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

Effective: September 1, 2015
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SECTION 1 - WELCOME

Quick Reference Box

■ Participant services, claim inquiries, Prior Authorization, Appeals: Contact Caremark toll-free at (888)886-8490.

■ Claims submittal address:
  
  Caremark Paper Claims
  PO Box 52136
  Phoenix AZ 85072-2136

■ Online assistance: www.caremark.com/ers

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

The HealthSelect℠ of Texas Prescription Drug Program (Program) is separately administered by Caremark and provides prescription drug Benefits to HealthSelect Participants. This Master Benefit Plan Document (MBPD) describes the prescription drug Benefits available to you and your eligible covered family members. It includes information regarding:

■ who is eligible;

■ medications and products that are covered under this Program, called Covered Drugs;

■ medications and products that are not covered, called Exclusions;

■ 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 if it is Medically Necessary. (See definitions of Medically Necessary and Covered Drug in Section 13, Glossary.) The fact that a Physician or other Provider has prescribed a medication or product, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not make the product a Covered Drug 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 HealthSelect of Texas Prescription Drug Program works. If you have questions, contact your Benefits Coordinator or HHS Employee Service Center, or call Caremark at (888)886-8490 toll-free.
IMPORTANT
All definitions, terms, and provisions recited in the Master Benefit Plan Document- Employees Retirement System of Texas HealthSelect℠ of Texas Managed Care (In-Area Benefits) Plan and the Master Benefit Plan Document- Employees Retirement System of Texas HealthSelect℠ of Texas Comprehensive Medical Care (Out-of-Area) Plan, except those contained in Sections 3 through 7, and 11, are hereby adopted and shall be construed to apply in like manner and with equal force to this Program; provided, that if any such provisions are in conflict with provisions herein contained, the provisions of this Program shall govern in 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.caremark.com/ers](http://www.caremark.com/ers) or request printed copies by calling Caremark toll-free at (888)886-8490.

- 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.

- The Employees Retirement System of Texas (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.
SECTION 2 - INTRODUCTION

IMPORTANT

Your enrollment in the HealthSelect℠ of Texas Prescription Drug Program is determined based upon your enrollment in the HealthSelect of Texas medical Plan (through United Healthcare). If you are enrolled in the HealthSelect of Texas Medical Managed Care (In-Area Benefits) Plan or Comprehensive Medical Care (Out-of-Area Benefits) Plan, you are automatically enrolled in either the HealthSelect of Texas Prescription Drug Program through Caremark, or the HealthSelect Medicare Rx plan through SilverScript Insurance Company, dependent upon your employment status and Medicare eligibility status.

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 HealthSelect of Texas Managed Care (In-Area Benefits) Plan or the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan. 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 and Non-Network Benefits;
- Coverage While Traveling Abroad;
- Annual Prescription Drug Deductible;
- Prescription drug Copayment;
- Coinsurance;
- Total Network Out-of-Pocket Maximum;
- Dispense As Written (DAW) Penalty

Accessing Benefits
You can choose to receive Network Benefits or Non-Network Benefits. Generally, when you receive Covered Drugs 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 will be lower if you use a Network Pharmacy.

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 them.

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

Non-Network Benefits apply to Covered Drugs that are provided by a Non-Network Pharmacy.

Looking for a Participating Pharmacy?
In addition to other helpful information, www.caremark.com/ers, HealthSelect's dedicated website, contains a directory of Network Pharmacies. While Network status may change from time to time, www.caremark.com/ers has the most current source of Network information. Use www.caremark.com/ers to search for Pharmacies available in your Program.

Network Pharmacies
Caremark arranges for Pharmacies to participate in the Network. At your request, Caremark 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, you can call Caremark at toll-free at (888)886-8490 or go to www.caremark.com/ers.

Coverage While Traveling Abroad
The Program pays limited Benefits for a Participant while traveling outside the United States. In order for a claim to be considered a Covered Drug, a valid Prescription Order written by a Physician or Other Provider within the United States of America must be written.

Eligible Expenses for medications dispensed while outside the United States are reimbursed at the Non-Network Benefit level. Any medication received must be a Covered Drug 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 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 Caremark as described in Section 8, Claims Procedures. If you have any questions about Benefits while traveling abroad, or before you travel, please call Caremark toll-free at (888)886-8490. To obtain a claims form, go to www.caremark.com/ers.

Don’t Forget Your HealthSelect Prescription Drug Program ID Card
Remember to show your HealthSelect Prescription Drug Program ID card every time you receive Covered Drugs 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.

Annual Prescription Drug Deductible
The Annual Prescription Drug Deductible is the amount you must pay each Calendar Year for Covered Drugs before you are eligible to begin receiving prescription drug Benefits.

The Annual Prescription Drug Deductible for each Participant is $50.

Prescription Drug Copayment
A prescription drug Copayment (Copay) is the amount you pay each time you receive Covered Drugs. The Copay is a fixed dollar amount and is paid at the time of service when receiving a Covered Drug. If the cost of the Covered Drug is less than the Copay, you are only responsible for paying the cost of the Covered Drug.

Network prescription drug Copays count toward the Total Network Out-of-Pocket Maximum.

Coinsurance
Coinsurance is a fixed percentage that you are responsible for paying for Covered Drugs received from a Non-Network Pharmacy. The amount you pay for Coinsurance for Covered Drugs received at a Non-Network Pharmacy is determined after you pay any applicable Copays and the Annual Prescription Drug Deductible.

The payments you make as Coinsurance do not apply to your Total Network Out-of-Pocket Maximum, since Coinsurance only applies to Covered Drugs received from a Non-Network Pharmacy under the Program.

Examples

Coinsurance: Let's assume that you receive a Covered Drug from a Non-Network Pharmacy. The Program pays 60% of the remaining balance as calculated using the lesser of (a) or (b) below:

a) The Usual and Customary price of the drug, minus the Annual Prescription Drug Deductible (if not met) and less the Copay amount; or

b) The ERS discounted price of the drug, plus any applicable Dispensing Fees, minus the Annual Prescription Drug Deductible (if not met) and less the Copay amount;

Therefore, you are responsible for paying the applicable drug Copay, and the other 40%. This 40% is your Coinsurance.

Copay: Let's assume that you receive a Generic Drug from a Network Pharmacy at the Tier 1 level. Your Tier 1 Copay is $10 and the Program pays 100% after you pay the Copay.
Total Network Out-of-Pocket Maximum

The Total Network Out-of-Pocket Maximum is the Plan/Program's overall limit on the amount you will pay out of pocket for your Network cost sharing for Covered Health Services and Covered Drugs each Calendar Year. The Total Network Out-of-Pocket Maximum includes Copays, Coinsurance (medical only) and applicable Deductibles, as described below. Once you reach the Total Network Out-of-Pocket Maximum, you will not be required to pay any more out-of-pocket expenses for Network Benefits for the remainder of the Calendar Year, except as noted below.

Note: There is no Total Out-of-Pocket Maximum for Non-Network Benefits. See Table 1 below and Table 2 in Section 5, Schedule of Benefits and Coverage, for details on what applies to the Total Network Out-of-Pocket Maximum.

If your eligible out-of-pocket expenses, except as noted below, in a Calendar Year exceed the annual maximum, the Plan/Program pays 100% of Eligible Expenses for Covered Health Services and Covered Drugs for that level of Benefits through the end of the Calendar Year.

Table 1 below identifies what does and does not apply toward your Total Network Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Program Features</th>
<th>Applies to the Total Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments toward the Annual Prescription Drug Deductible for Covered Drugs received from a Network Pharmacy</td>
<td>Yes</td>
</tr>
<tr>
<td>Payments toward the Annual Prescription Drug Deductible for Covered Drugs received from a Non-Network Pharmacy</td>
<td>No</td>
</tr>
<tr>
<td>Copays for Covered Drugs received from a Network Pharmacy</td>
<td>Yes</td>
</tr>
<tr>
<td>Copays for Covered Drugs received from a Non-Network Pharmacy</td>
<td>No</td>
</tr>
<tr>
<td>Coinsurance payments for Covered Drugs received from a Non-Network Pharmacy</td>
<td>No</td>
</tr>
<tr>
<td>The payment you make for a Non-Preferred Brand Name Drug when a Generic Drug is available (also referred to as the Dispense as Written Penalty)</td>
<td>No</td>
</tr>
<tr>
<td>Medications, services or supplies that are for non-Covered Health Services or conditions excluded under the Plan or Program</td>
<td>No</td>
</tr>
<tr>
<td>For Covered Drugs that require Prior Authorization, the amount you pay if you do not obtain Prior Authorization</td>
<td>No</td>
</tr>
<tr>
<td>For Covered Drugs that are subject to Step Therapy requirements, the amount you pay for a Preferred Brand Name Drug or Non-Preferred</td>
<td>No</td>
</tr>
</tbody>
</table>
TABLE 1

<table>
<thead>
<tr>
<th>Program Features</th>
<th>Applies to the Total Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name Drug if Step Therapy requirements have not been met</td>
<td></td>
</tr>
</tbody>
</table>

Dispense As Written (DAW) Penalty

The Dispense As Written (DAW) Penalty is the amount you pay for a Non-Preferred Brand Name Drug when a Generic Drug is available. In these instances, you pay the Tier 1 Copay plus the difference in cost to the Program between the Generic Drug and the Non-Preferred Brand Name Drug.

**Example**: You fill a prescription for Imitrex at a Network Pharmacy. Imitrex is a Tier 3 (Non-Preferred Brand Name Drug) with a cost to the program of $521.83. The generic equivalent for Imitrex is available at the Tier 1 (Generic Drug) level under the Program, and has a cost to the Program of $7.71. You choose to fill your Prescription for Imitrex instead of the generic alternative. For your Imitrex, you pay the $10 Generic Drug Copay plus $514.12 (the difference in cost between the Generic Drug and Non-Preferred Brand Drug), equaling $524.12.

How the Program Works - Example

The following example illustrates how the Annual Prescription Drug Deductible, Copays, Coinsurance, and the Total Network Out-of-Pocket Maximum work.

Let's say Gary has individual coverage under the Program. He has met his Annual Prescription Drug Deductible ($50) and needs to fill a medication from a Pharmacy. The flow chart below shows what happens when he visits a Network Pharmacy versus a Non-Network Pharmacy.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gary goes to his Network Pharmacy, and presents his HealthSelect Prescription Drug Program ID card.</td>
<td>1. Gary goes to a Non-Network Pharmacy, and presents his HealthSelect Prescription Drug Program ID card.</td>
</tr>
<tr>
<td>2. He hands the Pharmacy a Prescription Order for a 30-days’ supply of a Maintenance Medication under the Program, covered at the Tier 1 level.</td>
<td>2. He hands the Non-Network Pharmacy a Prescription Order for a 30-days’ supply of a Maintenance Medication under the Program, covered at the Tier 1 level ($10 Copay + 40% Coinsurance).</td>
</tr>
</tbody>
</table>
### Network Benefits

3. The Average Wholesale Price (AWP) of the medication is $30. The cost of his medication is $30, which is **more than** the cost of the Tier 1 copay ($10), so Gary pays a $10 Copay. Since Covered Drugs received at a Network Pharmacy are covered at 100% after the Copay, Gary does not pay any Coinsurance and he has met his financial obligations for this prescription.

4. The Program pays $20 ($30 drug cost minus the $10 Copay).

5. Caremark applies the $10 toward Gary's Total Network Out-of-Pocket Maximum.

### Non-Network Benefits

3. The Average Wholesale Price (AWP) of the drug is $30. Since the Pharmacy does not participate in the Network, Gary is responsible for paying the full cost ($30) of the Covered Drug to the Pharmacy when he receives it and must submit a claim to receive any reimbursement.

**Note: In some instances, Non-Network Pharmacies will charge much more than the AWP cost. Since the Program calculates reimbursement amounts based off of the AWP price, in these instances, members may be responsible for a majority, if not all, of the cost of the medication.**

4. Gary submits the Non-Network Pharmacy claim to Caremark for processing. After Caremark processes the claim from the Pharmacy, the Program pays 60% Coinsurance, after the Copay has been met. Gary is reimbursed $12 by Caremark ($30 drug cost, minus the $10 copay, multiplied by 60% = $12.)

5. Gary's financial responsible was $18 for his medication. ($10 Copay plus 40% Coinsurance after the Copay is applied.)

Since this claim is for a Covered Drug at a Non-Network Pharmacy, no Benefits apply to the Total Network Out-of-Pocket Maximum.
SECTION 4 – UTILIZATION MANAGEMENT

What this section includes:

- How to obtain Prior Authorization for certain Covered Drugs;
- What Covered Drugs require Prior Authorization;
- Quantity Limits;
- What Covered Drugs are subject to Quantity Limits;
- Step Therapy; and
- What Covered Drugs are subject to Step Therapy requirements.

Prior Authorization

The Program requires Prior Authorization for certain Covered Drugs. Your Prescribing Physician is responsible for obtaining Prior Authorization before you receive these medications.

It is recommended that you confirm with Caremark that all Covered Drugs you have been prescribed are listed within the Formulary and have been prior authorized as required.

To obtain Prior Authorization, have your provider call (800)294-5979 toll-free. This call starts the Prior Authorization review process. The Prior Authorization process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, prescription drugs. Once your physician has obtained the authorization, please review the documentation carefully so that you understand what prescriptions have been authorized.

Covered Drugs that Require Prior Authorization

Your Providers are responsible for obtaining Prior Authorization from Caremark before you receive certain Covered Drugs under the Program.

Covered Drugs that require Caremark’s Prior Authorization include, but are not limited to:

- All Specialty Drugs, such as Revlimid, Enbrel, Humira, Avonex, Xolair, Synagis and Harvoni;

  Note: Specialty Drugs are also subject to Specialty Guideline Management (SGM) requirements, as discussed in this Section 6, Details for Covered Drugs.

- Infertility drugs, such as Clomid, Milophene, and Serophene;
- The narcolepsy medication Xyrem;
- The neuropathic pain medication, Lidoderm;
- For quantities of influenza prevention medications above the covered limit, Tamiflu and Relenza;
- Certain controlled substances, such as Fentanyl, Oxycontin, Lazanda, and Subsys; and
- Multi-ingredient compounds with a total cost or $300 or more.

For a complete list of drugs that require Prior Authorization, visit www.caremark.com/ers or call (888)886-8490 to obtain a copy of the Program’s Formulary.

If your Provider does not obtain Prior Authorization from Caremark, as applicable, the Program will not pay any Benefits for Covered Drugs subject to Prior Authorization as described above.
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 Pharmacy and Therapeutics Committee to ensure that drugs are being used in quantities that are safe and appropriate.

If a Prescription Order for a drug filled by a Pharmacy exceeds the Quantity Limit established for that drug, you are responsible for the entire cost of the quantity of the drug that exceeds the Quantity Limit.

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

Covered Drugs that are subject to Quantity Limits

Covered Drugs that are subject to Quantity Limits under the Program include, but are not limited to:

- Influenza – Tamiflu and Relenza;
- Erectile Dysfunction Drugs – Cialis, Levitra, and Viagra;
- Oxycontin in 40mg, 60mg, and 80mg doses; and
- Stadol nasal spray

Note: Covered Drugs that are subject to Quantity Limits may have a post limit Prior Authorization process available, which will allow you to obtain more than the Quantity Limit of the drug if certain clinical criteria are met. For more information on this post limit Prior Authorization process, call Caremark (888)886-8490 toll-free.

For a complete list of drugs that are subject to Quantity Limits, visit www.caremark.com/ers or call (888)886-8490 to obtain a copy of the Program’s Formulary.

Step Therapy

Step Therapy is a process applied to certain Covered Drugs under the Program to contain costs and ensure the most appropriate use of drugs for the treatment of your condition. 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. This requires you to try a Generic Drug within a drug class first before the Preferred Brand Name Drug or Non-Preferred Brand Name Drug would be covered.

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

Covered Drugs that are subject to Step Therapy

Covered Drugs that are subject to Step Therapy requirements under the Program include, but are not limited to:

- Ace Inhibitors/ARBs – Benicar, Benicar HCT, Tekturna, Tekturna HCT;
- COX-2 Inhibitors/NSAIDS – Cambia, Nalfon, Voltaren Gel, Zipsor, Zorvolex;
- Statins – Crestor (excluding 40 mg), Simcor, and Vytorin; and
- Sleep Aids – Edluar, Silenor, Zolpimist

For a complete list of drugs that are subject to Step Therapy requirements, visit www.caremark.com/ers or call (888)886-8490 to obtain a copy of the Program’s Formulary.

**Note:** If you are unable to take the generic equivalent of a Covered Drug that is subject to Step Therapy requirements due to a medical condition or complication, you may be eligible to obtain coverage of the Brand Name Drug if certain clinical criteria are met. For more information on this Step Therapy exceptions process, call Caremark (888)886-8490 toll-free.
SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Table 2 below contains the Program’s Network Copays, Annual Prescription Drug Deductible, and Total Network Out-of-Pocket Maximum for Covered Drugs under the Program.

<table>
<thead>
<tr>
<th>Table 2- Network Benefits for Covered Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Features</strong></td>
</tr>
<tr>
<td><strong>Annual Prescription Drug Deductible</strong></td>
</tr>
</tbody>
</table>
| (per Calendar Year)
| $50 per Participant                         |

<table>
<thead>
<tr>
<th><strong>Program Features</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong> (Copay is per prescription)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Network Retail Pharmacy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong> (Typically Generic Drugs)</td>
</tr>
<tr>
<td>Up to a 30-day supply per prescription (or refill) of Non-Maintenance Medication</td>
</tr>
<tr>
<td>Up to a 30-day supply per prescription (or refill) of Maintenance Medication</td>
</tr>
<tr>
<td>Up to a 30-day supply of insulin</td>
</tr>
<tr>
<td>Up to a 30-day supply of each diabetic oral agent</td>
</tr>
<tr>
<td>Disposable syringes for up to a 30-day supply of insulin</td>
</tr>
<tr>
<td>Certain preventive medications (including female contraceptives)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Network Mail Order Pharmacy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong> (Typically Generic Drugs)</td>
</tr>
<tr>
<td>Up to a 90-day supply per prescription (or refill) Maintenance Medication*</td>
</tr>
<tr>
<td>Up to a 90-day supply of insulin</td>
</tr>
<tr>
<td>Item</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Up to a 90-day supply of each diabetic oral agent</td>
</tr>
<tr>
<td>Disposable syringes for up to a 90-day supply of insulin</td>
</tr>
</tbody>
</table>

**Network Extended Days' Supply (EDS) Retail Pharmacy**

<table>
<thead>
<tr>
<th>Item</th>
<th>Tier 1 (Typically Generic Drugs)</th>
<th>Tier 2(^4) (Typically Preferred Brand Name Drugs)</th>
<th>Tier 3(^4) (Typically Non-Preferred Brand Name Drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to a 90-day supply per prescription (or refill) Maintenance Medication*</td>
<td>$30</td>
<td>$105</td>
<td>$180</td>
</tr>
<tr>
<td>Up to a 90-day supply of insulin</td>
<td>$30</td>
<td>$105</td>
<td>$180</td>
</tr>
<tr>
<td>Up to a 90-day supply of each diabetic oral agent</td>
<td>$30</td>
<td>$105</td>
<td>$180</td>
</tr>
<tr>
<td>Disposable syringes for up to a 90-day supply of insulin</td>
<td>$105</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Network Out-of-Pocket Maximum\(^1\)**

<table>
<thead>
<tr>
<th>Total Network Out-of-Pocket Maximum (per Calendar Year)(^7)</th>
<th>Per Participant</th>
<th>Per Family(^6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,450</td>
<td>$12,900</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) The Annual Prescription Drug Deductible and Total Network Out-of-Pocket Maximum are per Calendar Year (January 1 - December 31).

\(^2\) Copays only apply after the Annual Prescription Drug Deductible has been met.

\(^3\) If the cost of your Covered Drug is less than the applicable Copay, you pay the cost of the drug instead of the Copay.

\(^4\) If a generic is available and you chose to buy the Brand Name Drug, you will pay the Generic Drug Copay 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 female contraceptives) may be covered without any Participant cost share dependent upon generic availability. Under the Affordable Care Act, 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 Preferred Brand Name Drug or Non-Preferred Brand Name Drug when a Generic 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 Copays, Coinsurance, and applicable Deductibles for both medical and pharmacy Network Benefits.
Table 3 below contains the Program’s Non-Network Copays, Coinsurance, and the Annual Prescription Drug Deductible for Covered Drugs. **Note:** There is no Total Out-of-Pocket Maximum for Non-Network Benefits.

<table>
<thead>
<tr>
<th>Table 3- Non-Network Benefits for Covered Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Features</strong></td>
</tr>
<tr>
<td><strong>Annual Prescription Drug Deductible</strong></td>
</tr>
<tr>
<td><strong>Copays</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Network Retail Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong></td>
</tr>
<tr>
<td>(Typically Generic Drugs)</td>
</tr>
<tr>
<td>- Up to a 30-day supply per prescription (or refill) of Non-Maintenance Medication</td>
</tr>
<tr>
<td>$10 + 60% after you pay the Copay</td>
</tr>
</tbody>
</table>

| **Tier 2**                                       |
| (Typically Preferred Brand Name Drugs)          |
| - Up to a 30-day supply per prescription (or refill) of Maintenance Medication |
| $35 + 60% after you pay the Copay                |

| **Tier 3**                                       |
| (Typically Non-Preferred Brand Name Drugs)      |
| - Up to a 30-day supply of insulin               |
| $35 + 60% after you pay the Copay                |

<p>| <strong>Tier 3</strong>                                       |
| (Typically Non-Preferred Brand Name Drugs)      |
| - Up to a 30-day supply of each diabetic oral agent |
| $35 + 60% after you pay the Copay                |
| Disposable syringes for up to a 30-day supply of insulin | $35 + 60% after you pay the Copay |
| Non-Network Mail Order Pharmacy |  |
| Tier 1 (Typically Generic Drugs) | Tier 2$ (Typically Preferred Brand Name Drugs) | Tier 3$ (Typically Non-Preferred Brand Name Drugs) |
| Up to a 90-day supply per prescription (or refill) Maintenance Medication* | $30 + 60% after you pay the Copay | $105 + 60% after you pay the Copay | $180 + 60% after you pay the Copay |
| Up to a 90-day supply of insulin | $30 + 60% after you pay the Copay | $105 + 60% after you pay the Copay | $180 + 60% after you pay the Copay |
| Up to a 90-day supply of each diabetic oral agent | $30 + 60% after you pay the Copay | $105 + 60% after you pay the Copay | $180 + 60% after you pay the Copay |
| Disposable syringes for up to a 90-day supply of insulin | $105 + 60% after you pay the Copay |
| Non-Network Extended Days' Supply (EDS) Retail Pharmacy |  |
| Tier 1 (Typically Generic Drugs) | Tier 2$ (Typically Preferred Brand Name Drugs) | Tier 3$ (Typically Non-Preferred Brand Name Drugs) |
| Up to a 90-day supply per prescription (or refill) | $30 | $105 | $180 |</p>
<table>
<thead>
<tr>
<th>Maintenance Medication</th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60% after you pay the Copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Up to a 90-day supply of insulin</th>
<th>+</th>
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<thead>
<tr>
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<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>$105</td>
<td>60% after you pay the Copay</td>
</tr>
</tbody>
</table>

1. The Annual Prescription Drug Deductible is per Calendar Year (January 1- December 31)
2. Copays only apply after the Annual Prescription Drug Deductible has been met.
3. If the cost of your Covered Drug is less than the applicable Copay, you pay the cost of the drug instead of the Copay.
4. If a generic is available and you chose to buy the Brand Name Drug, you will pay the Generic Drug Copay plus the cost difference between the Brand Name Drug and the Generic Drug. (This is referred to as the Dispense As Written Penalty.)
SECTION 6 - DETAILS FOR COVERED DRUGS

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

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

Reminders:
All Covered Drugs must be determined by the Program to be Medically Necessary. 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 and services identified below.

<table>
<thead>
<tr>
<th>Covered Diabetes Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Self-Management Items</td>
</tr>
<tr>
<td>■ Insulin;</td>
</tr>
<tr>
<td>■ Diabetic oral agents; and</td>
</tr>
<tr>
<td>■ Syringes for the administration of insulin.</td>
</tr>
</tbody>
</table>

Note: Diabetic supplies including, but not limited to: insulin pumps, test strips for blood glucose monitors, lancets, glucagon emergency kits, and alcohol wipes, are covered under the HealthSelect Plan administered by United Healthcare. For more information please go to www.healthselectoftexas.com

Drugs
Covered Drugs that are filled at a Pharmacy and are Medically Necessary 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; and
■ Sleep disorder agents

For a full list of covered medications and classes, visit www.caremark.com/ers or call (888)886-8490 to obtain a copy of the Program’s Formulary.

**Important**
A medication is only a Covered Drug if it is Medically Necessary. (See definitions of Medically Necessary and Covered Drug in Section 13, Glossary.) The fact that a Physician or other Provider has prescribed a medication, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not make the product a Covered Drug under the Program.

**Family Planning Medications**
The Program pays Benefits for voluntary family planning services and supplies. Coverage is provided for contraceptive classes required by the Affordable Care Act, including, but not limited to: oral contraceptives, injectable contraceptives, and implantable devices.

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

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

For services specifically excluded, refer to Section 7, Exclusions: What the 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 Affordable Care Act 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 recommendation provided by USPSTF as determined and interpreted by the Program. Coverage is subject to guidelines based on age, risk factors, dosage, and frequency.

**Specialty Drugs**

Certain complex chronic and/or genetic conditions require special pharmacy products, called Specialty Drugs. Specialty Drugs are usually drugs that:

- Are injected or infused;
- Are high-cost;
- Have special delivery and storage requirements, such as refrigeration; and/or
- Require close monitoring or care coordination by a pharmacist and Physician or Other Provider.

Specialty Drugs include, but are not limited to drugs for the treatment of: Hepatitis C, infertility, Multiple Sclerosis, cancer, and Rheumatoid Arthritis.

Specialty Drugs require the prescribing Physician or Other Provider to submit medical necessity documentation and meet drug specific criteria before the product is covered. Under the Program, Specialty Drugs that are filled at a Pharmacy are typically covered at the Tier 2 (Preferred Brand Name Drug) or Tier 3 (Non-Preferred Brand Name Drug) level.

**Note:** When Specialty Drugs are provided as part of a Physician’s or Other Provider’s office, Outpatient Facility, or during confinement while a patient in a Hospital, they are typically covered under the HealthSelect Plan. For more information on medications covered under the medical Plan, go to www.healthselectoftexas.com.

Specialty Drugs are subject to Caremark’s Specialty Guideline Management (SGM) program. The SGM program is a comprehensive program that ensures the appropriate use of these Specialty Drugs by Participants along with the supplies, equipment and required care coordination. For more information and a complete list of Specialty Drugs and services, visit www.caremark.com/ers or call Caremark Specialty at (800)237-2767.
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.

Please review all limits of Covered Drugs as described in Section 4, Utilization Management and Section 6, Details for Covered Drugs 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. For a list of all drugs subject to Prior Authorization, Quantity Limits, or Step Therapy requirements, please see the prescription drug Formulary at www.caremark.com/ers.

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, are the only available treatment for your condition or are determined by the Program to be Medically Necessary. You are solely responsible for payment of charges for all drugs, supplies, or other items excluded by the Program and described in this section.

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

Administration or Injection of a Drug

1. Administration or injection 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 United Healthcare. Go to www.healthselectoftexas.com for more information.

Devices or Durable Medical Equipment (DME)

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

Note: Certain devices and DME may be covered under the HealthSelect Plan administered by United Healthcare. Go to www.healthselectoftexas.com for more information on covered devices and DME.

Drugs, Devices, or Supplies Without a Valid Prescription Order

1. Drugs, insulin, or covered devices and supplies without a valid Prescription Order from a Physician or Other Provider.
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 or during confinement while a patient in a Hospital, substance abuse Facility, or other Facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or Facility.

2. 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 Drugs covered under Caremark’s Specialty Guideline Management program. For a list of all medications in the Specialty Guideline Management program, go to www.caremark.com/ers.

**Note:** These fluids, solutions, nutrients, and medications may be covered under the HealthSelect Plan administered by United Healthcare. Go to www.healthselectoftexas.com for more information.

Drugs Obtained through Illegal or Fraudulent Activity

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

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

Experimental or Investigational or Unproven Services

1. Drugs required by law to be labeled: “Caution - Limited by Federal Law to Investigational Use,” or Experimental or Investigational Services or Unproven Services, as described in Section 13, Glossary.

**Note:** This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

2. Drugs used for purposes other than those approved by the Food & Drug Administration (FDA) or consistent with the applicable clinical criteria approved by the PBM’s Pharmacy and Therapeutics Committee. This includes multi-ingredient compound medications and topical analgesics that are not FDA-approved for a particular Indication and/or the route of administration in which they are being used.

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 which do not by law require a Prescription Order from a Physician or Other Provider (except injectable insulin).

   - This exclusion does not apply to OTC Drugs prescribed at a strength requiring a Prescription Order, 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
Prescription Order. 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.

2. Vitamins, except those vitamins which by law require a Prescription Order and for which there is no OTC alternative.

3. OTC tobacco cessation products, including, but not limited to nicotine gum and nicotine patches.

**Physical Appearance/Cosmetic Drugs**

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

2. Drugs prescribed and dispensed for the treatment of obesity, with an FDA Indication 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.

**Products Containing Fluoride**

1. 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 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., Depo-Provera, Norplant) and contraceptive devices (e.g., diaphragm, intrauterine device (IUD) including fitting and removal), are covered under the HealthSelect Plan administered by United Healthcare. For more information please go to [www.healthselectoftexas.com](http://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.

   - This exclusion does not apply if a Physician states the Participant’s life would be endangered if the fetus was carried to term.

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. Under workers' compensation, no-fault automobile coverage or similar plan if you could purchase or elect it, or could have it purchased or elected for you.

3. While on active military duty.

4. 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 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 Plan ends, including pharmaceutical drugs or services for conditions that began before the date your coverage under the Plan 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 Formulary 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 Formulary for this Program, or any drugs or medications dispensed more than one year following the Prescription Order 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 Master Benefit Plan Document for the HealthSelect Plan administered by United Healthcare or for which benefits have been exhausted.

2. Physical or psychiatric 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; or
   
   D. required to obtain or maintain a license of any type.

3. Drugs for which the Pharmacy's Usual and Customary charge to the general public is less than or equal to the amount of Copay provided under this Program.
SECTION 8 - CLAIMS PROCEDURES

What this section includes:
■ How Network and Non-Network claims work; 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 from a Network Pharmacy, Caremark will pay the Pharmacy directly. If a Network Pharmacy bills you for any Covered Drug other than your Copay, please contact the Pharmacy or call Caremark at (888) 886-8490 toll free for assistance.

Important: Keep in mind; you are responsible for paying any Copay 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 a claim for a drug or pharmaceutical product received from a Non-Network Pharmacy at the time of service.

You may then submit the Non-Network Pharmacy claim, along with a completed claim form, to Caremark for reimbursement at the Non-Network Benefit level, if the drug is a Covered Drug under the Program. To download a copy of the claim form, please go to www.caremark.com/ers.

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

Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

If Your Pharmacy Does Not File Your Claim
You can obtain a prescription claim form by visiting www.Caremark.com/ers or calling Caremark at (888) 886-8490 toll-free. If you do not have a prescription claim 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
■ Participant member ID# as it's shown on your card
■ Pharmacy prescription receipts
■ Pharmacy cash register receipts
Mail your prescription claims to:

Caremark Claims Department  
P.O. Box 52136  
Phoenix, AZ 85072-2136

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

After Caremark 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.caremark.com/ers or by calling Caremark toll-free at (888) 886-8490 to place a request for a Track Your Rx Spend Report.

<table>
<thead>
<tr>
<th>Important - Timely Filing of Claims</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All claim forms for Network and Non-Network Covered Drugs 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 Caremark. This 365-day requirement does not apply if you are legally incapacitated.</td>
<td></td>
</tr>
</tbody>
</table>

Claim Denials and Appeals

*If Your Claim is Denied*
If a claim for Benefits is denied in part or in whole, you may call Caremark at (888) 886-8490 toll-free before requesting a formal appeal. If Caremark 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 Post-Service Claim, or appeal a rescission of coverage you or your Authorized Representative must submit your appeal as described below in writing within 180 days of receiving the adverse Benefit determination. This communication should include:

- the Participant’s name and ID number as shown on the prescription benefits 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.

You or your Authorized Representative may send a written appeal to:

Caremark  
Appeals Department  
MC 109,  
P.O. Box 52084  
Phoenix, AZ 85072-2084

Or fax your request to: 1-866-689-3092
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, your Provider should call Caremark at (866) 443-1183 toll free 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;
- Post-Service Claim; or
- rescission of coverage.

### First Internal Appeal

#### First Internal Appeal

Caremark 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 Caremark 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 additional appeal procedures, if applicable. If Caremark overturns the denial, you and your Provider will receive notification of its decision and Benefits will be paid, as appropriate.

#### Notes:

- 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 by the Program if you receive the denied drugs or supplies, unless you win a subsequent appeal.

- If your Urgent Request for Benefits was denied, you may request an expedited External Review at the same time that you request an expedited internal appeal to Caremark. Immediately upon receipt of your request for an Expedited External Review, Caremark will determine whether the request meets the reviewability requirements for an External Review. Immediately upon completing this review, Caremark 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 review.

### Second Internal Appeal to Caremark (of an Urgent Care Request for Benefits, a Pre-Service Request for Benefits)

If you are not satisfied with the first internal appeal decision regarding an Urgent Care Request for Benefits involving medical judgment or a Pre-Service Request for Benefits involving medical judgment, you have the right to request a second internal appeal from Caremark. You must file a
written request for the second internal appeal within 180 days from your receipt of the first internal appeal determination notification.

If the denial is upheld at the second internal appeal level, Caremark 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 Caremark’s notice. If Caremark overturns its decision at the second internal appeal level, Caremark 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. Caremark will review all claims in accordance with the rules established by the U.S. Department of Labor.

**Second Internal Appeal to ERS (of a Post-Service Claim or a Rescission of Coverage)**

If you are not satisfied with the first internal appeal decision regarding a Post-Service Claim or a rescission of coverage, you have the right to request a second internal appeal from ERS. 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 ERS upholds the denial at the second internal appeal level, ERS 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 or a rescission of coverage, you may request an external review. If ERS overturns the denial, Caremark will notify you and Benefits will be paid, as appropriate.

ERS does not review denials of Pre-Service Requests for Benefits or Urgent Care Requests for Benefits. Caremark and ERS will complete reviews within legally applicable time periods.

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

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>Urgent Care Request for Benefits¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action to Be Taken</strong></td>
<td><strong>Timing²</strong></td>
</tr>
<tr>
<td>If your Request for Benefits in complete, Caremark must notify you and your Provider of the benefit determination within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>If your Request for Benefits is incomplete, Caremark must notify you that it is incomplete within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide the completed Request for Benefits to Caremark within</td>
<td>48 hours after receiving notice of additional information required</td>
</tr>
<tr>
<td>Caremark must notify you and your Provider of the Benefit determination within:</td>
<td>48 hours after receipt of additional information</td>
</tr>
<tr>
<td>If Caremark denies your Request for Benefits, you must appeal an adverse Benefit determination no later than:</td>
<td>180 calendar days after receiving the adverse Benefit determination</td>
</tr>
<tr>
<td>Caremark must notify you of the first internal appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>
1You do not need to submit Urgent Care appeals in writing. You should call Caremark as soon as possible to appeal an Urgent Care Request for Benefits.

2From when the request is made unless otherwise noted below.
### TABLE 5

<table>
<thead>
<tr>
<th>Pre-Service Request for Benefits</th>
<th>Timing¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action to Be Taken</strong></td>
<td><strong>Timing</strong></td>
</tr>
<tr>
<td>If your Request for Benefits is filed improperly with Caremark, Caremark must notify you within:</td>
<td>5 calendar days</td>
</tr>
<tr>
<td>If your Request for Benefits is incomplete, Caremark must notify you within:</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>You must then provide completed Request for Benefits information to Caremark within:</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>Caremark must notify you of the Benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if your Request for Benefits is complete, within:</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>■ after receiving the completed Request for Benefits (if your Request for Benefits was incomplete as filed), within:</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>You must appeal an adverse Benefit determination no later than:</td>
<td>180 calendar days after receiving the adverse Benefit determination</td>
</tr>
<tr>
<td>Caremark must notify you of the first internal appeal decision within:</td>
<td>15 calendar days after receiving the first internal appeal</td>
</tr>
<tr>
<td>You must appeal the denial of your first internal appeal (by filing a second internal appeal) no later than:</td>
<td>180 calendar days after receiving the first internal appeal decision</td>
</tr>
<tr>
<td>Caremark must notify you of the second internal appeal decision within:</td>
<td>15 calendar days after receiving the second internal appeal</td>
</tr>
</tbody>
</table>

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

### TABLE 6

<table>
<thead>
<tr>
<th>Post-Service Claims</th>
<th>Timing¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action to Be Taken</strong></td>
<td><strong>Timing</strong></td>
</tr>
<tr>
<td>If your claim is incomplete, Caremark must notify you within:</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>You must then provide completed claim information to Caremark within:</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>Caremark must notify you of the Benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the claim was complete as filed, within:</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the claim was incomplete as filed), within:</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
## TABLE 6

<table>
<thead>
<tr>
<th>Post-Service Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action to Be Taken</td>
</tr>
<tr>
<td>You must appeal an adverse Benefit determination no later than:</td>
</tr>
<tr>
<td>Caremark must notify you of the first internal appeal decision no later than:</td>
</tr>
<tr>
<td>You must appeal the denial of your first internal appeal (by filing a second internal appeal with ERS) no later than:</td>
</tr>
<tr>
<td>Caremark or ERS must notify you of the second internal appeal decision within:</td>
</tr>
</tbody>
</table>

¹From 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 Caremark or ERS, or if Caremark or ERS fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an immediate external review of the determination made by Caremark or ERS. 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);
- rescission of coverage (coverage that was terminated retroactively); or
- as otherwise required by applicable law.

**Note:** You may also have the right to pursue external review in the event that Caremark or ERS have 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.

You or your Authorized Representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as detailed below, by calling Caremark at (866) 443-1183 toll free or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you receive Caremark’s or ERS’ determination.
An external review request should include all of the following:

- a specific request for an external review;
- the Participant's name, address, and prescription drug 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). Caremark has entered into agreements with three or more IROs that have agreed to perform such reviews. 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 all of the following:

- a preliminary review by Caremark of the request;
- a referral of the request by Caremark to the IRO;
- the review by the IRO; and
- a decision by the IRO.

Within the applicable time frame after receipt of the request, Caremark will complete a preliminary review to confirm whether the requesting Participant meets all of the following requirements:

- was covered under the Program at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that Caremark may process the request.

After Caremark completes the preliminary review, Caremark will forward the information to the IRO assigned to conduct reviews. Caremark will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

Caremark will provide the assigned IRO with the documents and information considered in making Caremark's or ERS' determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Caremark or ERS;
■ 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.

For Pre-Service appeals, the IRO will determine initially whether the request contains an issue
involving medical judgment and notify you in writing of the request’s eligibility and acceptance for
external review within 5 business days. For Post-Service appeals, ERS will determine whether
your claim involves a question of medical judgment or rescission that is subject to External
Review. If your claim involves an issue of medical judgment or rescission that is subject to
External Review, you may submit in writing to the IRO within ten (10) business days following the
date you receive notice from the IRO, any additional information that you want the IRO to
consider when conducting the external review. The IRO is not required to, but may, accept and
consider additional information submitted by you after ten (10) business days. In reaching a
decision, the IRO will review the claim anew and will not be bound by any decisions or
conclusions reached by Caremark or ERS. The IRO will provide written notice of its determination
(the “Final External Review Decision”) within 45 days after it receives the request for the external
review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of
Final External Review Decision to you and Caremark, and it will include the clinical basis for the
determination.

Upon receipt of a Final External Review Decision reversing Caremark’s or ERS’ determination,
Caremark will notify you within 48 hours of receiving the IRO’s decision. The Program will
immediately provide coverage or payment of the Benefits at issue in accordance with the terms
and conditions of the Program. If the Final External Review Decision is that payment will not be
made, the Program will not be obligated to provide Benefits for the prescription drug services and
you will have exhausted your appeal rights.

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

**Expedited External Review**

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, Caremark will determine whether the Participant meets both of the following:

- was covered under the Plan/Program at the time the prescription drug service that is at issue in the request was provided; and
- has provided all the information and forms required so that Caremark may process the request.

After completing the review, Caremark will immediately assign an IRO in the same manner Caremark utilizes to assign standard external reviews to IROs. The IRO will determine if the matter contains an issue involving medical judgment and, upon a determination that a request is eligible for expedited external review, immediately send a notice in writing to you. Caremark will provide all necessary documents and information considered in making the adverse Benefit determination or final adverse Benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Caremark. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the Participant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO’s notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to Caremark.

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 Caremark at (888) 886-8490 toll free for more information regarding external review rights, or if making a verbal request for an expedited external review.

| TABLE 7 |
|--- |--- |
| **External Review** | **Timing**
| **Action to Be Taken** | **Timing**
| You must submit a request for external review to Caremark within: | Four 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, Caremark 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 after receiving the request for the |
TABLE 7

<table>
<thead>
<tr>
<th>Action to Be Taken</th>
<th>Timing¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>external review</td>
</tr>
</tbody>
</table>

¹From when the request is made unless otherwise noted below.
²This 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.

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 individual designated by the Participant in writing on a form approved by Caremark;
- a health care Provider if the claim is an Urgent Care claim. However, a health care Provider may not be an Authorized Representative for the appeal of a claim, unless designated in writing by the Participant consistent with the above requirement;
- 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 to have care and custody of the Participant by a court of competent jurisdiction; or
- if the Participant is a minor, the Participant’s parent or legal guardian, unless Caremark 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 and the Participant shall 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 Caremark 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, Caremark 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, Caremark 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, Caremark will send all correspondence, notices and benefit determinations in connection with the Participant’s Claim to the Participant, but
Caremark will provide copies of such correspondence to the Authorized Representative upon the Participant’s written request.

4. It will take Caremark at least 30 days to notify all of its personnel about the termination of the Participant’s Authorized Representative. It is possible that Caremark 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 medical plans and only one has COB provisions, the plan without COB provisions will be the Primary Plan;
- 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.

Under any of the circumstances above, this Program will not pay more than it would have paid had it been the only plan in effect.

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 for a Covered Drug, 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 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 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>
<thead>
<tr>
<th>Subscriber is…</th>
<th>…and is covered as a dependent under another plan by:</th>
<th>…then HealthSelect is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an Active Employee</td>
<td>spouse's employer plan</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>an Active Employee</td>
<td>spouse's retiree plan</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>a Retiree</td>
<td>spouse's employer plan</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>a Retiree</td>
<td>spouse's retiree plan</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>Subscriber is…</td>
<td>…and has other coverage through:</td>
<td>…then HealthSelect is:</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>an Active Employee</td>
<td>the Subscriber's second active employment</td>
<td>either Primary or Secondary depending on which plan is in force the longest</td>
</tr>
<tr>
<td>an Active Employee</td>
<td>the Subscriber's retirement from another employer</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>a Retiree</td>
<td>the Subscriber's second active employment</td>
<td>the Secondary Plan</td>
</tr>
<tr>
<td>a Retiree</td>
<td>the Subscriber's retirement from another employer</td>
<td>either Primary or Secondary</td>
</tr>
</tbody>
</table>
TABLE 8

<table>
<thead>
<tr>
<th>Dependent is...</th>
<th>another employer</th>
<th>depending on which plan is in force the longest</th>
</tr>
</thead>
<tbody>
<tr>
<td>...and is covered by a Subscriber who is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>an active employee of a non-GBP Employer</td>
<td>an Active Employee</td>
<td>the Secondary Plan</td>
</tr>
<tr>
<td>an active employee of a non-GBP Employer</td>
<td>a Retiree</td>
<td>the Secondary Plan</td>
</tr>
<tr>
<td>a retiree of a non-GBP Employer</td>
<td>an Active Employee</td>
<td>the Primary Plan</td>
</tr>
<tr>
<td>a retiree of a non-GBP Employer</td>
<td>a Retiree</td>
<td>the Secondary Plan</td>
</tr>
</tbody>
</table>

When This Program is Secondary

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

- the Program determines the amount it would have paid based on the Average Wholesale Price (AWP) of the Covered Drug.
- the Program pays the difference between the amount paid by the Primary Plan and this Program’s AWP.
- 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.

Note: See the Glossary below for the definition of Average Wholesale Price.

Example 1: The total cost of a Covered Drug is $223.28 and you paid a $60 Copay for the drug under your Primary Plan; Under your Secondary Plan, you would have paid a $45 Copay for this drug, and the plan cost would have been $178.28 ($223.28 minus $45 Copay). Since the cost the Secondary Plan would have paid for your medication ($178.28) is greater than the Copay you paid under your Primary Plan, you receive the full reimbursement of $60.

Example 2: The total cost of the Covered Drug is $7.75. Under your Primary Plan, the Copay for this drug is $20. Since the total cost of the Covered Drug is less than the Copay amount, you pay $7.75 for the full cost of the drug. Under your Secondary Plan, the Copay for this drug is $10. Since the cost of the Covered Drug is less than the Copay you would have paid under the Secondary Plan, you will not receive a reimbursement.

You may be responsible for any Copay, Coinsurance or Annual Prescription Drug Deductible 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 under this Program.
Overpayment and Underpayment of Benefits

If you are covered under more than one pharmacy 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 Covered Persons under the Program, with the understanding that Caremark 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 HealthSelect of Texas Managed Care (In-Area Benefits) Plan or the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan. To review the Plan documents referenced above, go to www.healthselectoftexas.com.
SECTION 11 - WHEN COVERAGE ENDS

**Important**

Your coverage in the HealthSelect of Texas Prescription Drug Program is determined based upon your coverage in the HealthSelect of Texas medical Plan (through United Healthcare). If your coverage under the HealthSelect Plan is terminated or comes to an end, your coverage in the HealthSelect of Texas 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 HealthSelect of Texas Managed Care (In-Area Benefits) Plan or the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan. To review the Plan documents referenced above, go to [www.healthselectoftexas.com](http://www.healthselectoftexas.com).

**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 HealthSelect of Texas Managed Care (In-Area Benefits) Plan and the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan. To review the Plan documents referenced above, go to [www.healthselectoftexas.com](http://www.healthselectoftexas.com).
SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with Caremark and the Employees Retirement System of Texas;
- Interpretation of the Program;
- Records; and
- How to access the Master Benefit Plan Document.

Your Relationship with Caremark and the Employees Retirement System of Texas

In order to make choices about your prescription drug coverage, it is important for you to understand how Caremark interacts with the Program and how it may affect you. ERS has contracted with Caremark as a third-party administrator of the Program to assist in the administration of the Program.

Caremark 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, which are more fully described in this MBPD.

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

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. 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 Caremark 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 Master Benefit Plan Document and other Program information may be downloaded from www.caremark.com/ers. You may also request a copy of this Master Benefit Plan Document by making a written request to ERS. The copy will be provided for a reasonable charge within 30 days of its receipt of the request.
SECTION 13 - GLOSSARY

What this section includes:
■ Definitions of terms used throughout this Master Benefit Plan Document (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.

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 Master Benefit Plan Document and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Master Benefit Plan Document and/or Amendments to the Master Benefit Plan Document, 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). 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
2) Maximum Allowable Cost plus a contractually determined Dispensing Fee
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, 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.

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) – a nationally-tracked pricing index provided to the PBM by Medispan, or such other nationally available reporting service of pharmaceutical prices as recommended by PBM or approved by ERS. 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, 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.

Brand Name Drug – A drug marketed under a proprietary, trademark-protected name.

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.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Drugs as described in Section 3, How the Program Works. The percentage of Eligible Expenses paid by the Program for Covered Drugs 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. Please refer to the HealthSelect of Texas Managed Care (In-Area Benefits) Plan and the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan for additional information on COBRA. More information can be located at www.healthselectoftexas.com

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Drugs 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 – any Legend Drug or injectable insulin, including disposable syringes and needles needed for self-administration that meets the following requirements:

- That is Medically Necessary and is ordered by a Physician or Other Provider naming a Participant as the recipient;
- For which a written or verbal Prescription Order is prepared by a Physician or Other Provider;
- 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 PBM’s Pharmacy and Therapeutics (P&T) 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.
- That is not identified in Section 7, Exclusions: What the 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:

- Medically Necessary;
• included in Sections 5 and 6, Schedule of Benefits and Details for Covered Health Services, described as a Covered Health Service in the HealthSelect of Texas Managed Care (In-Area Benefits) Plan and the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan;

• provided to a Participant who meets the Plan’s eligibility requirements, as described under Eligibility in Section 2, Introduction in the HealthSelect of Texas Managed Care (In-Area Benefits) Plan and the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan; and

• not identified in Section 7, Exclusions: What the Medical Plan Will Not Cover, as not covered in the HealthSelect of Texas Managed Care (In-Area Benefits) Plan and the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan. To review the Plan documents 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 Non-Preferred Brand Name medication (that has been assigned a Maximum Allowable Cost (MAC)) when a Generic Drug is available. In these instances, you pay the Tier 1 Copay plus the difference in cost to the Program between the Generic Drug and the Non-Preferred Brand Name drug.

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

DME – see Durable Medical Equipment (DME).

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.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance-related and addictive disorder 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.

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 – for the purposes of this MBPD, drug or other therapies, medications or devices that, at the time the Program makes a determination regarding coverage in a particular case, the Program determines to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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 – A comprehensive list of all drug products covered by the Program.

Generic Drug – means a drug distributed and manufactured after the patent of the Brand Name Drug has expired. The Generic Drug must have the same active ingredients, strength, and dosage form as its Brand Name Drug counterpart. Typically, Generic Drugs fall under the Tier 1 Benefit level under this Program and are cheaper than Brand Name Drugs.

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

HealthSelect of Texas℠ Plan, Plan, or HealthSelect – a self-funded health benefit plan offered through the Group Benefits Program by ERS. It includes an In-Area Plan and an Out-of-Area Plan that are administered by United Healthcare.

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.

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 and 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.

**Maintenance Medication** – medications used for long periods of time to treat chronic conditions, for example, insulin or hypertension medications.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments and providing health care coverage to eligible low-income people.

**Medically Necessary, Medical Necessity** – those Covered Drugs that are:

1) Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, Sickness, disease, Injury, or bodily malfunction;

2) Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States;

3) Not primarily for the convenience, personal preference, or appearance of the Participant or his Physician or Other Provider;

4) The most economical Covered Drugs that are appropriate for the safe and effective treatment of the Participant; and

5) Not Experimental/Investigational in nature at the time the drugs are provided.

The PBM for the Program shall determine whether or not a Covered Drug is Medically Necessary under the Program and shall consider the views of the state and national medical communities and the views and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although a Physician or Other Provider may have prescribed Covered Drugs, such drugs may not be Medically Necessary within this definition.

**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.

**Network** – for purposes of this MBPD, Network means a group of independent Pharmacies or chain of Pharmacies having a particular agreement for providing prescription drug services in a Network serving this Program.

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

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

**Non-Network** – for purposes of this MBPD, Non-Network means a Pharmacy or group of Pharmacies which have not entered into an agreement with Caremark to provide Pharmacy services to Participants covered under this Program.

**Non-Network Benefits** – description of how Benefits are paid for Covered Drugs provided by Non-Network Pharmacies. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Non-Network Benefits apply.
Non-Preferred Brand Name Drug – designated prescription Brand Name Drugs available at a higher copay than most Preferred Brand Name Drugs.

Off Label Use – the use of FDA-approved drugs for non-approved Indications.

Over-the-Counter Drugs (OTC) – drugs that may be purchased without a Prescription Order. A drug that may be otherwise purchased without a Prescription Order but is prescribed at a strength requiring a Prescription Order 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 Master Benefit Plan Document are references to a Participant.

PBM – See Pharmacy Benefits Manager under this section.

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 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.

Pharmacy Benefits Manager (PBM) – for the purposes of this MBPD, this means Caremark Rx, L.L.C. (Caremark), administrator of the HealthSelect Prescription Drug Program.

Pharmacy and Therapeutics (P&T) Committee – a committee of independent members consisting of physicians and clinical pharmacists. The committee’s purpose is to develop the Formulary, prescribing guidelines, coverage criteria (e.g., Prior Authorization) and drug utilization review interventions. The P&T Committee meets periodically to review information on safety and efficacy of each drug considered for inclusion or exclusion from the Preferred Brand Name Drug and Non-Preferred Brand Name Drug lists.

Physician or Other Provider – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law to prescribe Legend Drugs to humans.

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 – the HealthSelect of Texas medical Plan, administered by United Healthcare. 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 that have already been provided.

Preauthorization or Predetermination – See Prior Authorization under this section.

Preferred Brand Name Drug – means a prescription drug, biological, and device approved by the Pharmacy and Therapeutics Committee for inclusion in the Program. The preferred drug list is subject to change. Typically, Preferred Brand Name Drugs are covered at the Tier 2 Benefit level.
**Prescription Order** – a written or verbal order from a Physician or Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or Other Providers located outside the United States to be dispensed in the United States are not covered under this Program.

**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 which the Program must approve or for which you must obtain Prior Authorization from Caremark before non-urgent care is provided.

**Primary or Primary Plan** - when you are covered by more than one 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 under the Program. The drugs and conditions for coverage are recommended by the P&T 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 HealthSelect of Texas Prescription Drug Program, administered by Caremark.

**Provider** – a Facility, Hospital, Physician or Mental Health 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;
- Christian Science Practitioner;
- 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 P&T 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 drugs exceeding the Quantity Limit. 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.

**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 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 Drugs** – drugs that are used in the treatment of rare or complex conditions and are typically injected or infused, are high cost, have special delivery and storage requirements, or require close monitoring or care coordination by a pharmacist and Physician or Other Provider.

**Specialty Guideline Management (SGM)** – a comprehensive program that provides and ensures the appropriate use of Specialty Drugs to Participants along with the supplies, equipment and required care coordination. For more information and a complete list of Specialty Drugs and services, visit [www.caremark.com/ers](http://www.caremark.com/ers), or call Caremark Specialty at (800)237-2767.

**Subrogation** – means the Plan/Program has paid monies to you or on your behalf for medical and/or prescription claims related to a Sickness or Injury for which a third party is or may be considered responsible.

**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.

**Tier** – a Copay level for Covered Drugs. There are three Tiers for Covered Drugs under the Program. Typically, Tier 1 drugs are Generic Drugs, Tier 2 drugs are Preferred Brand Name Drugs, and Tier 3 drugs are Non-Preferred Brand Name Drugs.

**Trustee** – a member of the Board of Trustees of the Employees Retirement System of Texas.

**Total Network Out-of-Pocket Maximum** – the most you are required to pay each Calendar Year for both pharmacy and medical Network Benefits including: Deductibles, Coinsurance and Copays, 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 – for the purposes of this MBPD, medications or services that have not been determined to be effective for treatment of the Sickness, Injury or other medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

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 Physician, 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 – the price a Participant would have paid for a medication on the day the prescription was dispensed, inclusive of all applicable discounts.
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 and Subrogation; utilization management and complaint resolution assistance. This contracted administrator for the Program is the claims administrator, Caremark RX, L.L.C. For Benefits as described in this MBPD, ERS also has selected a Pharmacy Network established by Caremark RX, L.L.C.

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 responsibility(s), as it has to Caremark RX, L.L.C with respect to the Program.

**Claims Administrator:** The company that provides certain administrative services for the Program described in this MBPD.

Caremark RX, L.L.C  
P.O. BOX 6590  
Lee’s Summit, MO 64064-6590  

(888) 886-8490.  
TDD (telecommunications device for the deaf) users please call toll-free (800)231-4403.

Caremark shall not be deemed or construed as an Employer for any purpose with respect to the administration or provision of Benefits under the Program. Caremark 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.state.tx.us. Our full notice is available at http://www.ers.state.tx.us/about/legislation/documents/hipaa_longform.pdf.

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 acknowledgement 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.state.tx.us. 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

Preventive medications that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed below. This list is subject to change according to the guidelines and recommendation provided by USPSTF. Coverage is subject to guidelines based on age, risk factors, dosage, and frequency.

<table>
<thead>
<tr>
<th>Covered Preventive Care Medications¹,²,³</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Adults</strong></td>
<td></td>
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<tr>
<td>• Tobacco cessation medications-</td>
<td></td>
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<tr>
<td><em>bupropion</em> and Chantix</td>
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<tr>
<td>• Aspirin- covered for adults age 45</td>
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<td>and older</td>
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<tr>
<td>• Vitamin D- covered for adults age 65</td>
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<td>and older</td>
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<tr>
<td><strong>Children</strong></td>
<td></td>
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<tr>
<td>• Iron Supplements- covered for children</td>
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<tr>
<td>age 6 months to 12 months</td>
<td></td>
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</tbody>
</table>

**Women**

- Breast cancer preventive medications, Tamoxifen and Raloxifene- covered for women age 35 and older
- Folic Acid- covered for women age 55 and younger
- Contraceptive Methods including:
  1. Implantable Rod – limited to 1 per year.
  2. IUD Copper - limited to 1 per year.
  3. IUD w Progestin - limited to 1 per year.
  4. Birth Control Shot/Injection – limited to 4 injections per year.
  5. Oral Contraceptives, Birth Control Pill
  6. Oral Contraceptives, the Mini Pill
  7. Oral Contraceptives, Extended, Continuous Use
  8. Birth Control Patch
  9. Vaginal Contraceptive Ring – limited to 12 per year.
  10. Diaphragm w Spermicide
  11. Sponge w Spermicide
  12. Cervical Cap with Spermicide
  13. Female Condom
  14. Spermicide, alone
  15. Plan B – Limited to 1 per 28 days
  16. Ella – Limited to 1 per 28 days

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

¹ In order to be considered a Covered Drug under the Program, a valid Prescription Order must be provided for all preventive care medications and devices listed within this Addendum.

² Certain preventive medications (including certain female contraceptives) may be covered without any Participant cost share dependent upon generic availability. Under the Affordable Care Act, 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.

³ If a generic is available and you chose to buy the Brand Name Drug, you will pay the Generic Drug Copay plus the cost difference between the Brand Name Drug and the Generic Drug. (This is referred to as the Dispense As Written Penalty.)