2025 PRESCRIPTION DRUG BENEFIT PLAN DOCUMENT

Welcome to the EPC Prescription Drug benefit, administered by BeneCard PBF. To receive the highest level of benefits, prescription drugs must be obtained from a pharmacy in BeneCard's national pharmacy network or directly from BeneCard via Benecard Central Fill for Mail Service and Specialty Medications. Register your account on-line at: https://benecardpbf.com/ and click on "Log in". Be sure to have your member ID number handy. Once your account is open you can access your plan details, the drug formulary, pharmacy network, and other beneficial information. BeneCard's member service number is 1-888-907-0070.

To minimize your out-of-pocket and co-pay costs, ask your prescriber to consider generic drugs, if a generic drug is not available then consider formulary brand drug in BeneCard's Performance Formulary as may be medically appropriate. Once you have registered with BeneCard you can go to the BeneCard website and view the list of medications available on your formulary. If your specific medication is not listed, there is a list of alternative medications that are on the Formulary you can discuss with your doctor or prescriber.

Prescription medications dispensed for acute care intended for short-term use are best filled at a local retail pharmacy. These include antibiotics and other medications that you take for short periods of time. Similarly, first time use of a medication intended to be used on a long-term basis should be filled at a local pharmacy in just a small quantity initially to determine if the medication is right for you. These include drugs that treat high blood pressure, cholesterol, diabetes, asthma, or other chronic conditions. Once the right medication, dosage, and strength are determined to be effective, a longer-term supply of up to 90 days may be filled at your local pharmacy or BeneCard's mail order pharmacy called BeneCard Central Fill. You may choose either depending on your preference. There is no copay penalty for selecting a local retail pharmacy.

Sending a new prescription or switching an existing prescription to BeneCard Central Fill is easy! You can call member services at 888-907-0070 and request a transfer of your existing medication. Or you can ask your prescriber to electronically submit a new prescription directly to BeneCard Central Fill.

Utilizing a short-term supply of a medication the first time you try it reduces the waste of having to dispose of unused medications that proved ineffective. Many medications are very expensive, for example the average cost of a 90-day supply of a medication is $1,770, for a Brand named it is $2,875 and for a specialized medication it is $13,960. To save on co-pays and reduce costs paid by your EPC plan be sure to ask your doctor for a generic form if available and to consider ordering a short-term supply the first time you try a new medication to avoid waste if it proves ineffective. Once your treatment is established you can ask your doctor to prescribe a 90-day supply with 3 refills giving you up to a year's supply. You can have that sent to BeneCard Central Fill or your local pharmacy.

To avoid additional waste, we ask that you **not** set up automatic refills for any of your medications. When you find yourself running low just call in for a refill using the information on the medication container. Automatic refills often lead to accumulations of thousands of dollars in medications in your cabinet when refills are sent early or after you have stopped the treatment. Certain common medications that may accumulate can

become targets for misuse by outsiders with dependencies and can be extremely dangerous to those who may find them with that intent.

There is another class of medications referred to as "Specialty Medications" used to treat complex health conditions. These are quite expensive and often need careful oversight from a healthcare provider to make sure they are properly administered, to watch for side effects, and to ensure that the medication is working as intended. Coverage for those is provided through BeneCard's specialty pharmacy BeneCard Central Fill. Coverage for Specialty Medications is described below.

Prescription Drug Plan Annual Deductibles

Plan Participants are responsible for paying the following deductibles before the Plan starts paying for prescription coverage. There is no charge or deductible for certain preventative drugs classified as such by HHS. After the deductible is met, plan participants will be responsible for the applicable co-payment for all prescriptions filled. If the actual cost of a medication is less than the stated co-payment you will be charged the lesser actual cost.

Annual Rx Deductibles	Individual	Two-Person	Family
Platinum POS Plan:	$0	$0	$0
Gold POS Plan:	$200	$400	$500
Silver POS Plan:	$250	$500	$700
Note: The High Deductible Health Plans (HDHP) have a combined Medical/Rx deductible. Please refer to individual plan coverage documents for specific information.			

Co-Payments for up to a 30-Day Supply of Medications

Participant pays 100% for medications until full deductible* is met, then is only responsible for the co-payment. **If the cost of the prescription is less than the stated co-payment you will only be required to pay the lesser actual cost.**

Up to a 30-day supply - Participants in the Platinum POS Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$40
Co-payment, Non-Formulary Brand:	$80

Up to a 30-day supply - Participants in the Gold POS Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$45
Co-payment, Non-Formulary Brand:	$90

Up to a 30-day supply - Participants in the Silver POS Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$50
Co-payment, Non-Formulary Brand:	$100

Up to a 30-day supply - Participants in the Gold HDHP:	
Co-payment, Generic	Member pays 20% coinsurance
Co-payment, Formulary Brand	
Co-payment, Non-Formulary Brand	

Up to a 30-day supply - Participants in the Bronze HDHP:	
Co-payment, Generic	Member pays 40% coinsurance
Co-payment, Formulary Brand	
Co-payment, Non-Formulary Brand	

**No deductible for Platinum POS. For Gold POS and Silver POS Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Rx deductible.*

Long-Term Use Medications

Medications for chronic conditions that are taken long-term can be dispensed with up to a 90-day supply each time the prescription order is filled. Before filling a 90-day supply of a newly prescribed medication, ask your healthcare provider to write a prescription for a shorter-term supply of 30 days or less. This will avoid waste if the medication dosage or strength needs to be adjusted or if side effects require a change to a different medication.

Long-term prescriptions of 31 to 90 days can be filled at either BeneCard Central Fill mail order pharmacy for home delivery or at a local pharmacy of your choice. Please do not set up to receive automatic refills to avoid waste and buildup of expensive, and potentially dangerous if misused, medications in your medicine cabinets.

Co-Payment for 31 to 90-day supply of Long-Term Maintenance Medications

Participant pays 100% until full deductible* is met, then is only responsible for the co-payment. **If the cost of the prescription is less than the stated co-payment you will only be required to pay the lesser actual cost.**

For 31 to 90-day supply - Participants in the Platinum POS Plan:	
Co-payment, Generic:	$20
Co-payment, Formulary Brand:	$80
Co-payment, Non-Formulary Brand:	$160

For 31 to 90-day supply - Participants in the Gold POS Plan:	
Co-payment, Generic:	$25
Co-payment, Formulary Brand:	$95
Co-payment, Non-Formulary Brand:	$190

For 31 to 90-day supply - Participants in the Silver POS Plan:	
Co-payment, Generic:	$25
Co-payment, Formulary Brand:	$100
Co-payment, Non-Formulary Brand:	$200

For 31 to 90-day supply - Participants in the Gold HDHP:	
Co-payment, Generic:	Member pays 20% coinsurance
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

For 31 to 90-day supply - Participants in the Bronze HDHP:	
Co-payment, Generic:	Member pays 40% coinsurance
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

**No deductible for Platinum POS. For Gold POS and Silver POS Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Rx deductible.*

Specialty Medications

Specialty Medications are high-cost medications dispensed exclusively through BeneCard's specialty pharmacy BeneCard Central Fill. To determine if a medication is part of the Specialty Program, review the list of impacted medications on the BeneCard website https://portal.benecardpbf.com/PBF/signIn.do, or call the BeneCard member service at 888-907-0070. Under this program, specialty medications prescribed for you or a covered family member that are on the list will only be covered under the prescription benefit when ordered through Central Fill. They will not be covered if ordered through another pharmacy. And they will not be covered when obtained through an outpatient clinic, a home infusion company, or a doctor's office unless that provider purchases them through BeneCard Central Fill under your prescription benefit. For a new prescription of a listed Specialty Medication, one initial fill is permitted from a retail pharmacy to allow time for you and your physician to transfer the prescription to BeneCard Central Fill. Please note that this program does not affect medications supplied in an emergency room or during an inpatient hospital stay. Due to the high cost and special handling required of these specialty medications, each fill is limited to a maximum of a 30-day supply.

The EPC Benefits office has established a co-pay subsidization program to enable plan participants using certain high-cost specialty medications to take full advantage of

manufacturer copay assistance programs wherever they are available. Those using any specialty medications where these subsidies are available will have the opportunity to enroll for this program and in many cases pay no co-pay for their medication! Some programs will allow a Specialty Coordinator to automatically complete enrollment on your behalf and other programs will require you to enroll directly with them through a website or phone call. In all cases, a Specialty Coordinator will provide guidance through the enrollment process. Members may contact the Specialty Operations Copay Assistance Team with any questions about the Copay Assistance Program at 1-888-907-2820, option 3, Monday through Friday, 8:00 AM – 8:00 PM EST

Co-Insurance for up to a 30-day supply of Specialty Medications dispensed through Central Fill

Participant pays 100% until full deductible* is met, then are only responsible for the coinsurance; except where manufacturer co-pay subsidies are available.

Up to 30-day supply for Participants in Platinum, Gold, and Silver POS Plans:	
Co-payment, Generic:	Member is responsible for 20% of specialty medication cost, up to a $600 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

Up to a 30-day supply for Participants in the Gold HDHP Plan:	
Co-payment, Generic:	Member is responsible for 20% of specialty medication cost, up to a $600 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

Up to a 30-day supply for Participants in the Bronze HDHP Plan:	
Co-payment, Generic:	Member is responsible for 40% of specialty medication cost, up to a $600 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

**No deductible for Platinum POS. For Gold POS and Silver POS Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Rx deductible.*

Prescription Plan Exclusions

The drugs or drug categories listed below are not covered by the Prescription Drug part of the Plan:

1. Photo-aged skin products
2. Hair growth agents

3. Depigmentation products
4. Injectable contraceptive agents
5. Contraceptive implants and devices
6. Emergency contraceptive agents (including the “morning-after pill”)
7. Abortifacients
8. Infertility Medications are included (Limited to lifetime $10,000 combined Medical/Rx)
9. Weight Loss medications coverage is limited to indications of clinically severe obesity or weight related comorbidities.
10. Injectable drugs used to treat erectile dysfunction.
11. Allergens
12. Gene modification and cellular therapies
13. Multi-vitamins, except those requiring a prescription.
14. Dental pastes, gels, and mouthwashes except those containing Fluoride.
15. Prescription drugs with an equivalent over-the-counter drug
16. Durable Medical Equipment.
17. Respiratory therapy peak flow meters.
18. Ostomy supplies
19. Nutritional therapies and medical foods for medical conditions
20. Infant formulas
21. Homeopathic drugs.
22. Over-the-counter drugs, except insulin and certain preventive care drugs specified by HHS.
23. Blood or blood plasma products
24. Experimental drugs and medicines.
25. <u>Brand name drugs</u> in the following categories are excluded: Flouride, vitamins children, vitamins non-prenatal, vitamins prenatal, Isotretinoins, MSD oral, severe allergic reaction.

Contact BeneCard member services at 888-907-0070 to discuss questions about your coverage of medications.

Should BeneCard deny coverage, you will receive a denial letter with instructions about how to appeal the denial. Note that the appeal process is fully compliant with the requirements of the Patient Protection and Affordable Care Act.

<u>Regarding **Medicare Part D**</u>, and creditable prescription drug coverage. The Evangelical Presbyterian Church (EPC) Benefits Plan has determined that the Prescription Drug coverage offered by the EPC Plan is better for the majority of Plan Participants and, on

average for all Plan Participants, and is expected to pay out more than the standard Medicare Part D prescription drug plan. Plan Participants eligible for Medicare should obtain from *www.epc.org/benefits/forms* a document titled "Important Notice from The Evangelical Presbyterian Church about Your Prescription Drug Coverage and Medicare Part D" before making a decision about which prescription drug plan is best in their personal circumstances.

In some cases, items excluded by the Prescription Drug portion of the Plan might be covered by the medical benefits portion of the Plan when administered in a Physician's office or Hospital. Questions in this regard should be directed to Meritain Health.

Members Have the Right to Appeal Denied Claims

When claims are submitted through the BeneCard PBF system, they go through Drug Utilization Review processes and, when applicable, clinical review is conducted for prior authorization to evaluate the prescribing, dispensing, and utilization of a patient's medication. These reviews help healthcare providers, pharmacists, and patients communicate together to increase patient safety, decrease unnecessary healthcare spend, and create more favorable patient outcomes.

For medications that may be denied as a result of these reviews, BeneCard PBF provides an appeal process to members who are eligible for prescription benefit coverage through their employers or union program.

When a claim is denied following clinical review, a letter is mailed to the member to notify them of the decision. This letter serves as the notice of Adverse Benefit Determination. If the member does not agree with the determination, they have the right to appeal the decision. The letter provides instructions on how to submit an appeal and includes an Appeal Filing Form. The Appeal Filing Form must be completed and returned within 180 days of the Adverse Benefit Determination letter to initiate the appeal.

Important Information on Appeal Rights Provided with the Notice of Denial

What if I need help understanding this denial? Contact BeneCard at the Member Services number on the back of your identification card for assistance with any questions you may have.

What if I do not agree with this decision? You have a right to appeal any decision made in whole or in part.

How do I file an appeal? To file an appeal, you can use one of the following methods:

- Send in appeal filing form to BeneCard PBF, Attn: Appeals, 5040 Ritter Road, Mechanicsburg, PA 17055
- Fax in the appeal filing form to 888-830-9450
- Call the Member Services number on the back of your identification card.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. An urgent situation is typically one in which your health may be in serious jeopardy, or, in the opinion of your

physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above to file an internal appeal. You may also request a simultaneous external review, which will be provided if your plan is subject to federal external review regulations.

Who may file an appeal? To designate an authorized representative, submit a copy of the legal documentation (e.g., Power of Attorney) that provides evidence of the individual's ability to act as your representative. Alternatively, you can call the Member Services number on the back of your identification card to request a Personal Representative Form.

Can I provide additional information about my claim? Yes, you may supply additional information. Send any information you may believe is relevant to your claim to: *BeneCard PBF, Attn: Appeals, 5040 Ritter Road, Mechanicsburg, PA 17055.* Or via fax: *(888) 830-9450.*

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). You can request copies of this information by contacting BeneCard at the Member Services number on the back of your identification card.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. You may contact the Member Services number on the back of your identification card to determine if your plan is subject to external review regulations.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Member Services number on the back of your identification card and ask for the Appeals Department. The Appeals Department will direct you to any available external resources for assistance.

Appeal Filing Form

Group Name: Evangelical Presbyterian Church (EPC) Benefits Plan **Group#:** 10127

Name Of Person Filing Appeal: ______________________________

Circle one:

Covered Person   Patient   Authorized Representative

Member Card ID: ______________________

Contact information of person filing appeal (if different from patient)

Address: ______________________________

Daytime phone: ______________ **Email:** ______________________

Patient Name (If different from above): ______________________

If person filing appeal is other than patient, patient must indicate authorization by signing here: ______________________________

Are you requesting an urgent appeal? Yes No

If yes to an urgent appeal, are you requesting a simultaneous external review?
Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

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Send this form and your denial notice to: *BeneCard PBF, Attn: Appeals, 5040 Ritter Road, Mechanicsburg, PA 17055.* Or via fax to: *(888) 830-9450.* **Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.**