Your Summary of Benefits
REEP

Anthem Blue Cross

Custom Value Deductible HMO $500 40/0 0% Select HMO Network (HMO 40 w/o Chiro)

Effective 07.01.2021

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy. This plan has a special network including a limited number of Physicians, Independent Practice Associations (IPAs) and Medical Groups.

Calendar Year Deductible: $500/individual:$1,000/family

The following services are subject to the calendar year deductible in addition to any other applicable copays: inpatient hospital charges (not including professional services), outpatient hospital facility charges, ambulatory surgical center & skilled nursing facility.

Annual copay maximum: Individual $1,500; Family $4,500

Deductible and Coinsurance and/or Copays applies to Annual Copay Maximum
The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), Additional preventive care for women provided for in the guidelines Supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay *(deductible waived*)
Physician Medical Services	
∘ Office & home visits (*includes Retail Health Clinic)*	$40/Visit
∘ Specialists	$40/Visit
∘ Preferred Online visits *(includes Mental/Behavioral Health and Substance Abuse)*	No copay
∘ Skilled nursing facility visits	No copay
∘ Hospital visits	No copay
∘ Surgeon & Surgical assistant	No copay
∘ Anesthesiologist or anesthetist	No copay

Covered Services	Per Member Copay
Acupuncture	$40/Visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
• Outpatient surgery & supplies	Deductible, then $250/copay
• CT or CAT scan, MRI or nuclear cardiac scan	$40/test
• PET scan	$40/test
• All other X-ray & laboratory tests (*including genetic testing, mammograms and ultrasounds)*	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care after an illness or injury; additional visits may be available when approved by the medical group)	No copay
General Medical Services (*when performed in non-hospital-based facility*)	
• CT or CAT scan, MRI or nuclear cardiac scan	$40/test
• PET scan	$40/test
• All other X-ray & laboratory tests (*including genetic testing, Mammograms, pap smears, & prostate cancer screening*)	No copay
• Allergy testing & treatment (including serums)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to 60-days period of care after an illness or injury; additional visits available when approved by the medical group)	No copay
Emergency Care In Area (within 20 miles of medical group) and Out of area	
• Physician & medical services	No copay
• Outpatient hospital emergency room services	$100/visit (*copay waived if admitted*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	Deductible, then $250/admit

Covered Services	Per Member Copay
Urgent Care (out of service area)	$40/Visit *(copay waived if admitted inpatient; deductible waived)*
Skilled Nursing Facility (*subject to utilization review)* Semi -private room, services & supplies (*limited to 100 days/calendar year*; *limit does not apply to mental health and substance abuse*)	No copay
Ambulance Services • Ground or air ambulance transportation when medically necessary including medical services & supplies	No copay
Ambulatory Surgical Center • Outpatient surgery & supplies	Deductible, then $250/copay
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services) • Complications of pregnancy or abortions **Genetic testing of fetus**	$40/Visit No copay No copay
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment Rental or purchase of DME including dialysis equipment and supplies, therapeutic shoes or inserts for members with diabetes *(Hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	No copay
Family Planning Services • Infertility studies & tests • Female Sterilization (*including tubal ligation and couseling/consultation)* • Male Sterilization • Counseling & consultation	 50% of covered expense† No copay $50 No copay
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care *(subject to utilization review; waived for emergency admissions)* • Inpatient physician visits • Outpatient care • Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	 No copay No copay No copay No copay

Covered Services	Per Member Copay
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	No copay
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 Deductible, then $250 $40/Visit $40/Visit
Outpatient Prescription Drug Benefits • Coverage provided by Express Scripts	

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

† Not applicable to the annual copay maximum

Premier HMO- Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Incarceration. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Clinical Trial Non-Covered Services. Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing Aids. . Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines, except as specified as covered in the Evidence of Coverage (EOC).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Medical Equipment, Devices and Supplies. • Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft. • Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury. • Non-Medically Necessary enhancements to standard equipment and devices. • Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. • Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). Gene therapy that introduces or is related to the

introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.

Gene Therapy. Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.

Third Party Liability – Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

• Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

• Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Wilderness. Wilderness or other outdoor camps and/or programs. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Services Received from Providers on a Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:

• Delivery Charges. Charges for the delivery of prescription drugs.

• Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.

• Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.

• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.

• Lost or Stolen Drugs. Refills of lost or stolen drugs.

• Non-Approved Drugs. Drugs not approved by the FDA.

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem.

Educational Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to the Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Private Duty Nursing. Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

Personal Care, Convenience and Mobile/Wearable Devices.

- Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats and shower chairs.
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).
- Home workout or therapy equipment, including treadmills and home gyms.
- Pools, whirlpools, spas, or hydrotherapy equipment.
- Hypo-allergenic pillows, mattresses, or waterbeds.
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

Autopsies. Autopsies and post-mortem testing.

Dental Devices for Snoring. Oral appliances for snoring.

Hospital Services Billed Separately. Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

Growth Hormone Treatment. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

Clinically-Equivalent Alternatives. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

REEP Benefits – HMO Rx Plan 3

The following outline of your group's outpatient prescription drug benefit is provided for your information. This document contains specific coverage and exclusion information related to your prescription benefit provided by REEP and administered by Express Scripts, Inc. For more information about these drugs or others, you can reach us by calling 1-888-806-4969 or by going to express-scripts.com. Just click on "Member Services" and login using your member ID. For more general information about drugs, vitamins and your health conditions, log on to express-scripts.com and select "Drug Digest".

Benefit Design

Retail Copayments -30 Day Supply	
Generic	$15
Formulary Brand	$40
Non Formulary Brand	$80
Mail Service Copayments – 90 Day Supply	
Generic	$30
Formulary Brand	$80
Non Formulary Brand	$160

*** Healthcare Reform preventative items will be covered for a $0 copay.*

*** Claims for Out-of-Network purchases will be reimbursed at 50%.*

*** Annual Out of Pocket $1500 Individual / $4500 Family*

Select Home Delivery Program – This Home Delivery program will encourage you to ***take action*** about where you purchase your maintenance medications. If you don't take any action, your copayment may increase. The program is designed to remind you of the benefits and potential savings through the Express Home Delivery pharmacy. You can call Express Scripts' **Member Choice Center at 877/603-1032** to review your options with a specialist; 1) You can either transfer your prescriptions to Home Delivery, or 2) ***opt out*** of the program.

Express Advantage Network - Certain pharmacies in the Express Scripts Network are identified as preferred pharmacies (Tier 1). Non-preferred pharmacies are in Tier 2. When you fill your prescriptions at a preferred Tier 1 pharmacy, you will pay the copay as outlined for your plan. *But, if you choose to use a Tier 2 pharmacy, you may pay up to an **additional $15 plus your copay for each prescription** you fill at a non-preferred pharmacy*. Some examples of preferred Tier 1 pharmacies include (but are not limited to) Rite Aid, Stater Bros., Albertsons, Vons, Costco, Target, Sam's Club and Walmart.

Other Programs will remain in place and include;

Generics Preferred - If you - OR - Doctor select a brand drug when a generic drug is available you will pay the brand copay plus the difference in cost between the brand and generic. Your doctor must provide medical necessity to override the additional cost.

Accredo Exclusive Specialty Program - All specialty medications must go through the Accredo Pharmacy after one fill at retail. Please call 1-800-922-8279 if you are on a specialty injectable medication or specialty drug.

All prescription medications are covered by your plan. However some prescription products are excluded under your plan and are noted below.

▪ All over-the-counter products & drugs, and over the counter equivalents** ▪ Serums, Toxoids, Vaccines ▪ Depigmentation agents and Injectable Cosmetic agents ▪ Durable Medical Equipment ▪ Drugs used for investigational purposes, of for off-label use ▪ Diagnostic, Testing and Imaging Supplies	▪ Homeopathic Medications and Medical Foods ▪ Fertility Agents ▪ Hair Growth Agents ▪ Contraceptive Devices, Implants, and IUDs ▪ Injectable Drugs to treat impotency (Yohimbine) ▪ Allergens ▪ Unit dose packaging, or repackaged products

The following OTC drugs are covered: Diabetic Supplies, Peak Flow Meters, Non Insulin Syringes, and Respiratory Therapy Supplies *Certain Injectable medications are not covered. ** Please call 1-888-806-4969 if you have a question on a drug that is not outlined or visit our website at express-scripts.com.

Prior Authorization & Step Therapy

Prior authorization is needed for certain medications. If you have questions on a particular drug, please contact Customer Service or visit express-scripts.com to perform a coverage check. Please have your doctor call Express Scripts at 1-800-753-2851 to go through a clinical review on your medication if it is subject to prior authorization.

Prior Authorization is a program that helps you get the prescription drugs you need ***with safety, savings and — most importantly — your good health in mind.*** It helps you get the most from your healthcare dollars with ***prescription drugs that work well for you and that are covered by your pharmacy benefit***. It also helps control the rising cost of prescription drugs for everyone in your plan.

The program monitors certain prescription drugs to ensure that you are getting the appropriate drugs for your disease state. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed a certain medication, that drug may need a "prior authorization." ***It makes sure you're getting a cost-effective drug that works for you.*** For instance, prior authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

Drug Quantity Limits

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines as recommended by the Food & Drug Administration (FDA). The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days' supply.

Express Scripts Home Delivery Pharmacy PO Box 66567 St Louis, Mo	Express Scripts Customer Service **1-888-806-4969** Open 24 hours, 365 days a year	Express Scripts Website www.express-scripts.com