EPC
Benefit Resources, Inc.

2021 PRESCRIPTION DRUG BENEFIT PLAN DOCUMENT

Welcome to the EPC Prescription Drug benefit, administered by Express Scripts, Inc. (ESI). To receive the highest level of benefits, prescription drugs must be obtained from a Pharmacy in ESI's national pharmacy network or directly via the Express Scripts Mail Service or Specialty Pharmacy. Once you register at *www.expressscripts.com* (be sure to have your member ID number handy), you can access your plan details, the drug formulary, pharmacy network, and other beneficial information. To minimize your out-of-pocket and co-pay costs, ask your doctor or prescriber to consider generic drugs, or when a generic is not available to consider formulary brand drugs on ESI's National Preferred Formulary (NPF) as may be medically appropriate. Once you have registered with ESI you can go to the ESI website and type in the name of any medication to determine if it is on the Formulary, if it is not there is a list of alternative medications that are on the Formulary that you can discuss with your doctor or prescriber.

Prescriptions dispensed for acute care (short-term) medications and initial fills of maintenance (long-term) medications may be obtained through any retail pharmacy for up to a 30-day supply. Short-term drugs include antibiotics and other medications that you take for short periods of time. Long-term drugs, also called maintenance medications, are those you take on an ongoing basis, such as drugs that treat high blood pressure, cholesterol or chronic diseases. Maintenance medications are only available under the Smart90 program. For those using Specialty Medications, these are dispensed through Accredo Health Group, Inc., ESI's preferred Specialty Pharmacy under the Specialty Medication program. Each program 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. After the deductible is met, plan participants will be responsible for the applicable co-payment for all prescriptions filled. Whenever the cost of a prescription is less than the stated co-payment you will only be required to pay the lesser actual cost.

Annual Rx Deductibles	Individual	Two-Person	Family
Platinum PPO Plan:	$100	$200	$300
Gold PPO Plan:	$200	$400	$500
Silver PPO 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.			

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Co-Payments for up to a 30-day supply of Short Term 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 Participants in the Platinum PPO Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$40
Co-payment, Non-Formulary Brand:	$80

For Participants in the Gold PPO Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$45
Co-payment, Non-Formulary Brand:	$90

For Participants in the Silver PPO Plan:	
Co-payment, Generic:	$10
Co-payment, Formulary Brand:	$50
Co-payment, Non-Formulary Brand:	$100

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

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

**For the Platinum, Gold, and Silver Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Rx deductible.*

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Long-Term Maintenance Medications Smart90 Program

The Express Scripts Smart90 Program allows you to pay less for each 90-day supply of maintenance medications than you would pay for three 30-day supplies at non-participating retail pharmacies. For new prescriptions of maintenance medications, you may receive up to two 30-day courtesy fills at any retail pharmacy and pay the 30-day retail co-pay as stated above for each fill. However, you will receive notice from Express Scripts upon your first fill that you will need to move the prescription to a participating Smart90 network pharmacy prior to your third fill or the refill will be denied.

Once you are established on a new long-term medication or are refilling an existing maintenance medication **make sure your physician writes your prescription for a 90-day supply with up to a year's (3) refills** (if allowed). If you are filling your prescription at any Walgreens or Walgreens-owned retail pharmacy in the Smart90 network or receiving home delivery through the Express Scripts Mail Order Pharmacy, you will automatically be charged the lower 90 day co-pay listed below. If you are not currently using a Smart90 participating pharmacy, you will need to obtain a new prescription from your doctor to be filled at a Smart90 participating pharmacy.

Co-Payment for up to a 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 Participants in the Platinum PPO Plan:	
Co-payment, Generic:	$20
Co-payment, Formulary Brand:	$80
Co-payment, Non-Formulary Brand:	$160

For Participants in the Gold PPO Plan:	
Co-payment, Generic:	$25
Co-payment, Formulary Brand:	$95
Co-payment, Non-Formulary Brand:	$190

For Participants in the Silver PPO Plan:	
Co-payment, Generic:	$25
Co-payment, Formulary Brand:	$100
Co-payment, Non-Formulary Brand:	$200

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

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

**For the Platinum, Gold and Silver Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Prescription Drug deductible.*

You can review your Smart90 Program options by logging in to *www.expressscripts.com* or calling 866-890-1419. If you are a first-time visitor to the website, take a minute to register (be sure you have your member ID number handy). You can also use the Express Scripts mobile app to locate a participating pharmacy.

Specialty Medications

Specialty Medications are high-cost medications dispensed exclusively by Accredo Health Group, Inc., ESI's preferred Specialty Pharmacy. To determine if a medication is part of the Specialty Program, review the list of impacted medications on the ESI website, call the number on your ESI ID card, or call Accredo at 800-922-8279. Under this program, specialty medications ordered for you or a covered family member by your physician or prescriber that are on the list will be covered only when ordered through Accredo and will no longer to be covered through Highmark or when obtained from an outpatient clinic, a home infusion company, a doctor's office, or from another pharmacy. For a new prescription of a listed Specialty Medication, an initial fill may be permitted from another provider to allow time for you and your physician to transfer the prescription to Accredo. Please note that this program does not affect medications supplied by 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 called SaveonSP 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 medications where these subsidies are available will automatically be enrolled

in the program and in many cases pay no co-pay for their medication!

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

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

For Participants in the Platinum, Gold, and Silver PPO Plans:	
Co-payment, Generic:	Member pays 20% of specialty medication cost, up to a $500 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

For Participants in the Gold HDHP Plan:	
Co-payment, Generic:	Member pays 20% of specialty medication cost, up to a $500 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

For Participants in the Bronze HDHP Plan:	
Co-payment, Generic:	Member is responsible for 40% of specialty medication cost, up to a $500 Maximum per prescription filled.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

**For the Platinum, Gold, and Silver Plans there is a separate prescription drug deductible. For Gold HDHP and Bronze HDHP there is a combined Medical/Prescription Drug 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. Drugs used to treat infertility.

8. Injectable drugs used to treat erectile dysfunction.
9. Weight management agents.
10. Injectable drugs (a select list of injectable drugs are covered with prior authorization; questions in this regard should be directed to ESI).
11. Allergens.
12. Serums, toxoids, and vaccines.
13. Prescription multi-vitamins, except pre-natal.
14. Dental pastes, gels, and mouthwashes except those containing Fluoride.
15. Drugs equivalent to over-the-counter drugs.
16. Alcohol swabs.
17. Blood glucose monitors.
18. Durable Medical Equipment.
19. Respiratory therapy peak flow meters.
20. Homeopathic Prescription Drugs.
21. Over-the-counter drugs, except insulin and certain preventive care drugs specified herein.
22. Experimental drugs and medicines.

Contact ESI member services to discuss questions about your coverage of medications.

Should ESI 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.

Regarding **Medicare Part D**, and creditable prescription drug coverage, the BOD has deemed that the Prescription Drug coverage offered by the Plan is better for the majority of Plan Participants and, on average for all Plan Participants, 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 Highmark.

To **appeal a denial for a Prescription Drug claim** please follow the appeal procedure as outlined under "Express Scripts Reviews and Appeals Overview" below.

Express Scripts Reviews and Appeals Overview

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review (also called prior authorization), the prescriber submits the request electronically. Information about electronic options can be found at *www.express-scripts.com/PA*.

To request an initial administrative coverage review, the member (or his or her representative) must submit the request in writing. Obtain a Benefit Coverage Request Form by calling the Customer Service phone number (on the back of your prescription card). Complete the form and fax to 877-328-9660 or mail to:

Express Scripts, Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at 1-800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	**Decision Timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (Home Delivery)	<u>Patient:</u> Automated call (letter if call not successful) <u>Prescriber:</u> Electronic or Fax (letter if not successful)	<u>Patient:</u> letter <u>Prescriber:</u> Electronic or Fax (letter if not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	<u>Patient:</u> Automated call and letter <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)	<u>Patient:</u> Live call and letter <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)

**If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.*

***Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48-hour extension will be granted.*

How to request a Level 1 Appeal or Urgent Appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Clinical review requests: Fax to 1-877-852-4070 or mail to:

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

Administrative review requests: Fax to 1-877-328-9660 or mail to:

Express Scripts, Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

An urgent appeal may be submitted if in the opinion of the attending provider the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone (1-800-753-2851) or fax (1-877-852-4070). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identified the appeal as urgent.

How a Level 1 Appeal or Urgent Appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 days	Patient: Automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if not successful)	Patient: letter Prescriber: Electronic or Fax (letter if not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: Automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

**If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.*

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a Level 2 Appeal after a Level 1 appeal has been denied

When a Level 1 Appeal has been denied (adverse benefit determination), a request for a Level 2 Appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the Level 1 Appeal adverse benefit determination. To initiate a Level 2 Appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Clinical review requests: Fax to 1-877-852-4070 or mail to:

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

Administrative review requests: Fax to 1-877-328-9660 or mail to:

Express Scripts, Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

An urgent Level 2 Appeal may be submitted if, in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone (1-800-753-2851) or fax (1-877-852-4070). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a Level 2 Appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist, Physician, panel of clinicians, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 days	Patient: Automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if not successful)	Patient: letter Prescriber: Electronic or Fax (letter if not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: Automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

**If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.*

When and How to request an External Review

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

To submit an external review, the request must be faxed to 1-617-375-7683 or mailed to:

MCMC, LLC
Attn: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929

The request must be received within 4 months of the date of the final Internal adverse benefit determination. If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline will be the next business day). The phone number is 1-617-375-7700, ext. 28253.

How an External Review is processed

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO). The patient will be notified within 1 business day of the decision.

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

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider the application of the time periods for making non-urgent care determinations could seriously jeopardize

the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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