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Pharmacy Benefit Plan Clarksville Montgomery County Employees Insurance Trust - 2024-2025 Pharmacy Reference Guide for the Standard Medical Plan

Your Prescription Drug Benefits are Administered by EpiphanyRx

EpiphanyRx is a pharmacy benefit manager known for clinical expertise and exceptional member service. The information provided is intended to provide a broad overview of benefit options and available programs. Please keep in mind that this Plan Summary does not have all of the details of the Plan.

To obtain information about your specific benefit plan, visit the member portal at www.epiphanyrx.com or contact Customer Care at 844-820-3260.

Prescription Drug Benefits

Prescription Drug Covered Expenses

Covered prescription drugs include drugs approved by the Food and Drug Administration (FDA) and that are required to be labeled, "Caution - Federal Law prohibits dispensing without a prescription", insulin and some diabetic supplies when prescribed by a physician or other authorized licensed health professional and dispensed by a licensed pharmacist. This excludes "over-the-counter" medications unless coverage is required by the Affordable Care Act (ACA).

Some FDA-approved drugs may not be covered by the plan if they have over-the-counter (OTC) equivalents (unless coverage is required by the Affordable Care Act) or provide low-value as compared to other drugs available on the plan's formulary. The formulary is a list of drugs covered under your plan. It can be found at www.epiphanyrx.com/resources and is updated periodically.

The Amount You Will Pay for Prescription Drug Coverage

Benefits are provided for the payment of the prescription charge, less the amount you pay, according to your benefit design, for each prescription order or refill. You will NEVER pay more than the cost of the drug.

Your plan may have a **deductible**. The deductible is the amount you must pay before the employer plan begins to pay. Once the deductible is satisfied, drugs are classified in tiers. Please access the member portal at www.epiphanyrx.com or call Customer Care at 844-820-3260 for more information.

Tier 1 drugs have the lowest member cost (copay or coinsurance). Tier 3 drugs have the highest member cost (copay or coinsurance). To determine the tier in which a drug is classified by your plan, log into www.epiphanyrx.com/resources. The tier drug classifications are updated periodically.

- Tier 1 - All covered generics and some lower cost brand products
- Tier 2 - Preferred brand products
- Tier 3 - Non-preferred brand products

There may also be a **maximum out-of-pocket** on your plan. This means any copay or coinsurance paid by you will apply to your out-of-pocket maximum. This is the maximum amount that a member must pay for drugs in a plan year. When the out-of-pocket maximum is met, the plan pays 100% of eligible expenses for the remainder of the plan year. To find your plan's deductibles, copay/coinsurance, maximum out-of-pocket, and tier information, refer to your member portal at www.epiphanyrx.com or call Customer Care at 844-820-3260.

If you or your provider choose a brand-name drug, when a generic or biosimilar is available, you may have to pay the copayment for the drug's tier plus the difference in cost between the brand drug and the generic or biosimilar drug. This cost difference will not apply to your deductible or out-of-pocket maximums.

Specialty Medications

Your plan may include coverage for specialty medications. Specialty medications are drugs that are used to treat complex conditions. Not all specialty drugs are covered by the pharmacy benefit, and some may be covered under the medical plan. Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are only available through Lumicera (855-847-3553). In rare instances, you may be required to use a use a different specialty pharmacy for limited distribution medications that are available only through select pharmacies. In those cases, you must use a pharmacy in the EpiphanyRX specialty pharmacy network. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. If you have any questions, refer to your member portal at www.epiphanyrx.com or call Customer Care at 844-820-3260.

Pharmacy Networks

Your prescription drug coverage has a retail pharmacy, a specialty pharmacy, and a mail order component. Your plan may include required network/preferred pharmacy options. Prescriptions must be obtained through an EpiphanyRx contracted network pharmacy. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. However, out-of-network prescription costs may be submitted for credit to deductible and/or out-of-pocket maximum. To identify an in-network pharmacy or enroll in the mail order service, refer to your member portal at www.epiphanyrx.com or call Customer Care at 844-820-3260.

Specialty prescriptions must be obtained through designated specialty pharmacies. Lumicera Health Services will provide guidance in obtaining your specialty prescription. There may be other considerations associated with specialty medication, such as shipping to your home or medical provider. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. Please call EpiphanyRx at 844-820-3260 if you have any questions about where to obtain your medications.

As an added benefit, your plan has a mail order pharmacy option. There may be different copays assigned or required pharmacies for your mail order benefit. You may also have the option to obtain maintenance drugs up to a 90-day supply through mail order. A complete maintenance list is available at www.epiphanyrx.com/resources.

Diabetic Products

Select insulin products, needles, syringes, test strips and glucose meters (non-continuous monitoring) are the only diabetic supplies available as prescription drug benefits under the plan and you will be responsible for your cost share based on your benefit design. All diabetic supplies, incuding glucose monitors, have a separate copayment fore each prescrtption order or refill.

Compound Medications

Your plan does not include coverage for compound drugs. These are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or clinically appropriate.

Preventive Drugs Covered Under the Affordable Care Act (ACA)

Select products may be covered at 100% without a copay if the prescription is preventive. When a generic product is available, only the generic will be covered at 100% without a copay. For a complete list of applicable medications refer to the preventive coverage list at www.epiphanyrx.com/resources.

Maintenance Drug List (MDL)

Maintenance drugs are certain drugs taken on an ongoing basis (three months or more), such as those used to treat high blood pressure or high cholesterol. The plan has established a list of maintenance drugs that are available up to a 90-day supply at a network pharmacy. A complete MDL list is available at www.epiphanyrx.com/resources. This list is subject to change periodically.

Non-Essential Health Benefits

The amount you pay for drugs designated as essential health benefits count toward your deductible and/or out-of-pocket maximum. Your plan covers select non-essential health benefits drugs. The amount you pay for non-essential health benefits drugs will NOT count toward your deductible and/or out-of-pocket maximum.

Access Guidance Services

The plan works with EpiphanyRx to provide access guidance services to assist you in obtaining copay assistance for certain drugs that have manufacturer-funded copay assistance programs. If the drug has copay assistance available, the amount you pay for that drug may vary. It may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. Once copay assistance is exhausted, the amount you pay will be no more than your benefits design.

To take advantage of this pricing, you will be required to remain enrolled in the manufacturer copay assistance program. Amounts paid by manufacturers on your behalf or directly reimbursed to you (including manufacturer coupons) will not count toward your annual out-of-pocket maximum or deductible. Instead, only those payments made directly by you, and not reimbursed by the manufacturer, will count toward your out-of-pocket maximum or deductible.

Medical Carve-Out

Your plan may include this medical specialty program. It moves coverage of select specialty drugs typically covered under the medical benefit to EpiphanyRx for coverage and management. Call Customer Care at 844-820-3260 for more information.

Drug Coverage Guidelines - Quality and Utilization Management

To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy through drug coverage guidelines. These guidelines can be found in the pharmacy section of our website. You may also call the customer service department number on the back of your ID card for more information.

1. **Prior Authorization** - The plan requires a review to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, EpiphanyRx will work with your prescriber to complete the prior authorization review. Either you or the pharmacy can ask your doctor to call 844-820-3260 to initiate the prior authorization.

   Prior Authorization forms can be found at www.epiphanyrx.com/resources. Once your prior authorization is reviewed, a clinician may contact your doctor to discuss your case and potential medication alternatives. Your doctor may change your prescription when medically appropriate to a different brand name or generic medication.

2. **Quantity Restrictions** - For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current scientific literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design.

3. **Step Therapy** - In some cases, you are required to first try certain drugs to treat your medical condition before the plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the plan may not cover Drug B unless you try Drug A first.

Please access the member portal at www.epiphanyrx.com or call Customer Care at 844-820-3260 for more information.

This Standard Plan Reference Guide (PRG) provides general information on pharmacy benefits under the Standard PPO Medical Plan. It is one of two documents that makes up the Standard Medical Plan Summary Description (SPD). The other document is the Standard and Preferred PPO Medical Plan Evidence of Coverage (EOC). That document is available from your employer upon request.

Eligibility requirements and termination provisions for this pharmacy coverage are the same as those outlined in the BCBSTN Standard and Preferred PPO Medical Plan Evidence of Coverage.

For pharmacy claim procedures and remedies for disputing denied pharmacy claims, contact EpiphanyRX at www.epiphanyrx.com or call 844-820-3260.

CMCEIT STANDARD PPO MEDICAL PLAN
THE AMOUNT YOU WILL PAY FOR PRESCRIPTION DRUG COVERAGE

The amount you pay for each prescription order or refill will be determined based on the applicable "tier" (or level) of the drug, and the day supply of the drug. Refills of prescriptions are allowed after 75% of the previous prescription has been used (e.g., 23 days in a 30-day supply).

DEDUCTIBLE	**DEDUCTIBLE TYPE**	**In And Out-of-Network**
You pay 100% of the drug cost up to the amounts listed to the right.	Your deductible is embedded, , meaning that your post-deductible copays/coinsurance will apply if you meet your individual deductible or any member of your family meets the family deductible.	Individual $2,000 Two-Person $4,000 Family $5,000

NON-MAINTENANCE PRESCRIPTION DRUGS (Maximum Day Supply 30)	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY AFTER DEDUCTIBLE
Tier 1-Generic	30% coinsurance after deductible	100%
Tier 2-Preferred Brand	30% coinsurance after deductible	100%
Tier 3 Non-Preferred Brand	30% coinsurance after deductible	100%
Specialty drugs-Tier 1	30% coinsurance after deductible	Not Covered
Specialty drugs-Tier 2	30% coinsurance after deductible	Not Covered
Specialty drugs-Tier 3	30% coinsurance after deductible	Not Covered

MAINTENANCE PRESCRIPTION DRUGS (Maximum Day Supply 90)	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE (Includes Costco Mail Order)	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1-Generic	30% coinsurance after deductible	100%
Tier 2 Preferred Brand	30% coinsurance after deductible	100%
Tier 3 Non-Preferred Brand	30% coinsurance after deductible	100%

OUT-OF-POCKET MAXIMUM	**OUT-OF-POCKET TYPE**	**IN-NETWORK**	**OUT-OF-NETWORK**
Your out-of-pocket maximum is the maximum amount you pay in any plan year. This means any co-pay or coinsurance paid by you will apply to your out-of-pocket maximum.	Your out-of-pocket maximum is embedded, meaning once you have meet your individual out-of-pocket maximum, you can receive post out-of-pocket benefits.	INDIVIDUAL $5,250 TWO-PERSON $10,500 FAMILY $10,500	Individual $15,750 Two-Person $31,500 Family $31,500

If you paid cash for a drug, the amount you paid for drug may count toward the deductible and/or out-of-pocket maximum amounts, if you paid the same or lower price as what the drug would have cost through EpiphanyRX. For the amounts to be considered, you must submit the receipt using the Prescription Reimbursement Request Form which can be found at www.epiphanyrx.com/resources.

NON-ESSENTIAL HEALTH BENEFITS DRUGS (Maximum Day Supply 30)	THE AMOUNT YOU PAY AT IN-NETWORK PHARMACY	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	50% coinsurance after deductible	100%
Tier 2 drugs	70% coinsurance after deductible	100%
Tier 3 drugs	80% coinsurance after deductible	100%

EXCLUSIONS UNDER THE PLAN INCLUDE:

PRESCRIPTION DRUG SERVICES, SUPPLIES, AND MEDICATIONS NOT COVERED UNDE THE PLAN INCLUDE:

- Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meanings drugs that may be prescribed, but are not approved for that condition or age group);
- Drugs labeled "Caution: Limited by federal law to investigational use";
- Any drug being used for cosmetic purposes;
- Medical devices or appliances;
- Diabetic pumps and pump supplies;
- Prescription drugs not covered by a current prescription order;
- Drugs not listed on the Plan's Formulary;
- Any compounded drugs that contain products excluded by the Plan;
- Drugs of unproven clinical efficacy and/or value;
- Drugs that have less expensive, but clinically equivalent alternatives;
- Products for nutritional support, unless required for coverage by the Affordable Care Act;
- Products recently approved by the FDA may not be covered upon release to the market;
- Coverage may be changed and/or the amount you pay may vary based on the condition being treated;
- Sexual Dysfunction Agents;
- Weight Loss Agents;
- Infertility Agents;
- All drugs and treatments that involve gene therapy. This includes, but is not limited to gene-editing treatments; gene therapy products; and any treatment that seeks to modify genetic material within a patient's cells for therapeutic purposes;
- All drugs and treatments that involve cell therapy. This includes, but is not limited to stem cell therapies, including both autologous and allogeneic stem cell treatments; CAR-T therapies and any other treatments that involve the modification of immune cells; and any treatment involving the extraction, modification, and reintroduction of cells for therapeutic purposes.