product, service or supply by considering a number of factors including, but not limited to, evaluation of therapy appropriateness, relative safety and relative efficacy of the Prescription Drug, as well as whether certain Quantity Limits or Prior Authorization requirements should apply.

All Prescription Drugs covered by the Program are categorized into three Tiers as shown on the Preferred Drug List (PDL). A Prescription Drug's Tier status can change periodically based on the Committee's frequent and ongoing evaluation of the PDL. Negative changes (e.g., a drug moves from Tier 2 to Tier 3 because the brand-name drug is no longer preferred) may occur twice a year (with effective dates of January 1 and July 1) and may result in additional costs to the Participant. Participants who have recently taken a drug that is moving to a higher tier or being excluded under the Program will be notified by letter no fewer than 30 days prior to the change. Positive changes (e.g., a generic alternative becomes available, and your provider allows this substitution from a Tier 2 Preferred Brand drug to the Tier 1 Generic) may occur more often. As a result of a positive change, you may pay less for that Prescription Drug. For the most up-to-date drug coverage and Tier information, you should visit **www.HealthSelectRx.com** or call Express Scripts at toll free **(800) 935-7189** (TTY 711).

Preferred Drug List (PDL)/Formulary

The PDL is a tool that helps guide you and your Prescriber in choosing the most cost-effective and clinically-effective medications to treat your condition that are covered under your Prescription Drug Benefit. The PDL is available at **www.HealthSelectRx.com**.

Coverage While Traveling Outside of the United States

The Program pays limited Benefits for a Participant who fills a Prescription Order or Refill outside of the United States. In order for a claim to be considered a Covered Drug or Supply, a valid Prescription Order or Refill must be written by a Prescriber within the United States. No Benefits are paid for Prescription Orders or Refills written by a Prescriber outside of the United States.

Eligible Expenses for medications dispensed outside of the United States are reimbursed at the Non- Network Benefit level. Any medication received must be a Covered Drug or Supply for Benefits to apply. Prescription Drugs obtained outside the United States must have an FDA-approved equivalent drug in the United States in order for the claim to be reimbursed. You must pay the Pharmacy at the time the Covered Drug or Supply is received and obtain appropriate documentation of Prescription Drugs received and the cost of these drugs, including itemized bills and receipts.

This information should be included when you submit your claim to Express Scripts as described in Section 8, Claims Procedures. If you have any questions about Benefits or coverage outside the United States, including while traveling abroad or before you travel, please call Express Scripts Rx toll-free at **(800) 935-7189** (TTY 711). To obtain a claim reimbursement form, visit **www.HealthSelectRx.com**

How the Program Works - Examples

The following example illustrates how the Annual Deductible, Coinsurance, and the Total Network Out-of- Pocket Maximum work. These are examples only and the medications and costs are subject to change without notice.

For example, Gary has individual coverage under the Program. He has met his Network Annual Deductible ($2,100) and needs to fill a Prescription from a Pharmacy. He has not yet met his Non-Network Annual Deductible ($4,200). The flow chart below shows what happens when he visits a Network Pharmacy instead of a Non-Network Pharmacy.

Network Benefits
1. Gary goes to his Network Pharmacy and presents his pharmacy ID card.
2. He gives the Pharmacy a Prescription Order for a 30-days' supply medication under the Program, covered at the Tier 1 level.

Non-Network Benefits
1. Gary goes to a Non-Network Pharmacy, presents his pharmacy ID card.
2. He gives the Non-Network Pharmacy a Prescription Order for a 30-days' supply medication under the Program, covered at the Tier 1 level.

3. The Prescription Drug Charge (medication's cost at the Network Pharmacy) is $245 and Gary pays 20% Coinsurance, which is $49. Covered Drugs or Supplies received at a Network Pharmacy are covered at 80% after the individual Network Annual Deductible ($2,100) has been met.	3. The Pharmacy's charge for the drug is $300. Since the Pharmacy does not participate in the Network, Gary pays the full cost ($300) of the Covered Drug or Supply at the time the prescription is filled. Because he is filling the prescription at a Non-Network pharmacy, Gary must submit a claim to receive any reimbursement. ***Note:*** In some instances, Non-Network Pharmacies will charge more than the Predominant Reimbursement Rate, which is what the Program uses to calculate reimbursement amounts. In these instances, Participants may be responsible for a portion or all the medication's cost.
4. Gary's financial responsibility is $49 and the Program pays $196 ($245 drug cost minus the $49 Coinsurance).	4. Since the Non-Network Deductible was not met, the full $300 would be applied to the deductible and no reimbursement would be made. ***Note:*** If the Non-Network Deductible was met then the predominant Reimbursement Rate for this example is $245. Gary pays 40% coinsurance based off of the Predominant Reimbursement Rate ($245 X 40% Coinsurance = $98.00) and the Program pays the remaining 60% ($245 x 60% = $147.00). Gary also pays the difference between the Non-Network Pharmacy's charge ($300) and the Predominant Reimbursement Rate ($245), which is $55. Gary's total financial responsibility was $153.00 for his medication ($98 Coinsurance + $55 paid to the Non-Network Pharmacy above the Predominant Reimbursement Rate).
5. Express Scripts applies the $49 toward Gary's Total Network Out-of-Pocket Maximum ($7,050).	5. Since this claim is for a Covered Drug or Supply at a Non-Network Pharmacy, no benefits apply to the Total Network Out-of-Pocket Maximum.

For example, Gary has individual coverage under the Program. He has met his Network Annual Deductible ($2,100) and needs to fill a Prescription from a Pharmacy. He has not yet met his Non-Network Annual Deductible ($4,200). The flow chart below shows what happens when he visits a Network Pharmacy versus a Non-Network Pharmacy. The following example illustrates how the Dispense as Written penalty works.

Network Benefits
1. Gary fills a prescription for Vyvanse at a Network Pharmacy.
2. Vyvanse is a Tier 3 Prescription Drug and for this example, the average Prescription Drug Charge is $350.00.
3. The Generic alternative for Vyvanse is available as a Tier 1 Prescription Drug and has a Prescription Drug Charge to the program of $90.00.
4. Gary chooses to fill his Prescription for Vyvanse instead of the Generic alternative.
5. For his Vyvanse, he pays a total of $278, which is the sum of the 20% Coinsurance of $18 plus $260, which is the difference in cost between the Tier 1 and Tier 3 Prescription Drug Charge (DAW Penalty = $350 minus $90).

If Gary chooses to get his prescription filled at a Non-Network Pharmacy, Gary will be expected to pay for the prescription out of pocket and submit a claim to the plan for reimbursement. The HealthSelect plan will reimburse Gary the Prescription Drug Charge for the Tier 1 Medication minus the 40% Coinsurance.

Non-Network Benefits
1. Gary fills a prescription for Vyvanse at a Non-Network Pharmacy.
2. Vyvanse is a Tier 3 Prescription Drug and for this example, the Predominant Reimbursement Rate is $350.00. Note: Because the location is Non-Network, they might charge more.
3. The Generic alternative for Vyvanse is available as a Tier 1 Prescription Drug under the Program and has a Predominant Reimbursement Rate to the Program of $90.00.
4. Gary chooses to fill his Prescription for Vyvanse instead of the Generic alternative. He will have a DAW penalty.
5. For his Vyvanse, Gary pays a total of $296, which is the sum of the 40% Coinsurance of $36 (40% of $90) plus $260 (the difference in cost between the Tier 1 and Tier 3 Prescription Drug).
6. Plan responsibility is calculated on the Predominant Reimbursement Rate of the generic drug, less the 40% Coinsurance. In this case that is $54 (60% of $90).

SECTION 4 - UTILIZATION MANAGEMENT

Utilization management refers to the processes and programs implemented by the CDHS Prescription Drug Program to ensure appropriate use of medications and ensure cost efficiency. These programs aim to encourage the use of safe, effective, and cost-effective drugs while addressing potential issues like overuse or misuse.

What this section includes:
- Prior Authorization Requirements;
- Quantity Limits; and
- Step Therapy

Note: Some preventive medications are subject to additional Prior Authorization based on Clinical Criteria that the Program and Express Scripts have developed, subject to periodic review and modification. See Addendum *List of Covered Preventive Care Medications and Devices* at the end of this document for a list of covered Preventative Care Services.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Prescriber to obtain Prior Authorization from Express Scripts. You are responsible for ensuring Prior Authorization is obtained prior to receiving the Prescription Drug from a Pharmacy. Prior Authorization is required for some medications to:

- ensure the Prescription Drug meets the definition of a Covered Drug or Supply as defined by the Program,
- verify the Prescription Drug is not Experimental or Investigational or an Unproven Service, as defined in Section 13, *Glossary*, and
- help control misuse and protect patient safety to ensure the best possible therapeutic outcomes.

It is recommended you confirm with Express Scripts that all Covered Drugs or Supplies you have been prescribed are listed within the Preferred Drug List (PDL) and have been prior authorized as required. To find out whether any medications you take require Prior Authorization, visit **www.HealthSelectRx.com** and select Preferred Drug List, or call a representative toll-free at **(800) 935-7189** (TTY 711).

When Prescription Drugs are dispensed at either a Network Pharmacy or a non-Network Pharmacy, your Prescriber is responsible for obtaining Prior Authorization from Express Scripts as required.

If Prior Authorization from Express Scripts is not obtained before the Prescription Drug is dispensed, the Program may not pay any benefits for your Prescription Drug, or you may pay more for that Prescription Drug. You will be required to pay for the Prescription Drug in full at the time of purchase.

You may seek reimbursement of a Prescription Drug as described in Section 8, *Claims Procedures*. Reimbursement to you for a Prescription Drug, received before Prior Authorization is obtained, is not guaranteed and will be subject to Express Scripts' coverage guidelines. When you submit a claim on this basis, you may pay more because you did not obtain Prior Authorization from Express Scripts before the Prescription Drug was dispensed.

To determine if a Prescription Drug requires Prior Authorization, either visit **www.HealthSelectRX.com** and click on Preferred Drug List, or call Express Scripts toll-free at **(800) 935-7189** (TTY 711). The Prescription Drugs requiring Prior Authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after Express Scripts reviews the documentation provided and determines that the Prescription Drug is not a Covered Drug or Supply or it is Experimental or Investigational or an Unproven Service.

In certain situations, your Prescriber may be exempt from the Prior Authorization requirement for specific medications. If a Prescriber is exempt from a Prior Authorization requirement on your specific medication at the time of your service, it is not a guarantee of continued exemption for the same medication at a later date, nor a guarantee of coverage or payment.

Note: Certain drugs used to treat autoimmune disease, hemophilia, or Von Willebrand disease may not be subject to Prior Authorization more than once annually. To determine if this applies to a medication you are currently taking or being prescribed, call Express Scripts toll-free at **(800) 935-7189** (TTY 711).

Quantity Limits

A Quantity Limit is a process applied to selected drugs to limit the amount of medication dispensed to an amount within nationally recognized guidelines. Quantity Limits are recommended by the National Pharmacy and Therapeutics Management Committee to ensure that drugs are being used in quantities that are safe and medically appropriate. Whether or not a Prescription Drug has a Quantity Limit is subject to periodic review and modification.

For a single Coinsurance payment, you may receive a Prescription Drug up to the stated Quantity Limit.

If a Prescription Order or Refill for a drug filled by a Pharmacy exceeds the Quantity Limit established for that drug, you are responsible for the entire cost that exceeds the Quantity Limit.. If there is an approved clinical justification for an additional quantity, you may submit an appeal to Express Scripts for review. See Section 8, *Claim Denials and Appeals* for more information on the process for submitting an appeal.

It is recommended that you and your Prescriber confirm whether your medication is subject to any Quantity Limits prior to having it filled at a Pharmacy.

To learn if your medication is subject to Quantity Limits, visit **www.HealthSelectRx.com** and click on Preferred Drug List or call Express Scripts toll-free at **(800) 935-7189** (TTY 711) to obtain a copy of the Program's Preferred Drug List.

Note: Some preventive medications are subject to additional Quantity Limits based on criteria that the Program and Express Scripts have developed, subject to periodic review and modification. See

Addendum List of Covered Preventive Care Medications and Devices at the end of this document for a list of covered Preventative Care Services.

Step Therapy

Step Therapy is a process applied to certain Covered Drugs or Supplies under the Program to ensure the most appropriate use of drugs for the treatment of your condition and contain costs. For Covered Drugs that are subject to Step Therapy requirements, you must try the most cost-effective drug therapy first before the Program will cover the more costly drugs, if appropriate, for the treatment of your condition. For example, you may be required to try one or more Tier 1 drugs within a drug class first before the Tier 2 drug would be covered

It is recommended that you and your Prescriber confirm whether your medication is subject to Step Therapy requirements prior to having it filled at a Pharmacy.

To learn if your medication is subject to Step Therapy requirements, visit **www.HealthSelectRx.com** and click on Preferred Drug List or call Express Scripts at **(800) 935-7189** (TTY 711) toll-free.

Note on utilization management: If you are unable to take a Generic or a therapeutic equivalent of a Covered Drug or Supply due to a medical condition or complication, and the Utilization Management requirements cannot be met as a result, you may be eligible to obtain coverage of the Brand-name Drug if certain Clinical Criteria are met. For more information on the Utilization Management exception process, call Express Scripts at (800) 935-7189 (TTY 711) toll-free.

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Table 2 below contains the Program's Network Coinsurance, Annual Deductible, and Total Network Out- of-Pocket Maximum[7] for Covered Drugs or Supplies under the Program.

TABLE 2 – Network Benefits for Covered Drugs or Supplies

Program Features	Individual Coverage	Family Coverage
Annual Deductible (per Calendar Year)[1]	$2,100 per individual	$4,200 per family

Network Retail Pharmacy: Up to a 30-Day Supply

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Per Prescription fill of Non-Maintenance Medication (refills allowed as prescribed)[2]	20%	20%
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	20%	20%
■ Certain preventive medications, including contraceptives (refills allowed as prescribed)[5] Network Annual Deductible does not apply	No charge	20%
■ Certain oral contraceptives eligible for a 12-month supply* (refills allowed as prescribed) Network Annual Deductible does not apply *Subject to supply availability at pharmacy	No charge	20%
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies		
■ Insulin (refills allowed as prescribed) Network Annual Deductible does not apply	20% up to $25	20% up to $25

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Diabetic oral agent (refills allowed as prescribed)[2]	20%	20%
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre.[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	Generic Not Available	20%
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with voucher[8] Network Annual Deductible does not apply Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies	No charge	No charge
■ Blood glucose meter purchased at a Network Retail Pharmacy (Applicable coinsurance will apply to all glucose meters not obtained through the Free Glucose Meter Program).[2]	20%	20%
■ Preferred blood glucose test strips[8] Network Annual Deductible does not apply See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge
■ Non-preferred blood glucose test strips Network Annual Deductible does not apply	20%	20%
■ Lancets and lancing devices, disposable insulin syringes, and needles Network Annual Deductible does not apply	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	20%	20%

Network Mail Order Pharmacy

Coinsurance (Coinsurance is per Prescription[2] Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	20%	20%
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) [5] Network Annual Deductible does not apply	No charge	20%
■ Certain oral contraceptives eligible for a 12-month supply* (refills allowed as prescribed) Network Annual Deductible does not apply *Subject to supply availability at pharmacy	No charge	20%
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies		
■ Insulin (refills allowed as prescribed) Network Annual Deductible does not apply	20% up to $75	20% up to $75
■ Diabetic oral agent (refills allowed as prescribed)[2]	20%	20%
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre.[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies	Generic not available	20%
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher[8] Network Annual Deductible does not apply Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	No charge	No charge

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Formulary-covered blood glucose meter purchased at a Network Mail Order Pharmacy (Applicable coinsurance will apply to all glucose meters not obtained through the Free Glucose Meter Program.)[2] Network Annual Deductible does not apply	20%	20%
■ Preferred blood glucose test strips[,8] Network Annual Deductible does not apply. See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge
■ Non-preferred blood glucose test strips Network Annual Deductible does not apply	20%	20%
■ Lancets and lancing devices, disposable insulin syringes, and needles Network Annual Deductible does not apply.	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	20%	20%

Network Extended Days' Supply (EDS) Retail Pharmacy

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	20%	20%
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) [5] Network Annual Deductible does not apply	No charge	20%
■ Certain oral contraceptives eligible for a 12-month supply* (refills allowed as prescribed) Network Annual Deductible does not apply *Subject to supply availability at pharmacy	No charge	20%
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies		
■ Insulin (refills allowed as prescribed) Network Annual Deductible does not apply	20% up to $75	20% up to $75
■ Diabetic oral agent (refills allowed as prescribed)[2]	20%	20%
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. [2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies	Generic not available	20%
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher[8] Network Annual Deductible does not apply Limited to one free glucose meter annually through the Free Glucose Meter Program. See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	No charge	No charge

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Formulary-covered blood glucose meter purchased at a Network Retail Pharmacy (Applicable coinsurance will apply to all glucose meters not obtained through the Free Glucose Meter Program)[2]	20%	20%
■ Preferred blood glucose test strips[8] Network Annual Deductible does not apply See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge
■ Non-preferred blood glucose test strips Network Annual Deductible does not apply	20%	20%
■ Lancets and lancing devices, disposable insulin syringes, and needles Network Annual Deductible does not apply	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	20%	20%

Total Network Out-of-Pocket Maximum[1]	
Total Network Out-of-Pocket Maximum (per Calendar Year)[7]	
Program Features	**Amount**
■ Participant, per Calendar Year (CY)	CY 2025: $8,050 CY 2026: $8,300
■ Family, per Calendar Year (not to exceed the applicable Individual amount per Participant for Network Benefits)[6]	CY 2025: $16,100 CY 2026: $16,600

[1] The Network Annual Deductible and Total Network Out-of-Pocket Maximum are per Calendar Year (January 1 - December 31).

[2] Coinsurance only applies after the Annual Deductible has been met.

[4] If a Generic Drug is available and you choose to buy the Brand-name Drug, you will pay the Generic Tier 1 Coinsurance plus the difference in cost between the Brand-name Drug and the Generic Drug. (This is referred to as the Dispense As Written Penalty.)

[5] Certain preventive medications (including certain contraceptives) may be covered without any Participant cost share dependent upon Generic availability. Under the Patient Protection and Affordable Care Act of 2010 (ACA), certain contraceptive methods for women with reproductive capacity are paid at 100% (i.e., at no cost to the Participant). In some cases, you will be responsible for payment (for example, if you choose a Tier 3 drug when a Tier 1 drug is available.)

[6] No one individual within the family will pay more than the Per Participant Total Network Out-of-Pocket Maximum.

[7] The Total Network Out-of-Pocket Maximum includes Coinsurance (medical and prescription), and the Annual Deductible for both medical and Prescription Drug Network Benefits.

[8] The blood glucose meters and test strips available under this benefit are subject to change. You can find a list of covered glucometers and test strips at **www.HealthSelectRx.com** or call **(800) 935-7189** (TTY 711).

Table 3 below contains the Program's Non-Network Coinsurance and Non-Network Annual Deductible for Covered Drugs or Supplies.

Note: There is no total out-of-pocket maximum for Non-Network Benefits in the CDHS Program.

TABLE 3 – Non-Network Benefits for Covered Drugs or Supplies

Program Features	Amount	Family Coverage
Non-Network Annual Deductible (per Calendar Year)[1]	$4,200 per individual	$8,400 per family

Non-Network Retail Pharmacy

Percentage of Predominant Reimbursement Rate Payable by the Participant

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Per Prescription fill of Non-Maintenance Medication (refills allowed as prescribed)[2]	40%	40%
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	40%	40%
■ Certain preventive medications, including contraceptives (refills allowed as prescribed)[2,4]	40%	40%
■ Certain oral contraceptives eligible for a 12-month supply (refills allowed as prescribed) Non-Network Annual Deductible does not apply *Subject to supply availability at pharmacy	40%	40%
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies		
■ Insulin (refills allowed as prescribed) Non-Network Annual Deductible does not apply	40% up to $25	40% up to $25
■ Diabetic oral agent (refills allowed as prescribed)[2]	40%	40%

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	(**Tier 2 and Tier 3**) You will pay
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre.[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	Generic not available	40%
■ Preferred blood glucose meter obtained through Free Glucose Meter Program with voucher[5] Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies. Non-Network Annual Deductible does not apply	No charge	No charge
■ Blood glucose meter purchased at a Non-Network Retail Pharmacy (Applicable coinsurance will apply to all glucose meters not obtained through the Free Glucose Meter Program)[2]	40%	40%
■ Preferred blood glucose test strips[5] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies. Non-Network Annual Deductible does not apply	40%	40%
■ Non-preferred blood glucose test strips Non-Network Annual Deductible does not apply	40%	40%
■ Lancets and lancing devices, disposable insulin syringes and needles Non-Network Annual Deductible does not apply	40%	40%
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetic supplies.	40%	40%

Non-Network Mail Order Pharmacy

Percentage of Predominant Reimbursement Rate Payable by the Participant

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	**(Tier 2 and Tier 3)** You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	40%	40%
■ Certain preventive medications, including contraceptives (refills allowed as prescribed)[2,4] Non-Network Annual Deductible does not apply	40%	40%
■ Certain oral contraceptives eligible for a 12-month supply (refills allowed as prescribed) Non-Network Annual Deductible does not apply *Subject to supply availability at pharmacy	40%	40%
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies		
■ Insulin (refills allowed as prescribed) Non-Network Annual Deductible does not apply	40% up to $75	40% up to $75
■ Diabetic oral agent (refills allowed as prescribed)[2]	40%	40%
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre.[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.	Generic not available	40%
■ Preferred blood glucose meter through the Free Glucose Meter Program[5] Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies. Non-Network Annual Deductible does not apply	Generic not available	40%

Coinsurance[2] (Coinsurance is per Prescription Order or Refill)		
Covered Drugs or Supplies (60–90-day supply)	**Tier 1** You will pay	**(Tier 2 and Tier 3)** You will pay
■ Formulary-covered blood glucose meter purchased at a Non-Network Mail Order Pharmacy (Applicable coinsurance will apply to all glucose meters not obtained through the Free Glucose Meter Program.)	40%	40%
■ Preferred blood glucose test strips[5] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies. Non-Network Annual Deductible does not apply	40%	40%
■ Non-preferred blood glucose test strips Non-Network Annual Deductible does not apply	40%	40%
■ Lancets and lancing devices, disposable insulin syringes and needles Non-Network Annual Deductible does not apply	40%	40%
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetic supplies.	40%	40%

[1] The Non-Network Annual Deductible is per Calendar Year (January 1 - December 31)

[2] Coinsurance only applies after the Non-Network Annual Deductible has been met.

[4] Certain preventative medications (including certain contraceptives) may be covered without any Participant cost share dependent upon Generic availability if they are provided by a Network Pharmacy. Any preventative medications filled at a Non-Network Pharmacy will be subject to the Non-Network Annual Deductible and Coinsurance amounts.

[5] The blood glucose meters and test strips available under this benefit are subject to change. You can find a list of covered glucometers and test strips at **www.HealthSelectRx.com** or call **(800) 935-7189** (TTY 711).

SECTION 6 - DETAILS FOR COVERED DRUGS OR SUPPLIES

What this section includes:
- Covered Drugs or Supplies for which the Program pays Benefits.

While Table 2 and Table 3 provide you with the percentage Benefits payable by the Program, along with Coinsurance, Total Network Out-of-Pocket Maximums, and Network Annual Deductible information for Covered Drugs or Supplies, this section provides more details on Covered Drugs or Supplies. Pharmaceutical drugs and services that are not covered are described in Section 7, *Exclusions: What the Prescription Drug Program Will Not Cover*.

Reminder:
All Covered Drugs or Supplies must be determined by the Program to meet Clinical Criteria. Capitalized terms are defined in Section 13, *Glossary*, and may help you to understand the Benefits in this section.

Diabetes Supplies and Insulin

The Program pays benefits for the Covered Drugs, Supplies and services identified below.

Covered Diabetes Services

The following diabetes self-management items are covered under the Program:

- Insulin
- Diabetic oral agents
- Continuous Glucose Monitors (CGMs) and related supplies
- Test strips
- Lancets and lancing devices
- Alcohol wipes and swabs
- Glucagon emergency kits
- Syringes/pen needles for the administration of insulin
- Omnipod and V-Go Products
- Glucometers

The CDHS Prescription Drug Program covers Formulary insulin products without requiring the Network Annual Deductible to be met first when filled at a Network Pharmacy. Participants are still responsible for the applicable Coinsurance.

Coverage of Certain Diabetes-Related Covered Supplies at No Cost:

Certain brands of preferred blood glucose test strips are covered under the Program at no cost to Participants when purchased at Network Pharmacies. Note that non-preferred brands of blood glucose test strips are covered at the applicable Tier coinsurance.

Lancets, lancing devices and disposable insulin syringes are covered are no cost to Participants when purchased at Network Pharmacies.

The CDHS Prescription Drug Program covers glucagon-like peptide-1 (GLP-1) medications when being used for an FDA-approved use, which is in addition to diet and exercise to improve glycemic (blood sugar) control in adults with type 2 diabetes mellitus. When starting GLP-1 therapy, participants will be required to meet Prior Authorization requirements, and if approved, be limited to a 30-day supply fill until they have obtained three consecutive months of the same dosage. After that, participants will be able to get 60–90-day supply refills.

Insulin pumps are not covered under the CDHS Program. This is typically covered under the CDHS High-Deductible Health Plan administered by (BCBSTX) For more information on diabetes-related supplies specific to continuous glucose monitors and insulin pumps covered under the medical plans, go to **www.healthselectoftexas.com**.

Consumer Directed HealthSelect High-Deductible Health Plan Coverage of Diabetic Equipment and Supplies: Blood glucose meters, test strips, and diabetic supplies are not covered under the Consumer Directed HealthSelect High-Deductible Health Plan. Insulin pumps and continuous glucose monitors and supplies specific to covered insulin pumps and continuous glucose monitors are available through the medical plan. For more information, please go to **www.healthselectoftexas.com**.

Free Glucose Meter Program: Both LifeScan (the manufacturer of OneTouch®) and Abbott (the manufacturer of FreeStyle®) offer Free Glucose Meter Programs. These programs allow Participants to receive a free glucometer annually. The LifeScan Program is limited to the OneTouch Verio Flex® or OneTouch Verio Reflect® glucometer. After speaking with your doctor about which meter is best for you, contact the appropriate service center using the information below. Be sure to provide the corresponding order code. Your free blood glucose meter voucher will be delivered to your address, or you can take the processing information listed below to your local pharmacy to obtain your device.

For your free OneTouch meter, contact the OneTouch Service Center at:
Phone: (888) 907-0710
Website: www.onetouch.orderpoints.com
Order Code: 236DMT001 Voucher will be mailed to obtain at retail pharmacy
Retail Pharmacy: Present Voucher information and valid prescription to the pharmacy
BIN: 601341
Rx PCN: OHS
Group ID:
OH6504161 ID #:
NOCHARGEMETR

For your free FreeStyle brand meter, contact the Abbott Service Center at:
Phone: (866) 224-8892
Website: www.ChooseFreeStyle.com
Order Code: RAFITLWP Voucher will be mailed to obtain at retail pharmacy
Retail Pharmacy: Present Voucher information and valid prescription to the pharmacy

For more information about the Free Glucose Meter Program, visit **www.HealthSelectRx.com.**

Note: The brands of blood glucose meters and test strips covered under this Benefit are subject to change. You can also find a list of covered glucometers and test strips online or by calling **(800) 935-7189** (TTY 711).

Drugs

Prescription Orders or Refills for Covered Drugs or Supplies that are filled at a Pharmacy that meet the Clinical Criteria are covered under the Program.

This includes, but is not limited to, drugs within the following classes:

- analgesics, excluding topical analgesics
- anti-inflammatory agents
- anti-bacterials
- antidepressants
- anti-migraine agents
- anti-psychotics
- anti-virals
- blood glucose regulators
- cardiovascular agents
- central nervous system agents
- dermatological agents
- gastrointestinal agents
- hormonal agents, suppressants
- immunological agents
- respiratory tract agents
- skeletal muscle relaxants
- sleep disorder agent

For a full list of Covered Drugs, Supplies and classes, visit **www.HealthSelectRx.com** and click on Preferred Drug List or call Express Scripts toll-free at **(800) 935-7189** (TTY 711) to obtain a copy of the Program's Preferred Drug List.

IMPORTANT

A medication is only a Covered Drug or Supply if it meets Clinical Criteria (See definitions of *Clinical Criteria* and *Covered Drug or Supply* in Section 13, *Glossary*). The fact that a Prescriber has prescribed a medication, or the fact that it may be the only available treatment for a Sickness, Injury, condition, disease or its symptoms does not make the product a Covered Drug or Supply under the Program.

Hormone Replacement Therapy

Various hormone therapies are covered by the program. Express Scripts may need to gather more information from the Participant's prescriber to authorize coverage of products utilized for hormone replacement therapy.

For a complete listing of covered products, visit **www.HealthSelectRx.com** and click on Preferred Drug List or call Express Scripts toll free at **(800) 935-7189** (TTY 711) to obtain a copy of the Program's Preferred Drug List.

Family Planning Medications

The Program pays Benefits for voluntary family planning services and supplies. Coverage is provided for contraceptive Drugs or supplies required by the ACA, including, but not limited to: oral contraceptives or injectable contraceptives.

For a complete listing of covered contraceptives, see *Addendum-List of Covered Preventative Care Services.*

Note: Covered oral contraceptives will be eligible to be dispensed for a 12-month supply, following verification that the contraceptive was previously filled for 3 cycles. Tier 3 contraceptives are subject to applicable coinsurance. For more information, please contact Express Scripts toll free at **(800) 935-7189** (TTY 711).

Note: Contraceptive counseling, elective sterilization procedures (tubal ligation or vasectomy),

contraceptive drugs administered by a Provider (e.g., Norplant) and contraceptive devices (e.g., intrauterine device (IUD) including fitting and removal), are covered under the Consumer Directed HealthSelect Health Plan administered by (BCBSTX). For more information, please go to **www.healthselectoftexas.com**.

For services specifically excluded, refer to Section 7, *Exclusions: What the CDHS Prescription Drug Program Will Not Cover* under the heading **Reproduction/Infertility.**

Preventive Care Medications

The Program pays Benefits for Preventive Care medications and other items that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include, as required under applicable law, evidence-based medications that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force. Preventive Care medications described in this section are those that are relevant for implementing the ACA to the extent required by applicable law, and as it may be amended, and subject to determination and interpretation by the Program.

Preventive medications that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed in *Addendum -List of Covered Preventive Care Medications*. This list is subject to change according to the guidelines and recommendations provided by USPSTF as determined and interpreted by the Program. Coverage is subject to guidelines based on age, risk factors, dosage, and frequency, as well as receiving these medications in-Network.

Medication-Assisted Treatment (MAT)

The Program pays Benefits for Covered Drugs that are used for the purpose of Medication-Assisted Treatment (MAT) although the different medication options may be covered at different tiers. MATs are prescribed along with behavioral therapy.

Note: If a drug or therapy treatment is administered in a Physician, Therapist or Other Provider’s office, Outpatient Facility, or during confinement while a patient in a Hospital, it may be covered under the HealthSelect Plan administered by BCBSTX. Go to **www.healthselectoftexas.com** for more information.

Specialty Prescription Drugs

Accredo Specialty Pharmacy provides home delivery services and educational materials for most Specialty Prescription Drugs. In addition to using Accredo Specialty Pharmacy, Participants can receive Specialty Prescription Drugs at a retail Network Pharmacy. For a list of Express Scripts Network Pharmacies, go to **www.HealthSelectRx.com** and click on Locate a Pharmacy.

Specialty Prescription Drugs are injectable, oral, or inhaled drugs may be limited to a 30-day supply that and usually:

- are administered by injection or infusion;
- are high-cost;
- have special delivery and storage requirements, such as refrigeration;
- may not be available at retail pharmacies; and/or
- require close monitoring, additional education or care coordination by a pharmacist and Prescriber.

Specialty Prescription Drugs include, but are not limited to, certain drugs for the treatment of: Hepatitis C, Multiple Sclerosis, cancer, and Rheumatoid Arthritis. To find out whether a medication you take is considered a Specialty Prescription Drug, call Express Scripts at **(800) 935-7189** (TTY 711) toll-free or go to **www.HealthSelectRx.com**, choose your medication name and click on “More Information”.

Most Specialty Prescription Drugs require the Prescriber to submit for a Prior Authorization and meet drug specific Clinical Criteria before the product is covered. Under the Program, Specialty Prescription Drugs that are filled at a Pharmacy, including Accredo Specialty Pharmacy are typically covered at the Tier 2 or Tier 3 level.

Note: When Specialty Prescription Drugs are provided as part of a Physician’s or Other Provider’s office visit, Outpatient Facility visit, or during confinement while a patient in a Hospital, they are typically covered under the Consumer Directed HealthSelect High-Deductible Health Plan administered by BCBSTX. For more information on medications covered under the Health Plan, go to **www.healthselectoftexas.com**.

Accredo Specialty Pharmacy provides:

- access to your Specialty Prescription Drugs;
- pharmacists available 24/7;
- support through clinical and adherence programs;
- any medication-related supplies at no additional cost;
- proactive refill reminders; and
- timely delivery and shipping in confidential, temperature-sensitive packaging.

To fill a prescription at Accredo Specialty Pharmacy, call a customer care representative toll-free at **(800) 455-8340**.

Routine Vaccines

The Program pays Benefits for Routine Vaccines. Express Scripts contracts with a variety of national Pharmacy chains to provide members with easy access to Routine Vaccines. These Routine Vaccines are covered at $0 coinsurance under this Program's Preventative Care coverage when administered at a Network Pharmacy. Routine Vaccines are determined to prevent illnesses like tetanus, pneumonia and shingles. The following list shows the most common routine vaccines covered by the plan. However, other less common preventative vaccines are covered. Check coverage of a specific vaccine by visiting **www.HealthSelectRx.com** and click on Preferred Drug List or call Express Scripts toll free at **(800) 935-7189** (TTY 711). Coverage may be subject to guidelines based on age, risk factors, dosage, and frequency.

- COVID-19
- Hepatitis A and Hepatitis B
- Herpes Zoster and Recombinant Zoster
- Human Papilloma Virus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Respiratory Syncytial (RSV)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Tetanus, Diphtheria
- Varicella

SECTION 7 - EXCLUSIONS: WHAT THE PRESCRIPTION DRUG PROGRAM WILL NOT COVER

What this section includes:

- Drugs and services that are not covered under the Program, except as may be specifically provided for in Section 6, *Details for Covered Drugs or Supplies*.

Please review all limits of Covered Drugs or Supplies as described in Section 4, *Utilization Management* and Section 6, *Details for Covered Drugs or Supplies* carefully, as the Program will not pay benefits for any of the medications or services that exceed the benefit limits or have not been Prior Authorized when required. For a list of all drugs subject to Prior Authorization, Quantity Limits, or Step Therapy requirements, please see the Preferred Drug List at **www.HealthSelectRx.com**.

Please note that in listing services or examples, when the MBPD says "this includes," or "including, but not limited to," it is not the Program's intent to limit the items to that specific list.

The Program does not pay benefits for the excluded drugs, supplies, or other items even if they are recommended or prescribed by a Provider or are the only available treatment for your condition. You are solely responsible for payment of charges for all drugs, supplies, or other items excluded by the Program.

Contacting Express Scripts is easy.
Simply call Express Scripts toll-free at **(800) 935-7189** (TTY 711)

The following pharmaceutical services, supplies, and items are excluded from coverage under the CDHS Prescription Drug Program:

Administration or Injection of a Drug

1. Administration or injection by Provider of any drug is excluded under the Program.

Note: If a drug is administered or injected in a Physician's or other Provider's office, outpatient Facility, or during confinement while a patient in a Hospital, it may be covered under the HealthSelect Plan administered by (BCBSTX). Go to **www.healthselectoftexas.com** for more information.

Devices or Durable Medical Equipment (DME)

1. Devices or Durable Medical Equipment (DME) of any type such as therapeutic devices, artificial prosthetics, or similar devices.

2. Insulin pumps.

Note: Certain devices and DME, including insulin pumps, and diabetic supplies specific to that equipment, may be covered under the CDHS Health Plan administered by BCBSTX. Go to **www.healthselectoftexas.com** for more information on covered devices and DME. CGM's are covered under both the CDHS medical plan and the CDHS Prescription Drug Program. For more information on coverage under this Program see Section 6, *Details for Covered Drugs or Supplies.*

Drugs, Devices, or Supplies without a Valid Prescription Order

1. Drugs, insulin, or covered devices and supplies without a valid Prescription Order or Refill from a Prescriber.

Drugs Dispensed in a Home Setting, Physician's or Other Provider's Office, Inpatient or Outpatient Setting, Nursing Home, or Other Facility

1. Drugs dispensed in a Physician's or Other Provider's office, including take-home drugs. This exclusion does not apply to contraceptives as listed in the *Addendum - List of Covered Preventative Care Services* at the end of this document.

2. Drugs dispensed or intended for use during confinement while a patient in a Hospital or Facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or Facility.

> ***Note:*** These drugs may be covered under the CDHS Health Plan administered by BCBSTX. Go to **www.healthselectoftexas.com** for more information.

3. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (internal) infusion or by intravenous injection in the home setting. This does not include intravenous Specialty Prescription Drugs covered under the Program as described in Section 6, Details for Covered Drugs or Supplies. To find out whether a medication you take is considered a Specialty Prescription Drug, call Express Scripts at **(800) 935-7189** (TTY 711) toll-free or go to **www.HealthSelectRx.com**, choose your medication name and click on "More Information".

> ***Note:*** These fluids, solutions, nutrients, and medications may be covered under the CDHS Health Plan administered by BCBSTX. Go to **www.healthselectoftexas.com** for more information.

Drugs Obtained through Illegal or Fraudulent Activity

1. Drugs obtained by unauthorized, fraudulent, abusive, or improper activity.

2. Drugs used or drugs intended to be used illegally or unethically.

Experimental or Investigational or Unproven Services

1. Drugs that have not been shown through *reliable clinical evidence* to be effective and safe for treating the condition for which they are prescribed or used. Examples may include the following:

   - Off-label drug uses without supporting evidence,
   - Experimental gene therapies,
   - Emerging digital therapeutics not yet validated in clinical studies,
   - Supplements or compounded medications with no proven benefit.

2. Express Scripts uses evidence-based guidelines and clinical review committees to evaluate whether a service meets the threshold for being considered proven and medically necessary.

Note: These exclusions apply even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Homeopathic Products and Herbal Remedies

1. Homeopathic products and herbal remedies, including but not limited to: over-the-counter allergy drops and teething tablets.

Over-the-Counter (OTC) Drugs, Vitamins, or Other Items

1. Drugs that are available OTC that do not require a Prescription Order or Refill by federal or state law before being dispensed.
   - This exclusion does not apply if the Program has designated an OTC medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Prescriber.
2. Prescription Drugs that are available in OTC form or comprised of components that are available in OTC form or equivalent.
3. Certain Prescription Drugs that Express Scripts has determined are Therapeutically Equivalent to an OTC drug.
4. Program may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
   - This exclusion does not apply to OTC drugs prescribed at a strength requiring a Prescription Order or Refill, even if available without a prescription at a lesser strength.
   - This exclusion does not apply to OTC preventive drugs that are rated an “A” or “B” by the United States Preventive Services Task Force (USPSTF) and that are accompanied by a valid Prescription Order or Refill. Examples of OTC Preventive drugs that are covered under the Program include, but are not limited to: folic acid for women, iron supplements, aspirin, and vitamin D.

   See *Addendum-List of Covered Preventative Care Services* for more details.
5. Vitamins, except those vitamins which by law require a Prescription Order and for which there is no OTC alternative.
6. OTC tobacco cessation products, except for those specifically listed in *Addendum-List of Covered Preventative Care Services* as covered.

Cosmetic Drugs

1. Drugs used primarily for cosmetic purposes such as, but not limited to: Retin-A, Renova, Solage, Rogaine.

Drugs Prescribed for the Treatment of Obesity

Drugs prescribed and dispensed solely for the treatment of obesity, with an FDA Indication only for weight loss or for use in any program of weight reduction, weight loss, or dietary control, even if the Participant has medical conditions which might be helped by a reduction of obesity or weight and even though prescribed by a Physician or Other Provider. Examples: Zepbound, Saxenda, Qsymia.

Wegovy, prescribed in combination with a reduced-calorie diet and increased physical activity, to reduce the risk of major adverse cardiovascular events (MACEs), may be covered for adults with established cardiovascular disease (CVD) and who are either obese or overweight. Participants will be required to meet Prior Authorization requirements.

Products Containing Fluoride and Dental Products

1. Dental products including, but not limited to, prescription fluoride topicals.
2. Any prescription mouthwashes, mouth rinses, topical oral solutions, pastes, gels or lozenges containing Fluoride.

Reproduction/Infertility

1. Contraceptive devices and contraceptive materials other than those listed in Section 6, *Details for Covered Drugs or Supplies* under the heading ***Family Planning and Infertility***, and *Addendum- List of Covered Preventive Care Medications*.

Note: Contraceptive counseling, elective sterilization procedures (tubal ligation or vasectomy), contraceptive drugs administered by a Provider (e.g., Norplant) and contraceptive devices (e.g., intrauterine device (IUD) including fitting and removal), are covered under the CDHS Health Plan administered by BCBSTX. For more information please go to **www.healthselectoftexas.com**.

2. Any drugs, services, or supplies used in any procedure in preparation for or performed as a direct result of and immediately after in vitro fertilization.
3. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
4. Elective drug induced pregnancy termination.

Services Provided Under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*.
2. For any condition, Injury, Sickness or illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
3. Under no-fault automobile coverage or similar plan if you could purchase or elect it or could have it purchased or elected for you.
4. While on active military duty.
5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and Facilities are reasonably accessible, as determined by the Program.

All Other Exclusions

1. Expenses for pharmaceutical drugs, services, and supplies:

   A. that would otherwise be considered Covered Drugs, Supplies or services and are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone,

   B. that are received after the date your coverage under the Program ends, including Prescription Drugs or services for conditions that began before the date your coverage under the Program ends,

   C. for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Program.

   D. that are dispensed in quantities in excess of the amounts stipulated in the Preferred Drug List for this Program, or Refills of any prescriptions in excess of the number of Refills specified by the Physician or Other Provider or by law, or dispensed in quantities in excess of the amounts stipulated in the Preferred Drug List for this Program, or any drugs or medications dispensed more than one year following the Prescription Order or Refill date.

   E. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the MBPD for the CDHS Prescription Drug Program administered by Express Scripts for which benefits have been exhausted.

2. Drugs, vaccinations, immunizations or treatments when:

   A. required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.

   B. conducted for purposes of medical research.

   C. related to judicial or administrative proceedings or orders. D. required to obtain or maintain a license of any type.

   D. required to obtain or maintain a license of any type.

3. Compounded drugs that contain certain bulk chemicals.
4. Prescription Drug as a replacement for a previously dispensed Preferred Drug that was lost, stolen, broken or destroyed. This exclusion does not apply when a police report is filed for a stolen Prescription Order or Refill.
5. Prescription Order or Refill dispensed (days' supply or Quantity Limit) which exceeds the Quantity Limit.
6. Prescription Drugs that the Program determines do not meet the definition of a Covered Drug or Supply.
7. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

Note: Nutritional products such as enteral feedings or other nutritional formulas that are the only source or the majority of nutrition or that are specifically created to treat inborn errors of metabolism or heritable diseases such as phenylketonuria (PKU) and certain amino-acid based elemental formulas that meet Clinical Criteria may be covered.

8. Prescription Drug that contains medical marijuana including cannabidiol (CBD) products except for Epidiolex as prescribed.

9. Hormone therapies for the purpose of gender transition or affirmation in children under the age of 18. This exclusion does not apply to certain drugs when used for the treatment of precocious puberty, certain genetic disorders or chromosomal differences.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and Non-Network claims work;
- What to do if your pharmacy does not file your claim;
- Claim payment and assignment; and
- What you may do if your claim is denied, in whole or in part.

Note: You may designate an Authorized Representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an Authorized Representative, any references to "you" or "Participant" in this Section 8 will refer to the Authorized Representative. See *Authorized Representative* below for details.

Network Benefits

In general, if you receive a Covered Drug or Supply from a Network Pharmacy, Express Scripts will pay the Pharmacy directly. If a Network Pharmacy bills you for any amount other than your Annual Deductible or Coinsurance, please contact the Pharmacy or call Express Scripts toll-free at **(800) 935-7189** (TTY 711) for assistance.

Important: Keep in mind; you are responsible for paying any Annual Deductible or Coinsurance amounts owed to a Pharmacy at the time of service. You are also responsible for the full cost of medications that are not covered by your Program.

Non-Network Benefits

You are responsible for paying the full cost for any drug or other item received from a Non-Network Pharmacy at the time of service.

You may then submit the Non-Network Pharmacy claim, along with a completed paper claim reimbursement form, to Express Scripts for reimbursement at the Non-Network Benefit level, if the drug is a Covered Drug or Supply under the Program. To download a copy of the paper claim reimbursement form, please go to **www.HealthSelectRx.com**.

To make sure the claim is processed promptly and accurately, a completed paper claim reimbursement form must be mailed to Express Scripts at:

ATTN: Express
Scripts Commercial
Claims
P.O. Box 14711
Lexington, KY 40512-4711

If Your Pharmacy Does Not File Your Claim

You can obtain a prescription claim form by visiting **www.HealthSelectRx.com** or calling Express Scripts at **(800) 935-7189** (TTY 711) toll free. You may also fax your claim to (608) 741-5475. If you do not have a paper claim reimbursement form, simply submit a brief letter containing the items listed below. Make sure that all of your Pharmacy claim receipts and cash register receipts accompany either your claim form or a letter containing your Participant information.

- Participant first and last name;
- Address;

- Date of birth;
- ID number as it's shown on your card;
- Pharmacy prescription receipts; and
- Pharmacy cash register receipts.

Mail your prescription claims to:
Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Failure to provide all the information listed on the claim form may delay any reimbursement that may be due to you.

Claim Payment and Assignment

After Express Scripts has processed your claim, you will receive payment for Benefits that the Program allows. It is your responsibility to pay the Non-Network Pharmacy the charges you incurred, including any difference between what you were billed and what the Program paid.

You may review your prescription history by visiting **www.HealthSelectRx.com** or by calling Express Scripts at **(800) 935-7189** (TTY 711) toll-free.

Express Scripts will pay Benefits to you unless:

- the Provider notifies Express Scripts that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the Non-Network Provider to be paid directly at the time you submit your claim.

Express Scripts will only pay Benefits to you or, with written authorization by you, to your Provider, and not to another third party, even if your Provider has assigned Benefits to that party.

Important – Timely Filing of Claims
All claim forms for Network and Non-Network Covered Drugs or Supplies must be submitted within 365 days after the date of service. Otherwise, the Program will not pay any benefits for that expense, or benefits will be reduced, as determined by Express Scripts. This 365-day requirement does not apply if you are legally incapacitated.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Express Scripts toll-free at **(800) 935-7189** (TTY 711) before requesting a formal appeal. If Express Scripts cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-Service Request for Benefits, a non-covered Benefit or a Post-Service Claim, you or your Authorized Representative must submit your appeal as described below in writing within 180 days from the date of the adverse benefit determination. This communication should

include:

- the Participant's name;
- ID number as shown on the card;
- the Provider's name
- the date of service;
- the reason you disagree with the denial or the coverage decision; and
- any documentation or other written information to support your appeal.

For Appeal requests, you or your Authorized Representative may send a written appeal to:

Express Scripts Attn: Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

Or may fax to: 877-852-
4070 Or may call: 800-753-
2851

See page 52, Authorized Representative, for more information on how to assign an Authorized Representative.

You do not need to submit appeals of Urgent Care Requests for Benefits in writing. For Urgent Care Requests for Benefits that have been denied, you or your Provider should call Express Scripts toll-free at **(800) 935-7189** (TTY 711) to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Request for Benefits;
- Pre-Service Request for Benefits; or
- Post-Service Claim.

First Internal Appeal

Express Scripts will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Express Scripts upholds the denial, you and your Provider will receive a written explanation of the reasons and facts relating to the denial and a description of the additional appeal procedures. If Express Scripts overturns the denial, you and your Provider will receive written notification of its decision and Benefits will be paid, as appropriate.

Note: A denial of Benefits for prescription coverage does not mean that you cannot receive the drugs or supplies. A denial of the benefits simply means that the drugs or supplies are not covered under the Program and no payments will be made to you or any Providers or Pharmacies by the Program if you receive the denied drugs or supplies, unless the denial is overturned on a subsequent appeal.

If your Urgent Care Request for Benefits was denied, you may request an expedited external review at the same time that you request an expedited internal appeal to Express Scripts. Immediately upon receipt of your request for an expedited external review, Express Scripts will determine whether the request meets reviewability requirements for an external review. Immediately upon completing this review, Express Scripts will notify you that: (i) the request is complete and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request is complete, but not eligible for expedited external review. If the request for appeal does not meet the expedited external appeal criteria as determined by Express Scripts, the appeal will be handled as an expedited internal appeal to Express Scripts.

Second Internal Appeal to Express Scripts (of an Urgent Care Request for Benefits or a Pre-Service Request for Benefits)

If you are not satisfied with the first internal appeal decision regarding an Urgent Care Request for Benefits or a Pre-Service Request for Benefits, you have the right to request a second internal appeal from Express Scripts. You must file a written request for the second internal appeal within 60 days from your receipt of the first internal appeal determination notification.

If the denial is upheld at the second internal appeal level, Express Scripts will notify you of the reasons for its decision and that your internal appeal options are exhausted. If the appeal involves issues of medical judgment, you may request an external review of the denial within four months of receiving Express Scripts' notice. If Express Scripts overturns its decision at the second internal appeal level, Express Scripts will notify you of its decision and benefits will be paid, as appropriate.

Note: Upon written request and free of charge, Participants may examine documents relevant to their claims and/or appeals and submit opinions and comments. Express Scripts will review all claims in accordance with the rules established by the U.S. Department of Labor.

Second Internal Appeal to Express Scripts (of a Post-Service Claim)

If you are not satisfied with the first internal appeal decision regarding a Post-Service Claim, you have the right to request a second internal appeal from Express Scripts. You must file a written request for the second internal appeal within 90 days from your receipt of the first level appeal determination notification.

If Express Scripts upholds the denial at the second internal appeal level, Express Scripts will notify you of the reasons for its decision and that your internal appeal options are exhausted. If your appeal involves issues of medical judgment, you may request an external review of the denial within four months of receiving Express Scripts' notice. If Express Scripts overturns the denial, Express Scripts will notify you and benefits will be paid, as appropriate.

Express Scripts will complete reviews within legally applicable time periods.

Tables 4 through 6 below describe the time frames which you and Express Scripts are required to follow.

TABLE 4 – Urgent Care Request for Benefits[1]

Action to Be Taken	Timing[2]
If your Request for Benefits is complete, Express Scripts must notify you and your Provider of the benefit determination within:	**72 hours**
If your Request for Benefits is incomplete, Express Scripts must notify you that it is incomplete within:	**24 hours**
You must then provide the completed Request for Benefits to Express Scripts within:	**48 hours** after receiving notice of additional information required
Express Scripts must notify you and your Provider of the Benefit determination within:	**72 hours** after receipt of additional information
If Express Scripts denies your Request for Benefits, you must appeal an adverse benefit determination no later than:	**180 calendar days** from the date of the adverse benefit determination letter
Express Scripts must notify you of the first internal appeal decision within:	**72 hours** after receiving the appeal

[1] You do not need to submit Urgent Care appeals in writing. You should call Express Scripts as soon as possible to appeal an Urgent Care Request for Benefits.

[2] From when the request is made unless otherwise noted below.

TABLE 5 – Pre-Service Request for Benefits

Action to Be Taken	Timing[1]
If your Request for Benefits is filed properly with Express Scripts, must notify you within:	**5 calendar days**
If your Request for Benefits is incomplete Express Scripts must notify you within:	**15 calendar days**
You must then provide completed Request for Benefits information to Express Scripts within:	**45 calendar days**
Express Scripts must notify you of the Benefit determination: ■ if your Request for Benefits is complete, within:	**15 calendar days**
Express Scripts must notify you of the Benefit determination: ■ after receiving the completed Request for Benefits (if your Request for Benefits was incomplete as filed), within:	**15 calendar days**

Action to Be Taken	Timing
You must appeal an adverse benefit determination no later than:	**180 calendar days** from the date of the adverse benefit determination letter
Express Scripts must notify you of the first internal appeal decision within:	**15 calendar days** after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal) no later than:	**60 calendar days** after receiving the first internal appeal decision
Express Scripts must notify you of the second internal appeal decision within:	**15 calendar days** after receiving the second internal appeal

[1] From when the request is made unless otherwise noted below.

TABLE 6 – Post-Service Claims

Action to Be Taken	Timing[1]
If your claim is incomplete, Express Scripts must notify you within:	**30 calendar days**
You must then provide completed claim information to Express Scripts within:	**45 calendar days**
Express Scripts must notify you of the Benefit determination: ■ if the claim was complete as filed, within:	**30 calendar days**
Express Scripts must notify you of the Benefit determination: ■ after receiving the completed claim (if the claim was incomplete as filed), within:	**30 calendar days**
You must appeal an adverse benefit determination no later than:	**180 calendar days** from the date of the adverse benefit determination letter
Express Scripts must notify you of the first internal appeal decision no later than:	**30 calendar days** after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal to Express Scripts) no later than:	**90 calendar days** after receiving the first internal appeal decision
Express Scripts must notify you of the second internal appeal decision within:	**30 calendar days** after receiving the second internal appeal

[1] From when the request is made unless otherwise noted below.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Express Scripts and the determination was based on an issue of medical judgment, or if Express Scripts fails to respond to your appeal in accordance with applicable regulations regarding internal review, you may be entitled to request an immediate external review of the determination made by Express Scripts. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of an adverse benefit determination based upon any of the following:

- clinical reasons (the determination involves a question of medical judgment); or
- as otherwise required by applicable law.

Note: You may also have the right to pursue external review under the above criteria in the event that Express Scripts has failed to comply with the internal claims and appeals process, except for those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you.

When and How to Request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

You or your Authorized Representative may request a standard external review by sending a written request to the address sent out in the determination letter and listed below. MCMC LLC will facilitate, on behalf of Express Scripts, your request for an external review by sending it to an independent review organization.

To submit an external review, the request must be mailed or faxed to:

MCMC
Attn: Express Scripts Appeal Program
1451 Rockville Pike, Suite 440
Rockville, MD 20852

Phone: (617) 375-7700
Fax: (800) 882-4715

The request must be received within 4 months of the date of the final internal adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

An external review request should include all of the following:

- a specific request for an external review;
- the Participant’s name, address, and pharmacy card ID number;
- your Authorized Representative’s name and address, when applicable;
- the service that was denied, the date of service, the Provider’s name; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Express Scripts

has entered into agreements with MCMC to administer the IRO review process. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of the following:

- MCMC receives request;
- MCMC checks with Express Scripts to confirm that the participant is eligible for the external appeal. This is referred to as a preliminary review by Express Scripts of the request;
- if the preliminary review by Express Scripts is verified per the step above, MCMC sends the request to the IRO;
- the request is reviewed by the IRO; and
- a decision by the IRO goes out to the Participant via mail

During the preliminary review stage, Express Scripts determines whether the requesting Participant meets all of the following requirements:

- was covered under the Program at the time the Preferred Drug that is at issue in the request was provided;
- has exhausted the applicable internal appeals process;
- has provided all the information and forms required so that Express Scripts may process the request; and
- has met the legal requirements for external review.
- Express Scripts will provide MCMC with the documents and information considered in making Express Scripts' determination. The documents include:
- all relevant medical records;
- all other documents relied upon by Express Scripts;
- all other information or evidence that you or your Provider submitted regarding the claim; and
- all other information or evidence that you or your Provider wish to submit regarding the claim, including, as explained below, any information or evidence you or your Provider wish to submit that was not previously provided.

If the request is eligible to be forwarded to an IRO, MCMC will assign to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to MCMC for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, MCMC and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Expedited External Review for Urgent Care Matters

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the Participant received Emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request, Express Scripts will determine whether the Participant meets all of the following:

- was covered under the Program at the time the Preferred Drug that is at issue in the request was provided;
- has provided all the information and forms required so that Express Scripts may process the request; and
- met the legal requirements for expedited external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

You may contact MCMC at **(617) 375-7700** toll-free for more information regarding external review rights, or if making a verbal request for an expedited external review.

Table 7 below describes the time frames which you, Express Scripts and the IRO are required to follow.

TABLE 7 – External Review

Action to Be Taken	Timing[1]
You must submit a request for external review to Express Scripts within:	**4 months** after the date you receive the second internal appeal determination
For an expedited external review, the IRO will provide notice of its determination within:	**72 hours**
For a standard external review, Express Scripts will complete a preliminary review to ensure the request meets requirements for an external review within:	**5 business days**
You may submit in writing to the IRO any additional information that you want the IRO to consider within:	**10 business days**
For a standard external review, the IRO will provide written notice of its determination within:	**45 days**[2] after receiving the request for the external review

[1] From when the request is made unless otherwise noted below.

[2] This time frame may be extended if the IRO requests additional time and you agree.

Authorized Representative

A Participant may have one Authorized Representative, and only one Authorized Representative at a time, to assist in submitting a claim or appealing a claim.

Except as set forth below with respect to a health care Provider acting as an Authorized Representative, an Authorized Representative shall have the authority to represent the Participant in all matters concerning the Participant's claim or appeal of a claim determination. If the Participant has an Authorized Representative, any references to "you" or "Participant" in this Section 8 will refer to the Authorized Representative.

One of the following persons may act as a Participant's Authorized Representative:

- an eligible individual designated by the Participant in writing;
- a health care Provider designated by the Participant in writing. For Urgent Care claims, a health care Provider may act as a Participant's Authorized Representative without the Participant's designation.
- a person holding the Participant's durable power of attorney;
- if the Participant is incapacitated due to illness or injury, a person appointed as guardian of the Participant by a court of competent jurisdiction; or
- if the Participant is a minor, the Participant's parent or legal guardian, unless Express Scripts is notified that the Participant's claim involves prescription drug services where the consent of the Participant's parent or legal guardian is or was not required by law in which case the Participant may represent himself or herself with respect to the claim

The authority of an Authorized Representative shall continue for the period specified in the Participant's appointment of the Authorized Representative or until the Participant is legally competent to represent himself or herself and notifies Express Scripts in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative

1. If the Authorized Representative represents the Participant because the Authorized Representative is the Participant's parent or legal guardian or attorney in fact under a durable power of attorney, Express Scripts shall send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Authorized Representative.
2. If the Authorized Representative represents the Participant in connection with the submission of a Pre-Service Claim, including a claim involving Urgent Care, Express Scripts shall send all correspondence, notices and benefit determinations in connection with the Participant's claim to the Authorized Representative.
3. If the Authorized Representative represents the Participant in connection with the submission of a Post-Service Claim, Express Scripts will send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Participant and the Authorized Representative.
4. It will take Express Scripts at least 30 days to notify all of its personnel about the termination of the Participant's Authorized Representative. It is possible that Express Scripts may communicate information about the Participant to the Authorized Representative during this 30-day period.

SECTION 9 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Program coordinate with other plans;
- Procedures in the event the Program overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one prescription drug plan, including, but not limited to, any one of the following:

- another employer-sponsored prescription drug plan;
- another group insurance plan;
- no-fault or traditional “fault” type pharmaceutical payment benefits or personal injury protection benefits under an automobile insurance policy;
- pharmaceutical benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental prescription drug benefit plan.

If coverage is provided under two or more plans, COB determines which plan is Primary and which plan is Secondary. The plan considered Primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered Secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- a plan that covers a Participant as an employee pays benefits before a plan that covers the Participant as a dependent;
- the plan that has covered the individual claimant for the longest period will pay first; the expenses must be covered in part under at least one of the plans;
- the plan that covers an active employee pays before a plan covering a laid-off or retired employee;
- your Dependent children will receive Primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the plan that has been in effect the longest is the Primary Plan. This birthday rule applies only if:
  - A. the parents are married or living together whether or not they have ever been married and not legally separated; or
  - B. a court decree awards joint custody to the parents without specifying that one parent has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - A. the parent with custody of the child; then
  - B. the spouse of the parent with custody of the child; then

C. the parent not having custody of the child; then

D. the spouse of the parent not having custody of the child;

- if you have coverage under two or more prescription drug plans and only one has COB provisions, the plan without COB provisions will be the Primary Plan;
- if you are covered as an active employee by two plans, or you are covered as a retiree by two plans, the plan that has covered the individual claimant for the longest period will pay first; the expenses must be covered in part under at least one of the plans;
- if you are receiving COBRA continuation coverage under another employer plan, this Program is the Primary Plan; and
- finally, if none of the above rules determines which plan is Primary or Secondary, the allowable expenses shall be shared equally between the plans meeting the definition of an eligible plan for COB purposes.

The following examples illustrate how the Program determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1. Let's say you and your spouse both have family prescription drug coverage through your respective employers. You are unwell and go to see a Physician. The Physician provides you with a Prescription Order or Refill for a Covered Drug or Supply, which you take to a Pharmacy. Since you're covered as a Subscriber under this Program, and as a Dependent under your spouse's plan, this Program will pay Benefits for any Covered Drugs, Supplies or pharmaceutical items first.
2. Again, let's say you and your spouse both have family prescription drug coverage through your respective employers. You take your Dependent child to fill a Prescription Order or Refill at the Pharmacy. This Program will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

Table 8 summarizes common situations of dual coverage and whether HealthSelect would be considered the Primary Program or the Secondary Program.

TABLE 8

Subscriber is…	…and is covered as a Dependent under another plan by:	…then Consumer Directed HealthSelect is:
an Active Employee	spouse's employer plan	the Primary Plan
an Active Employee	spouse's retiree plan	the Primary Plan
a Retiree	spouse's employer plan	the Primary Plan
a Retiree	spouse's retiree plan	the Primary Plan

Subscriber is…	…and has other coverage through:	…then Consumer Directed HealthSelect is:
an Active Employee	the Subscriber's second active employment	either Primary or Secondary depending on which plan is in force the longest
an Active Employee	the Subscriber's retirement from another employer	the Primary Plan

Subscriber is…	…and has other coverage through:	…then Consumer Directed HealthSelect is:
a Retiree	the Subscriber's second active employment	the Secondary Plan
a Retiree	the Subscriber's retirement from another employer	either Primary or Secondary depending on which plan is in force the longest

Dependent is…	…and is covered by a Subscriber who is:	…then Consumer Directed HealthSelect is:
an active employee of a non-GBP Employer	an Active Employee	the Secondary Plan
an active employee of a non-GBP Employer	a Retiree	the Secondary Plan
a retiree of a non-GBP Employer	an Active Employee	the Primary Plan
a retiree of a non-GBP Employer	a Retiree	the Secondary Plan

When This Program is Secondary

When this Program is the Secondary Plan, the Program determines the amount it will pay for a Covered Drug or Supply according to the following:

- The Program pays after the Annual Deductible has been met, if applicable.
- The Program determines the amount it would have paid based on the Program's discounted Average Wholesale Price (AWP) or Maximum Allowable Cost (MAC) for the Covered Drug or Supply.
- The Program pays the lesser of: amount remaining after the Primary Plan paid (member responsibility amount) or this Program's liability had the program been the primary payer.
- the Program does not pay more than the amount the Program would have paid had it been the only plan providing coverage.
- the maximum combined payments from all plans cannot exceed 100% of the total allowable expense.

See Section 13, *Glossary* for the definition of Average Wholesale Price.

You may be responsible for any Coinsurance or Annual Prescription Drug Deductible payments as part of the COB payment.

Example 1:

You have primary prescription drug coverage through your own employment (your Primary Plan), and secondary prescription drug coverage in the CDHS Prescription Drug Program (your Secondary Plan) through your spouse's employment. You have not met your family In-Network Annual Deductible of $4,200 for the Calendar Year. The total cost of a Covered Drug or Supply is $20 and you paid a $10 Copay for the drug under your Primary Plan. Under the CDHS Prescription Drug Program (your Secondary Plan), you would have paid $20 (i.e., the full cost for this drug) since you have not met your Annual Deductible. Since the Program's liability for this drug is $0 (because you have not met your Annual Deductible), you will not receive a reimbursement under the Program. Once you meet your Annual Deductible, the Program would begin to pay Benefits.

Example 2:

You have primary prescription drug coverage through your own employment (your Primary Plan), and secondary prescription drug coverage in the CDHS Prescription Drug Program (your Secondary Plan) through your spouse's.

You have met your family In-Network Annual Deductible of $4,200 in this Program.

You go to a Network Pharmacy and fill a Prescription Order for a Covered Drug or Supply. The total cost of the Covered Drug or Supply is $200 and you paid a $60 Copay for the drug under your Primary Plan. Under your Secondary Plan, you would have paid $40 in Coinsurance (20%) for this drug, and the plan cost would have been $160 ($200 minus $40 Coinsurance). Since the cost the Secondary Plan would have paid for your medication ($160) is greater than the Copay you paid under your Primary Plan, you receive the full reimbursement of $60.

Note: You will not receive a reimbursement for Covered Drugs or Supplies under this Program until your Annual Deductible has been met. After your Annual Deductible has been met, you may be responsible for any Coinsurance payments as part of the COB payment.

What is an allowable expense?

For purposes of COB, an allowable expense is a Prescription Drug expense that meets the definition of a Covered Drug or Supply under this Program.

Overpayment and Underpayment of Benefits

If you are covered under more than one prescription drug plan, there is a possibility that the other plan will pay a benefit that the Program should have paid. If this occurs, the Program may pay the other plan the amount it should have paid.

If the Program pays you more than it should under this COB section, you should pay the excess back promptly. Otherwise, ERS may recover the overpayment by offsetting the amount owed to ERS from future Benefits or by taking other legal action.

If the Program overpays a Pharmacy, the Program may recover the excess amount from the Pharmacy pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Program pays Benefits to or for a Participant, that Participant, or any other person or organization that was paid, must make a refund to the Program if:

- the Program's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Participant, but all or some of the expenses were not paid by the Participant or were not legally required to be paid by the Participant;
- all or some of the payment the Program made exceeded the benefits under the Program; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Program paid in excess of the amount that the Program should have paid under the Program. If the refund is due from another person or organization, the Participant agrees to help the Program get the refund if requested.

If the Participant, or any other person or organization that was paid, does not promptly refund the full amount owed, the Program may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Participant that are payable under the Program; or (ii) future Benefits that are payable to other Participants under the Program, with the understanding that Express Scripts will then reimburse the Program the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Program. The Program may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action. Alternatively, ERS may impose one or more sanctions against the involved Participant(s) under Section 1551.351, Texas Insurance Code.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

See Section 10, *Subrogation and Reimbursement* in the CDHS Health Plan MBPD. To review the Plan document referenced above, go to **www.healthselectoftexas.com**.

SECTION 11 - WHEN COVERAGE ENDS

Important

Your coverage in the CDHS Prescription Drug Program is determined based upon your coverage in the Consumer Directed HealthSelect High-Deductible Health Plan (administered by BCBSTX). If your coverage under the Health Plan is terminated or comes to an end, your coverage in the CDHS Prescription Drug Program will also end.

For more information regarding:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends:

See Section 11, *When Coverage Ends* in the Consumer Directed Health Plan MBPD. To review the Plan document referenced above, go to **www.healthselectoftexas.com**.

If you are a retiree enrolled in the HealthSelect Medicare Advantage Plan administered by UnitedHealthcare, go to **www.HealthSelect-MAPPO.com** to review your plan document.

COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, *Glossary*.

For information on COBRA eligibility and enrollment, see Section 11, *When Coverage Ends* in the CDHS Health Plan MBPD. To review the Plan document referenced above, go to **www.healthselectoftexas.com**.

SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with Express Scripts and the ERS;
- Interpretation of the Program;
- Records; and
- How to access the MBPD.

Your Relationship with Express Scripts and ERS

In order to make choices about your Prescription Drug coverage, it is important for you to understand how Express Scripts interacts with the Program and how it may affect you.

ERS has contracted with Express Scripts as a third-party administrator of the Program to assist in the administration of the Program.

Express Scripts processes claims for benefits and communicates with you regarding decisions about whether the Program will cover the drugs or services that you may receive. The Program pays for Covered Drugs or Supplies, which are more fully described in this MBPD.

Express Scripts is not an employer or employee of ERS for any purpose with respect to the administration or provision of benefits under this Program.

Interpretation of the Program

ERS has discretion to interpret Program provisions, including this MBPD and any Amendment or Addendum.

ERS has delegated to Express Scripts the discretion to determine whether a drug service is a Covered Drug or Supply and how the Eligible Expenses will be determined and otherwise covered under the Program, according to guidelines established by the Program and/or Express Scripts.

In certain circumstances, for purposes of overall cost savings or efficiency, ERS, in its discretion, may approve Benefits for drugs or services that would otherwise not be Covered Drugs or Supplies. The fact that ERS does so in any particular case shall not in any way be deemed to require ERS to do so in other similar cases.

Records

All Participant records that are in the custody of ERS or Express Scripts are confidential and not subject to public disclosure under Chapter 552, Texas Government Code; Section 1551.063, Texas Insurance Code; they are subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

How to Access the Master Benefit Plan Document

A copy of this MBPD and other Program information may be downloaded from **www.HealthSelectRx.com.** You may also request a copy of this MBPD by making a written request to Express Scripts or calling Express Scripts toll-free at **(800) 935-7189** (TTY 711).

SECTION 13 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this MBPD.

Many of the terms used throughout this MBPD may be unfamiliar to you or have a specific meaning with regard to the way the Program is administered and how Benefits are paid. This section defines terms used throughout this MBPD, but it does not describe the Benefits provided by the Program.

Accredo Specialty Pharmacy – the Express Scripts specialty pharmacy.

Act – the Texas Employees Group Benefits Act (Texas Insurance Code, Chapter 1551).

Addendum – an attached written description of additional or revised provisions to the Program. The Benefits and exclusions of this MBPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and MBPD and/or Amendments to the MBPD, the Addendum shall be controlling.

Affordable Care Act (ACA) – federal law that includes the Patient Protection and Affordable Care Act (Public Law 111-148; March 23, 2010; 124 Stat. 119) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; March 30, 2010; 124 Stat. 1029), as amended. This is also referred to as the federal health care reform statute.

Allowable Amount – the allowable amount is the lesser of:

1. The Usual and Customary charge
2. The price specified on the Maximum Allowable Cost (MAC) List
3. The Average Wholesale Price less a contractually determined discount amount plus Dispensing Fee

See definitions within the *Glossary* for more information on Usual and Customary, Maximum Allowable Cost List, Dispensing Fee, and Average Wholesale Price.

Amendment – any attached written description of additional or alternative provisions to the Program. Amendments are effective only when distributed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Program, except for those that the Amendment specifically changes.

Annual Deductible – a set amount you pay out-of-pocket each Calendar Year for Covered Health Services and Covered Drugs before the HDHP/Program begins to pay for anything except Preventive Care services. **Authorized Representative –** a person authorized to act on behalf of a Participant. This does not include a Provider or other entity acting as an assignee of a Participant's claim. See Authorized Representative in Section 8, *Claims Procedures*, for information on how to properly designate an Authorized Representative. An Authorized Representative must be properly designated in order to protect against improper disclosure of information about a Participant including protected health or other confidential information.

Average Wholesale Price (AWP) – AWP is the list price charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Benefits – Program payments for Covered Drugs or Supplies, subject to the Act, the ACA, the Rules of the ERS Board of Trustees, the terms and conditions of the Program and any Addendums and/or Amendments.

Benefits Coordinator – a person employed by your Employer to provide assistance for Participants with various benefit programs, including the Program. ERS is the Benefits Coordinator for Retirees.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand-name – a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer.
- Identified by Express Scripts as a Brand-name product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as “brand name” by the manufacturer, Pharmacy, or your Prescriber may not be classified as Brand-name by Express Scripts.

Calendar Year – the annual period of time from January 1 to December 31, as distinguished from Plan Year which is from September 1 through August 31.

Clinical Criteria – Specific qualitative/quantitative guidelines used by Express Scripts for the purpose of determining drug coverage. These include criteria for Prior Authorization drugs (including Step Therapy), Quantity Limit drugs, formulary exception drugs, and benefit exclusion drugs. The criteria comes from the National Pharmacy and Therapeutics Committee. The committee is designed to ensure an unbiased clinical perspective from practicing physicians and pharmacists who reflect a variety of practice specialties. Before drug criteria is put into use, the committee thoroughly reviews and approves all criteria. Criteria is updated annually and more frequently when clinical changes are necessary.

Chemically Equivalent – when Prescription Drugs contain the same active ingredient.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Drugs at a Non-Network Pharmacy as described in Section 3, *How the Program Works*. The percentage of Eligible Expenses paid by the Program for Covered Drugs or Supplies is shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage at the insured’s expense to certain Employees and their Dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Drugs or Supplies as described in Section 3, *How the Program Works*.

Cosmetic Drug – a drug that is used primarily to enhance appearance, including, but not limited to: correction of skin wrinkles, skin aging and hair loss, even if the drug may have other non- cosmetic uses.

Covered Drug or Supply – any Prescription Drugs or supplies, other pharmaceutical products, services or supplies dispensed by a Pharmacy to a Participant for which coverage is provided in

accordance with this Program and which meets the following requirements:

- that meets Clinical Criteria and is ordered by a Prescriber naming a Participant as the recipient;
- for which a written or verbal Prescription Order or Refill is prepared by a Prescriber;
- for which a separate charge is customarily made;
- that is used for the purpose for which U.S. Food and Drug Administration (FDA) approval has been given, or used consistent with the applicable program criteria approved by the National Pharmacy & Therapeutics Committee;
- that is dispensed by a Pharmacy and is received by the Participant while covered under this Program, except when received in a Physician's or Other Provider's office, or during confinement while a patient in a Hospital or other acute care institution or Facility; and
- that is not identified in Section 7, *Exclusions: What the CDHS Prescription Drug Program Will Not Cover*, as not covered.

Covered Health Services – those health services, supplies and pharmaceutical products, which the Plan determines to be:

- meets Clinical Criteria;
- included in Sections 5 and 6, *Schedule of Benefits and Details for Covered Health Services*, described as a Covered Health Service in the Consumer Directed HealthSelect High-Deductible Health Plan;
- provided to a Participant who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction* in the Consumer Directed HealthSelect High-Deductible Health Plan; and
- not identified in Section 7, *Exclusions*: *What the Health Plan Will Not Cover,* as not covered in the Consumer Directed HealthSelect High-Deductible Health Plan. To review the Plan document referenced above, go to **www.healthselectoftexas.com**.

Dependent – an individual who, because of a statutorily defined relationship with a Subscriber, meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*, and is enrolled as a Participant in the Plan. A Dependent does not include anyone who is enrolled in the Plan as a Subscriber. No one can be enrolled as a Dependent of more than one Subscriber.

Dispense As Written (DAW) Penalty – the amount you pay for a Brand-name Drug when a Generic Drug is available. If you or your Prescriber chooses not to substitute a Generic Drug for the Brand-name Drug, you will pay the Generic Drug Coinsurance plus the difference in cost to the Program between the Generic Drug and the Brand-name Drug.

Dispensing Fee – agreed upon rate paid to the Pharmacy to cover costs associated with dispensing a medication.

Durable Medical Equipment (DME) – any medical equipment appropriate for use in the home to aid in a better quality of living for Participants with a Sickness, Injury or disability.

Eligible Expenses – prescription costs or other charges deemed under the Program contract as being eligible for coverage.

Employee – an appointive or elective state officer (including a judicial officer) or employee in the service of the state of Texas, including an employee of an Institution of Higher Education, as defined in Section 1551.003 of the Act and in this Glossary, and any persons required or permitted by the Act to enroll as Subscribers. Eligibility for participation in the Plan for Employees is limited to the specific

statutes that include them as Employees. This definition does not infer any greater eligibility for or right of access to the Benefits provided by this Program than the statutes establishing each class of eligible persons.

Employer – the state of Texas and all its agencies, certain political subdivisions or Institutions of Higher Education, as defined in this Glossary, that employ or employed a Subscriber.

Experimental or Investigational Services –refer to drugs, treatments, procedures, or medical technologies that are not yet widely accepted as standard practice within the medical community and have not been proven through sufficient, peer-reviewed clinical evidence to be safe and effective for the condition being treated. These services may still be undergoing clinical trials or may not have received approval from regulatory authorities such as the U.S. Food and Drug Administration (FDA) for the specific indication prescribed.

Exception:

- If you have a significantly life-threatening Sickness, Injury or other medical condition, ERS, or Express Scripts as its designee, may, at its discretion, consider an otherwise Experimental or Investigational item to be a Covered Drug, Supply and/or Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Program must first establish, based on good faith medical judgment supported by sufficient scientific evidence, that although Experimental or Investigational, the item has significant potential as an effective life- sustaining treatment for that Sickness, Injury or other medical condition.

  In making its determination, ERS, or Express Scripts as its designee, will refer to a certification the Participant's Physician must provide stating that he or she, based on good-faith medical judgment, believes:

  - the Sickness, Injury or other medical condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Drugs, Supplies and/or Covered Health Services; and
  - although designated as Experimental or Investigational, the item has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

Appeals from an Express Scripts pre-service decision not to consider the Experimental or Investigational Service to be a Covered Drug, Supply and/or Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures* of this MBPD.

Extended Days' Supply (EDS) Retail Pharmacy – a retail Pharmacy that has agreed to dispense a 60-90 day supply of certain Maintenance Medications to you at the same rates as a Mail Order Pharmacy.

Facility – a Hospital, alternate Facility, inpatient rehabilitation Facility, skilled nursing Facility, residential treatment Facility or urgent care center or other institution that is licensed to provide services and supplies covered by the Plan. In states where there is a licensure requirement, other Facilities must be licensed by the appropriate state administrative agency.

Formulary – the list of Prescription Drugs or other pharmaceutical products, services or supplies as developed by the Program and approved by ERS for use with and as covered by this Program. The Formulary will be made available to Physicians, Pharmacies and other healthcare Providers to guide the prescribing, dispensing, and sale of Covered Drugs or Supplies. See Preferred Drug List (PDL).

Generic – a Prescription Drug that is either:

- Chemically Equivalent to a Brand-name drug.
- Identified by Express Scripts as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a

number of factors.

You should know that all products identified as a "generic" by the manufacturer, Pharmacy or your Prescriber may not be classified as a Generic by Express Scripts.

Group Benefits Program (GBP) – the Texas Employees Group Benefits Program as established by the Act and administered by the ERS and its Board of Trustees pursuant to the Act.

HealthSelect℠ of Texas Plan or HealthSelect – a self-funded health benefit plan offered by ERS through the Texas Employees Group Benefits Program. It includes an In-Area Plan, a HealthSelect℠ Out-of-State Plan, a High-Deductible Health Plan that is part of Consumer Directed HealthSelect℠, a HealthSelect℠ Secondary Plan, and a Prescription Drug Program.

Hospital – an institution, operated as required by law, that:

- is primarily engaged in providing health care services, on an Inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorder, diagnostic and surgical Facilities, by or under the supervision of a staff of Physicians; and
- has 24-hour nursing services.

A Hospital is not primarily a place for rest, custodial care, domiciliary care or care of the aged and it is not a skilled nursing Facility, convalescent home or similar institution.

High-Deductible Health Plan(HDHP) – a self-funded health benefit plan offered through the Group Benefits Program by ERS as part of Consumer Directed HealthSelect.

Indication – the FDA-approved use of the drug.

Injury – bodily damage other than Sickness or disability, including all related conditions and recurrent symptoms.

Institution of Higher Education – a public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61, Texas Education Code. It does not include an entity in The University of Texas System, as described in Section 65.02, Texas Education Code, or an entity in The Texas A&M University System, as described in Subtitle D, Title 3, Texas Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

Mail Order Pharmacy – a Pharmacy that dispenses 60-90 day supply of certain Maintenance Medications to you through the mail.

Maintenance Medication – medications used for long periods of time to treat chronic conditions, for example, cholesterol-stabilizing or hypertension medications.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drugs that will be covered at a price level that Express Scripts establishes. This list is subject to Express Scripts' periodic review and modification.

Medical Emergency – a serious medical condition or symptom resulting from Injury, Sickness, or condition which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

The Program determines if a medical condition is an Emergency based on factors that include, but are not limited to, medical information supplied by the Participant's Provider.

Medically Necessary – Covered Drugs or supplies that meet "Clinical Criteria". Refer to the

glossary term “Clinical Criteria”.

Medicare – Parts A, B, C and D of the insurance program for Americans 65 years of age and over as well as younger Americans with certain disabilities, established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medication-Assisted Treatment (MAT) – is the use of FDA-approved medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

National Pharmacy & Therapeutics Committee – the committee that Express Scripts designates for, among other responsibilities, determining if a Prescription Drug should be considered a Covered Drug or Supply by the Program and classifying Covered Drugs or Supplies into specific Tiers.

Network –Network means a group of independent Pharmacies and chains of Pharmacies having a particular agreement for providing Prescription Drug services in a Network serving this Program.

Network Benefits – Benefits that the Program pays for Covered Drugs or Supplies provided by Network Pharmacies. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Network Benefits apply.

Network Pharmacy – a Pharmacy that has:

- Entered into an agreement with Express Scripts or an organization contracting on its behalf to provide Prescription Drugs to Participants;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Been designated by Express Scripts as a Network Pharmacy.

Non-Maintenance Medication – medications that are prescribed for temporary and often short- term conditions (for example, antibiotics and decongestants).

Non-Network – Non-Network means a Pharmacy or group of Pharmacies which have not entered into an agreement with Express Scripts to provide Pharmacy services to Participants covered under this Program.

Non-Network Benefits – Benefits that the Program pays for Covered Drugs or Supplies provided by Non-Network Pharmacies. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Non-Network Benefits apply.

Over-the-Counter Drugs (OTC) – drugs that may be purchased without a Prescription Order or Refill. A drug that may be otherwise purchased without a Prescription Order or Refill but is prescribed at a strength requiring a Prescription Order or Refill is not considered to be OTC.

Participant – an Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees, or other persons eligible for coverage as provided under the Act while eligible for coverage and enrolled under the Plan/Program. References to “you” and “your” throughout this MBPD are references to a Participant.

Pharmacy – a state and federally licensed establishment where the practice of pharmacy occurs that is physically separate and apart from any Physician’s or Other Provider’s office and where legend drugs (drugs that, by law, can be obtained only by prescription) and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he/she practices.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Please Note: The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

Please note: The fact that a Provider is described as a Physician does not mean that Benefits for

medications prescribed by that Provider are available to you under the Program.

Plan – HealthSelect of Texas, administered by (BCBSTX), including each of the HealthSelect℠ of Texas In-Area Plan, Consumer Directed HealthSelect℠ High-Deductible Health Plan, HealthSelect℠ of Texas Secondary Plan HealthSelect℠ of Texas Out-of-State Plan. For more information please go to **www.healthselectoftexas.com**.

Plan Administrator – the Employees Retirement System of Texas (ERS) or its designee.

Post-Service Claim – a claim for Benefits that is not a Pre-Service Request for Benefits or Urgent Care Request for Benefits. Post-Service Claims include claims that involve only the payment or reimbursement of Eligible Expenses for Covered Drugs or Supplies that have already been provided.

Preauthorization or Predetermination – see Prior Authorization under this section.

Predominant Reimbursement Rate – the amount Express Scripts will pay to reimburse you for a Prescription Drug that is dispensed at a Non-Network Pharmacy. At a Non-Network pharmacy, you are responsible for 100% of the Usual and Customary Charge, which includes the dispensing fee and any applicable sales tax. Express Scripts calculates the Predominant Reimbursement Rate using Express Scripts' Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

Preferred Drug List (PDL) – a list that categorizes Covered Drugs or Supplies into Tiers. This list is subject to the Program's periodic review and modification. Negative changes may occur twice a year (January 1 and July 1), and Participants who have recently taken a drug that is moving to a higher tier or being excluded under the Program will be notified by letter no fewer than 30 days prior to the change. Positive changes may occur monthly throughout the year. When that occurs, you may pay more or less for a Prescription Drug, depending on its Tier assignment. Since the PDL may change periodically, you can visit **www.HealthSelectRx.com** or call Express Scripts at **(800) 935-7189** (TTY 711) toll-free for the most current information.

Prescriber – any health care professional who is properly licensed and qualified by law to prescribe Prescription Drugs to humans and acts within the scope of that license. The fact that a Prescriber has prescribed a medication or product, or the fact that it may be the only available treatment for a Sickness (including mental illness, substance-related and addictive conditions), Injury, or disease (or its symptoms) does not make the product a Covered Drug or Supply under the Program.

Prescription Drug Charge – the rate Express Scripts has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy. You are responsible for paying the lowest of the:

- Applicable Copayment or Coinsurance amount;
- Network pharmacy's Usual and Customary Charge for the Prescription Drug; or
- Prescription Drug Charge that Express Scripts agreed to pay the Network Pharmacy.

Prescription Drug – a Brand-name or Generic medication or product that can, under federal or state law, only be dispensed as authorized by a Prescription Order by a Prescriber. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non- skilled caregiver. For purposes of Benefits under this Program, this definition includes, but is not limited to:

- inhalers (with spacers);
- insulin; and
- standard insulin syringes with needles.

Prescription Order or Refill – a written or verbal order from a Prescriber to a pharmacist for a drug to be dispensed.

Pre-Service Request for Benefits – a claim for Benefits where the Program conditions receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the drug(s). This includes Covered Drugs or Supplies which the Program must approve or for which you must obtain Prior Authorization from Express Scripts before non-urgent care is provided.

Preventive Care – Services, medications and other items that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include, as required under applicable law, evidence-based medications that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

Primary or Primary Plan – when you are covered by more than one health benefit plan, the Primary Plan is the plan that pays benefits first under coordination of benefits (COB) guidelines. Remaining Eligible Expenses may be paid under the other plan, which is called the Secondary Plan. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Prior Authorization – (sometimes known as preauthorization or predetermination) the utilization review process that the Program uses to determine whether certain drugs are Covered Drugs or Supplies under the Program. The drugs and conditions for coverage are recommended by the National Pharmacy and Therapeutics Management Committee and are subject to periodic review and modification. If a Prescription Drug is not prior authorized or exceeds the Quantity Limit, the Participant will be responsible for the entire cost of the Prescription Drug once the limits have been exceeded. See Section 4, *Utilization Management* for the list of drugs requiring Prior Authorization and for details on the Prior Authorization process.

Program – The Consumer Directed HealthSelect (CDHS) Prescription Drug Program, administered by Express Scripts.

Provider – a Facility, Hospital, Physician or other Provider (all as defined in this section) or other Provider that is licensed to provide health care services and supplies and acts within the scope of that license.
Other Providers include, but are not limited to, the following when acting within the scope of his or her license:

- Doctor of Chiropractic;
- Doctor of Medical Dentistry;
- Doctor of Dental Surgery;
- podiatrist;
- licensed audiologist;
- licensed dietitian;
- licensed hearing aid fitter and dispenser;
- licensed speech, physical or occupational therapist;
- optometrist or ophthalmologist;
- Physicians’ Assistant;
- advanced practice nurse;
- licensed surgical assistant;
- Nurse-Anesthetist;
- DME/prosthetics provider;

- Home Health Agency;
- Network home infusion therapy provider; and
- Convenience Care Clinic.

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Quantity Limit – a process applied to selected classes of drugs to limit the amount of medication dispensed to an amount agreed upon per nationally recognized guidelines. Quantity Limits are recommended by the National Pharmacy and Therapeutics Management Committee and are subject to periodic review and modification. If a Prescription Drug exceeds the Quantity Limit, the Participant will be responsible for the entire cost of the Prescription Drug. See Section 4 *Utilization Management* for more information on Quantity Limits and drugs that may be subject to them.

Retiree – (also known as annuitant) an Employee who has retired as defined in the Act.

Routine Vaccines – Vaccines recommended for infectious diseases. Coverage may be subject to guidelines based on age, risk factors, dosage and frequency. See Section 6, *Details for Covered Drugs and Supplies* under the heading **Routine Vaccines** for more information.

Secondary or Secondary Plan – when you are covered by more than one health benefits plan, the Secondary Plan is the plan that pays benefits second, following the Primary Plan, under coordination of benefits (COB) guidelines. The Secondary Plan may or may not pay all remaining Allowable Amounts after the Primary Plan has paid, depending on how COB is determined. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Sickness – physical illness, disease or conditions related to pregnancy. The term Sickness as used in this MBPD includes mental illness and substance-related and addictive disorder, regardless of the cause or origin of the mental illness or substance-related and addictive disorder.

Specialty Prescription Drugs – Prescription Drugs that are used in the treatment of rare or complex conditions and typically administered by injection or infusion, may be high cost, may have special delivery and storage requirements, and/or require close monitoring or care coordination by a pharmacist or Prescriber. To find out whether a medication you take is considered a Specialty Prescription Drug, call Express Scripts at **(800) 935-7189** (TTY 711) toll-free or go to **www.HealthSelectRx.com**, choose your medication name and click on “More Information.”

Step Therapy – Step Therapy is a process applied to certain Covered Drugs or Supplies under the Program to contain costs and ensure the most appropriate use of drugs for the treatment of your condition. For Covered Drugs or Supplies that are subject to Step Therapy requirements, you must try the most cost-effective drug therapy first before the Program will cover the more costly drugs, if appropriate, for the treatment of your condition.

Subscriber – the Participant who is the Employee, Retiree, or other person enrolled in the Program as provided for under the Act, and who is not a Dependent.

Therapeutically Equivalent – when Prescription Drugs have essentially the same clinical effectiveness and safety characteristics.

Tier – a Coinsurance level for Covered Drugs or Supplies. There are three Tiers for Covered Drugs or Supplies on the Preferred Drug List (PDL) under the Program. See Section 3 *How the Program Works* for information.

Trustee – the Board of Trustees of the Employees Retirement System of Texas (ERS).

Total Network Out-of-Pocket Maximum – the most you are required to pay each Calendar Year for both Network Prescription Drug and Network medical benefits including: Annual Deductibles and Coinsurance,

as detailed in Section 5, *Schedule of Benefits and Coverage*. Refer to Section 3 *How the Program Works*, for a description of how the Total Network Out-of-Pocket Maximum works.

Unproven Services - drugs that have not been shown through reliable clinical evidence to be effective and safe for treating the condition for which they are prescribed or used.

Express Scripts has a process by which it compiles and reviews clinical evidence with respect to certain covered services. From time to time, Express Scripts issues drug policies that describe the clinical evidence available with respect to specific prescription drug services. These drug policies are subject to change without prior notice. For information on a certain policy, please call a representative toll-free at **(800) 935-7189** (TTY 711).

Note: If you have a significantly life-threatening Sickness, Injury or other condition, ERS, or Express Scripts as its designee may, at its discretion, consider an otherwise Unproven item to be a Covered Drug, Supply and/or Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Program must first establish, based on good faith medical judgment supported by sufficient scientific evidence that albeit unproven, the item has significant potential as an effective treatment for that Sickness, Injury or other condition.

In making its determination, ERS, or Express Scripts as its designee, will refer to a certification the Participant's Physician must provide stating that he or she, based on good-faith medical judgment, believes:

- the Sickness, Injury or other condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Drugs, Supplies and/or Covered Health Services; and
- although designated as Experimental or Investigational, the item has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Unproven item, the Program may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Program reserves the right to obtain expert opinion(s) in determining whether an otherwise Unproven item shall be considered as a Covered Drug, Supply and/or Covered Health Service for a particular Sickness, Injury or other condition. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Program's sole discretion.

Appeals from an Express Scripts decision not to consider the Unproven item to be a Covered Drug, Supply and/or Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures,* of this MBPD.

Urgent Care – Health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health,

Urgent Care Request for Benefits – for the purposes of this MBPD, a claim for medications with respect to which application of the time periods for making non-urgent determinations (a) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or (b) in the opinion of the Participant's Prescriber, would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Usual and Customary Charge – the usual fee that a Pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax

SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Program administrative information.

This section includes information on the administration of the Program. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Administrator: The Plan Administrator is the Employees Retirement System of Texas (ERS). ERS may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of administrative services including arrangement of access to a Network Pharmacy; claims processing and payment services, including coordination of Benefits, utilization management and complaint resolution assistance. This contracted administrator for the Program is the claims administrator, Express Scripts, a subsidiary of UnitedHealth Group. For Benefits as described in this MBPD, ERS also has selected a Pharmacy Network established by Express Scripts.

The Employees Retirement System of Texas
200 East 18th Street
Austin, TX 78701
(877) 275-4377

ERS retains all fiduciary responsibilities with respect to the Program except to the extent ERS has allocated to other persons or entities one or more fiduciary responsibilities, as it has to Express Scripts with respect to the Program.

Claims Administrator: The company that provides certain administrative services for the Program described in this MBPD. The claims administrator for the Program is Express Scripts.

Express
Scripts 1
Express
Way
St. Louis, MO 63121
(800) 935-7189 (TTY
711)

Express Scripts Pharmacy shall not be deemed or construed as Employers for any purpose with respect to the administration or provision of Benefits under the Program. Express Scripts Pharmacy shall not be responsible for fulfilling any duties or obligations of an Employer with respect to the Program.

ATTACHMENT I - THE EMPLOYEES RETIREMENT SYSTEM OF TEXAS SUMMARY NOTICE OF PRIVACY PRACTICES

The Employees Retirement System of Texas ("ERS") administers the Texas Employees Group Benefits Program, including your health plan, pursuant to Texas law. THIS NOTICE DESCRIBES HOW ERS MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO YOUR OWN INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") PRIVACY RULE. PLEASE REVIEW THIS NOTICE CAREFULLY.

Uses and Disclosures of Health Information:

ERS and/or a third-party administrator under contract with ERS may use health information about you on behalf of your health plan to authorize treatment, to pay for treatment, and for other allowable health care purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods.

By law, ERS may use or disclose identifiable health information about you without your authorization for several reasons, including, subject to certain requirements, for public health purposes, for auditing purposes, for research studies, and for emergencies. ERS provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, ERS will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. ERS cannot use or disclose your genetic information for underwriting purposes. ERS may change its policies at any time. When ERS makes a significant change in its policies, ERS will change its notice and post the new notice on the ERS website at **www.ers.texas.gov**. Our full notice is available at https://www.ers.texas.gov/PDFs/Forms/HIPAA-Notice-of-Privacy-Practices- long-form

For more information about our privacy practices, contact the ERS Privacy Officer. ERS originally adopted its Notice of Privacy Practices and HIPAA Privacy Policies and Procedures Document April 14, 2003, and subsequently revised them effective February 17, 2010, and September 23, 2013.

Individual Rights:

In most cases, you have the right to look at or get a paper or electronic copy of health information about you that ERS uses to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. For all authorized or by law requests made by others, the requestor will be charged for production of medical records per ERS' schedule of charges. You also have the right to receive a list of instances when we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that ERS correct the existing information or add the missing information. You have the right to request that ERS restrict the use and disclosure of your health information above what is required by law. If ERS accepts your request for restricted use and disclosure then ERS must abide by the request and may only reverse its position after you have been appropriately notified. You have the right to request an alternative means of communications with ERS. You are not required to explain why you want the alternative means of communication.

Complaints:

If you are concerned that ERS has violated your privacy rights, or you disagree with a decision ERS has made about access to your records, you may contact the ERS Privacy Officer. You also may send a written complaint to the U.S. Department of Health and Human Services. The ERS Privacy Officer

can provide you with the appropriate address upon request.

Our Legal Duty:

ERS is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this Notice, and obtain your acknowledgment of receipt of this Notice.

Detailed Notice of Privacy Practices:

For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Office of the Privacy Officer or by visiting ERS' web site at **www.ers.texas.gov**. If you have any questions or complaints, please contact the ERS Privacy Officer by calling (512) 867-7711 or toll-free **(877) 275-4377** or by writing to ERS Privacy Officer, The Employees Retirement System of Texas, P.O. Box 13207, Austin, TX 78711-3207.

ADDENDUM – LIST OF COVERED PREVENTIVE CARE MEDICATIONS AND DEVICES

Express Scripts' standard offering is based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), in conjunction with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), along with the Health Resources and Services Administration (HRSA). Coverage is subject to guidelines based on age, risk factors, dosage, and frequency.

Covered Preventive Care Medications[1,2,3]

- Tobacco cessation medications (Age: 18 years and older), max quantity of 180 days/365-day period; additional Rx at standard coinsurance
  - Nicotine replacement gum, lozenge, or patch
  - bupropion, Nicotrol, Varenicline
- Aspirin only generic, single-entity aspirin 81mg
- Statins available at $0 cost-share
  - Lovastatin (all strengths)
  - Atorvastatin 10 & 20mg
  - Simvastatin 5, 10, 20 & 40mg
- Routine Vaccines (when administered at a Network Pharmacy) See Section 6, *Details for Covered Drugs and Supplies* under the heading **Routine Vaccines** for more information Colonoscopy preparation products (generics only) ages 45 to 75
  - Bisacodyl EC tab
  - Magnesium Citrate Sol
  - PEG 3350 (generic Miralax)
  - Generic Colyte, Generic Golytely, Generic Nulytely
- HIV Pre-exposure Prophylaxis (PrEP)
  - Emtricitabinel Tenofovir Disoproxil Fumarate 200mg/300mg (Generic Truvada)
- Generic Rx/OTC single-entity and combination Fluoride oral tablets and solution providing greater than or equal to 1.0mg/day for children age 6 months through 16 years
- Breast cancer preventive medications, tamoxifen, raloxifene, Anastrozole, exemenstane, and Soltamox
- Folic Acid – Generic only (Rx/OTC) 0.4-0.8mg; single-entity and combination products
- Contraceptive Methods including:
  - Birth Control Shot/Injection
  - Oral Contraceptives, Birth Control Pills
  - Birth Control Patch
  - Vaginal Contraceptive Ring
  - Diaphragm
  - Sponge
  - Cervical Cap
  - Female and Male Condom
  - Spermicide
  - Emergency Birth Control

Note: Surgical contraceptive categories (surgical sterilization and surgical sterilization implant) may be covered under the HealthSelect of Texas plan. For more information, visit **www.healthselectoftexas.com**.

Routine Vaccine Coverage may be subject to guidelines based on age, risk factors, dosage, and frequency.

[1] In order to be considered a Covered Drug or Supply under the Program, a valid Prescription Order or Refill must be provided for all Preventive Care medications and devices listed within this Addendum.

[2] Certain preventive medications (including certain contraceptives) may be covered without any Participant cost share dependent upon Generic availability. Under the Affordable Care Act, certain contraceptive methods are paid at 100% (i.e., at no cost to the Participant). In some cases, you will be responsible for payment.

[3] If a Generic Drug is available and you choose to buy the Brand-name Drug, you will pay the Coinsurance plus the difference in cost between the Brand-name Drug and the Generic Drug. (This is referred to as the Dispense As Written Penalty.)