Outpatient Prescription Drug Rider

MHS Association - Sunshine Inc. Residential and Support Services – Regular Deductible (1312545)

Effective 1/1/2026

Outpatient Prescription Drugs are provided by Express Scripts. **No plan benefit if purchased outside of Express Scripts Pharmacy Network**. The attached Outpatient Prescription Drug Rider provides benefit information. and guidelines when purchasing outpatient prescription drugs. **If you have questions about your outpatient prescription drug coverage, please contact Express Scripts at (800) 818-9787**.

Copay/Coinsurance	**Retail (up to 30 day at in-network pharmacy and up to a 90 day at Walgreens)** $10 Generics $50 Preferred Brand (Higher copay may apply if Brand is dispensed when generic is available) $100 Non-Preferred Brand (Higher copay may apply if Brand is dispensed when generic is available) **Exception Drug Pricing:** $2 Diabetic Supplies/Insulin Needles, Syringes $2 Generic Drug on Preventative Drug List $20 Preferred Brand on Preventative Drug List (Higher copay may apply if Brand is dispensed when generic is available) $35 Non-Preferred Brand on Preventive Drug List (Higher copay may apply if Brand is dispensed when generic is available) **Specialty Drugs (limited to 30 day):** 20% Coinsurance Specialty (max $200 - Higher copay may apply if Brand is dispensed when generic is available) **Specialty Drugs on SaveOnSP (limited to 30 day and must be enrolled in program):** $0 Cost to member if enrolled in Program 30% Coinsurance if program is declined (will not apply to accumulators)

	Mail (up to a 90 day supply) from Express Scripts or EnGuide, (the Express Scripts Pharmacy dedicated to dispensing and shipping GLP-1 medications) $20 Generics $100 Preferred Brand (Higher copay may apply if Brand is dispensed when generic is available) $200 Non-Preferred Brand (Higher copay may apply if Brand is dispensed when generic is available) **Exception Drug Pricing** $2 Diabetic Supplies/Insulin Needles, Syringes $2 Generic Drug on Preventative Drug List $40 Preferred Brand on Preventative Drug List (Higher copay may apply if Brand is dispensed when generic is available) $70 Non-Preferred Brand on Preventive Drug List (Higher copay may apply if Brand is dispensed when generic is available)
Out Of Pocket* (Combined medical and prescription)	**$9,200 Individual** **$18,400 Family**

*Out-of-pocket limits protect you in case you or a family member has a condition that requires prescriptions that would be very expensive. The limit is the most you would ever pay out of your pocket for prescription drug expenses. Once your payments reach the limit, the plan pays 100% of your prescription drug expenses for the rest of the year.

If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Generic Drug Rules

If you request a brand name drug when a generic drug is available, the plan will only cover the cost of the generic drug. You will need to pay the difference in cost between the brand and generic drug plus the generic copay. If there is a clinical reason for you to receive the brand drug, please contact Member Services to discuss if a clinical exception can be made.

Applicable Plan Benefits:

Non-Grandfathered Plan
Drug Quantity Management (DQM)
Prior Authorization
Step Therapy
SaveOn SP
EnCircle Rx

Prescription Plan Definitions

Accredo: An Express Scripts specialty pharmacy.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the member's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing member complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations. For more information, members can call Express Scripts member services at (800) 818-9787.

Appeals process: A specific process that a member needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Members are notified of the decision and of any rights to appeal an adverse benefit decision. For ERISA plans: Under Section 502(a) of ERISA, members have the right to bring a civil action if their final appeal is denied.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the member's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

Compound: A medicine that is made of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order.

Copay/coinsurance: The cost of a covered drug paid by the member at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Coverage review: Also known as the initial review or initial determination, this process is followed when a member requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

EnCircleRx: A program managed by Express Scripts to provide enhanced controls to ensure GLP-1 access to members with a higher BMI, lower BMI with 2 or more comorbidities, or a diabetes diagnosis supported by documentation from the physician. The goal is to improve clinical outcomes for diabetes and weight management.

A lifestyle modification program may be required through Omada for weight management. An invitation to the program will be sent via email or letter to the member. The program requires self-directed enrollment, instructions are available as needed. Omada will supply a scale to the member who will also gain access to a support group, coach, and a program app. As the member progresses along their weight management journey, the prior authorization requirement is reassessed to verify the member has lost the prerequisite amount per program guidelines. If the member does not meet Omada specific requirements they will no longer be able to fill prescriptions for the GLP-1.

Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand-name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Grandfathered plans (GF): Health plans that were in existence prior to the Affordable Care Act. The provisions of Preventive services mandated by the ACA are not required to be provided by Grandfathered plans, some plans have chosen to implement them.

Home delivery: A distribution channel in which the member receives a prescription drug through the mail from the Express Scripts Pharmacy℠.

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide members with lower costs and more convenience.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, members need to use a network pharmacy to pay the amounts specified by the Plan.

Non-Grandfathered Plans (NGF): Heath plans that comply with the guidelines under the Affordable Care Act. This includes coverage at no cost for some preventive medications.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and members will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as "benefit exclusion," this includes a drug or drug class that is not included in the member's benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that is available without a prescription from a doctor.

Preventive Drugs (if applicable): Medications used for chronic conditions that have a lower copay or no cost.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence-based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

SaveOnSP Copay Offset Program (if applicable): We can support more than one-third of our patients in receiving financial assistance from manufacturers and foundations for specialty medications. Our relationship with SaveOnSP, a third-party vendor, actualizes plan and member savings by maximizing copay assistance from manufacturers. The SaveOnSP program leverages the Affordable Care Act state benchmark requirements to reclassify certain specialty medications under the category of non-essential health benefits. This SaveOnSP targets over 300 drugs in more than 20 specialty categories, including:

- Oncology
- Inflammatory conditions
- Multiple sclerosis
- Blood cell deficiency
- Hepatitis C

- Hereditary angioedema
- Pulmonary arterial hypertension
- Cystic Fibrosis
- Hemophilia
- Asthma & Allergy

Within the SaveOnSP program, certain specialty products will be reclassified as non-essential health benefits, removing them from member accumulators. The member copay will be inflated to match the amount of manufacturer funding available through the copay assistance program, bringing the member's final responsibility to $0, and resulting in $0 applied to member deductible and out of pocket totals.

Prescription plan FAQs

What is covered?

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and brand-name drugs. The Plan also maintains a formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money.

An expert panel of physicians and pharmacists carefully reviews the drugs on the formulary for safety, quality, effectiveness and cost. The formulary and conditions of drug coverage under the Plan is subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services at (800) 818-9787. A pharmacist can also check whether a medication is on the formulary or covered at any time.

Immunizations/Vaccines (if applicable) which are recommended and considered as the standard of care, based on information from the Centers for Disease Control, may be obtained at the Pharmacy. The member must use a Pharmacy that is In-Network with Express Scripts.

Most immunizations will not need a prescription from the doctor but, there may be special cases when additional information is needed.

Most plans generally do not cover immunizations required for foreign travel or employment. For more information, go to express-scripts.com or call Express Scripts Member Services at (800) 818-9787.

Weight loss medications (if applicable) may be covered with clinically appropriate documentation from your doctor. For more information, go to express-scripts.com or call Express Scripts Member Services at (800) 818-9787.

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there are no alternatives to try or exceptions to coverage. The following list of benefit exclusions outlines general categories of items not covered under the Plan. Other drugs may also be excluded from the formulary, to check whether a medication is excluded, go to express-scripts.com or call Express Scripts Member Services.

- Prescriptions that require a prior authorization when a prior authorization is not on file or approved.
- Physician's office allergy therapy – this may be covered by the medical part of the plan.
- Medications that are not approved by the Federal Drug Administration.
- Compounds, unless all National Drug Codes submitted by the compounding pharmacy are covered.

To see if a drug is covered on the formulary, go to express-scripts.com or call Express Scripts Member Services.

What is the difference between generic and brand-name drugs?

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs.

These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists and have been added to the Express Scripts formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the Express Scripts formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any particular drug on the Plan's formulary, log onto express-scripts.com or contact Express Scripts Member Services. A medication's inclusion on the formulary is no guarantee of effectiveness. Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

How are claims paid?

Generally, members do not need to submit claims under the prescription plan. A member pays the copay, coinsurance or other amount required by the Plan when filling a prescription. However, if a member needs to submit a paper claim for reimbursement for payment of the cost of a covered drug (for example, if the pharmacy's computer system was not working or the card was left at home), the member should contact human resources or their plan sponsor.

When should a retail pharmacy be used?

The retail pharmacy is the most convenient option when a medication is needed immediately, such as an antibiotic for a short-term illness or infection. Members simply present their ID card to the pharmacist, along with the doctor's written prescription if it has not been sent electronically, to receive a 30-day supply of the medicine.

Express Scripts' retail pharmacy network includes more than 70,000 participating pharmacies, including national chains as well as independent retailers.

Some plans may not cover a medication filled at a neighborhood pharmacy because it is not "in network," but the medication will be covered at a large retail pharmacy chain or grocery store if those pharmacies are "in network." To find a participating retail pharmacy, members can visit express-scripts.com and use the Pharmacy Locator to find a list of pharmacies close to where they live or work. Members can also download the Express Scripts mobile app to find a pharmacy when they're on the go. To download the mobile app for free, search for "Express Scripts" in smartphone app stores. If members do not have computer access, they can call Express Scripts Member Services.

Prescriptions filled at a nonparticipating retail pharmacy are not covered under the Plan, which means if members fill prescriptions there, they pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's deductible or out-of-pocket maximums.

When should the home delivery pharmacy be used?

Express Scripts offers home delivery, or a mail pharmacy service, for prescriptions taken on a regular basis for long-term conditions, such as asthma, depression or high blood pressure. With home delivery, members can receive up to a 90-day supply of medicine from the Express Scripts Pharmacy℠, often for a lower cost than they would pay at a retail pharmacy.

Home delivery advantages

- Fewer refills and fewer trips to the pharmacy
- Free standard shipping costs included as part of the Plan
- Medicine is delivered in tamper-proof, weather- resistant packages
- Drugs that require refrigeration are shipped in cold packs
- Pill bottles have child-resistant safety caps, but easy-open caps may be requested when the order is placed

How to get started with home delivery?

Express Scripts offers members a variety of convenient ways to submit new prescription orders.

- **New prescriptions** may be submitted directly from the doctor's office or through the mail.
- **Refills** can be ordered electronically using the Express Scripts mobile app or website, through the mail or by phone.

Visit express-scripts.com to learn more.

Pharmacy Program Descriptions

Drug Quantity Management (DQM) makes sure that members are getting the right amount of medication and that it is prescribed in the most efficient way. For example, the doctor may say, "take two 20mg pills each morning." If that medication is also available in 40mg pills, Express Scripts will contact the doctor about prescribing one 40mg pill a day instead of two 20mg pills. In addition, if the doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and the members will have just one copayment, not two.

DQM also makes sure that a member's prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Formulary Overview: Clinically sound, cost-effective Express Scripts formulary options help decrease prescription drug expenses when combined with a well-designed benefit plan. To ensure the clinical appropriateness of their formularies, Express Scripts physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics (P&T) Committee, which reviews and approves Express Scripts formularies.

Prior Authorization monitors both cost and safety. If a pharmacist tells a member that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug. This is similar to when a healthcare plan authorizes a medical procedure in advance.

When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered but the member wants to take it, the member will pay the full price of the medicine.

SaveOn SP Copay Offset Program (If applicable) helps reduce member cost. The member copay will be reduced to $0.00 by utilizing copay assistance from manufacturers and foundations. If the member chooses not to utilize SaveON SP the member will be responsible for the 30% copay and it will not apply to any out-of-pocket accumulators, such as deductible or Rx accumulators.

The SaveOn SP program targets over 300 specialty drugs in multiple categories, including: oncology, inflammatory conditions, multiple sclerosis, blood cell deficiency, pulmonary arterial hypertension, cystic fibrosis, hemophilia and other conditions.

Specialty drugs must be obtained through a Specialty Pharmacy that is in Network with the SaveOn SP program. If a specialty drug is obtained through a Specialty Pharmacy that is not part of the SaveOn SP network there is no coverage.

Step Therapy (if applicable) is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets members get the treatment they need affordably. First-line medicines are the first step.

- First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

The first time a member tries to fill a prescription that is not for a first-line medicine, the pharmacist should explain that step therapy asks the member to try a first-line medicine before a second-line drug. Only the doctor can change the current prescription to a first-line medicine covered by the Plan.

To get a first-line medicine that the Plan covers, a member should ask the pharmacist to call the doctor and ask for a new prescription. If it is easier, the member can also call the doctor to ask for a new prescription. Also, the pharmacist should explain to the member that there's an option to choose a second-line alternative to the first-line medicine. However, because the Plan will not cover second-line drugs until after the member and the doctor have considered a first-line medicine to treat the condition, the member will pay full price for that second-line drug.