Medical Practice Consortium

HSA 2800

PLAN REFERENCE GUIDE *2022*

epiphanyRX™

The following language is suggested language only. The terms used in these sections should be adjusted to match your SPD's defined terms. Use of the language is at the client's own risk and should not be relied upon as a substitute for legal advice. Clients should consult with their own legal counsel or experts to determine appropriate SPD language.

Prescription Drug Benefits

The Plan's prescription drug benefits are administered by EpiphanyRx.

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 or provide low-value as compared to other drugs available on the plan's formulary. The formulary can be found at www.epiphanyrx.com/resources and is updated from time-to-time.

Prescription drug services, supplies, and medications not covered under the Plan include:

- Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group);
- Drugs available without a prescription;
- Drugs labeled "Caution: Limited by federal law to investigational use";
- Any drug being used for cosmetic purposes, including those for hair growth and anti-wrinkle agents;
- 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;

Pharmacy Network

Your prescription drug coverage has a retail pharmacy, specialty pharmacy, and a mail order component. 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. To identify an in-network pharmacy or enroll in the mail order service, go to www.epiphanyrx.com/resources.

Specialty prescriptions must be obtained through Lumicera. In rare instances you may be required to 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. Please call EpiphanyRx at 844-820-3260 if you have any questions about where to obtain your medications.

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. 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).

If the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design or the amount determined by the manufacturer-funded copay assistance program. Once copay assistance is exhausted, the amount you pay will be no more than your benefit design. Dollars used from copay assistance programs will not be considered member out-of-pocket costs and will not count toward your deductible and/or out-of-pocket maximums. Your monthly contribution includes the cost of access to copay assistance services.

Drugs are classified in tiers generally by their cost to the plan, with Tier 1 drugs having the lowest cost to the plan and Tier 3 having the highest cost to the plan. 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.

Deductible	Deductible Type	Individual	Family
You pay 100% of the drug cost up to the amounts listed to the right.	Your deductible is embedded, meaning your post-deductible copays/coinsurance will apply if you meet your individual deductible or any member of your family meets the family deductible.	$2800	$5600

Non-Maintenance prescription drugs	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 drugs	$0	100%
Tier 2 drugs	$0	100%
Tier 3 drugs	$0	100%
Specialty drugs	$0	100%
Compounds	$0	100%
Maximum Day Supply	30 Days	N/A

Maintenance prescription drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	$0	100%
Tier 2 drugs	$0	100%
Tier 3 drugs	$0	100%
Compounds	$0	100%
Maximum Day Supply	90 Days	N/A

Out-of-Pocket Maximum	Out-of-Pocket Type	Individual	Family
Your out-of-pocket maximum is the maximum amount you will pay in any plan year. This means any copay or coinsurance paid by you will apply to your out-of-pocket maximum	Your out-of-pocket maximum is embedded, meaning once you have met your individual out-of-pocket maximum, you can receive post out-of-pocket benefits.	$2800	$5600

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. The form can be found at www.epiphanyrx.com/resources.

HSA Preventive Drug List

Your plan includes HSA Preventive Drug coverage as part of your prescription benefit plan. Preventive care medications are drugs that can help you prevent health problems or problems caused by a health condition. You must purchase drugs listed on the HSA list at a network pharmacy and quantity limits, utilization management, Step Therapy, etc., will apply if applicable. The HSA Preventive list can be found at: www.epiphanyrx.com/resources.

HSA Preventive prescription drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY BEFORE DEDUCTIBLE	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	20% copayment	100%
Tier 2 drugs	20% copayment	100%
Tier 3 drugs	20% copayment	100%
Compounds	20% copayment	100%
Maximum Day Supply	90 Days	N/A

Essential Health Benefits

The amount you pay for drugs designated as Essential Health Benefits counts toward your deductible and/or out-of-pocket maximum. Your plan covers select Non-Essential Health Benefits Drugs at the

tiers outlined below. The amount you pay for Non-Essential Health Benefits Drugs will NOT count toward your deductible and/or out-of-pocket maximum.

Non-Essential Health Benefits Drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	50% coinsurance	100%
Tier 2 drugs	70% coinsurance	100%
Tier 3 drugs	80% coinsurance	100%
Tier 4 drugs	90% coinsurance	100%
Maximum Day Supply	30 Days	N/A

Lifetime Maximums

Your plan covers up to $5,000 for medications used to treat infertility during your lifetime. The list of drugs to treat infertility may change from time-to-time and any claims for infertility medications are subject to your copays outlined in Section 3. If you use more than $5,000 of fertility medications, you will be responsible for any additional drug costs.

Generic and Brand-Name Medications

Prescription drugs are dispensed under three names: the biosimilar name, generic name and the brand name. Biosimilar drugs are alternatives to brand specialty drugs and are almost an identical copy. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, biosimilar, generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

If you choose a brand-name drug, when a generic or biosimilar is available, you may have to pay the copayment for the tier the drug is on that you are choosing 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.

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 retail pharmacy or as a 90-day supply at a network mail order pharmacy. A complete MDL list is available at: www.epiphanyrx.com/resources. This list is subject to change periodically.

Specialty medications

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

Not all specialty drugs are covered by the benefit, and some specialty drugs may be covered under the medical benefit. Select specialty medications, typically covered under the medical benefit, may be covered under the pharmacy benefit only. You may be required to obtain certain medications covered under the medical benefit at the most cost-effective site of care. Likewise, select medications that are

administered by a health care professional may be required to be obtained through your pharmacy benefit.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are only available through the approved EpiphanyRx specialty pharmacy network. To obtain a specialty medication, contact Lumicera at 855-847-3553. This pharmacy is subject to change.

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, including glucose monitors, have a separate copayment for each prescription order or refill.

Compound medications

Compound drugs 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. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. In addition, it must not include drugs excluded from plan coverage. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded prescriptions may be subject to additional coverage criteria and utilization management edits. Compounded prescriptions must be obtained from an in-network EpiphanyRx pharmacy.

Preventive Drugs Covered under the Affordable Care Act (ACA)

The following products will be covered at 100% without a copay if you have a prescription as a preventive service. If a generic product is available, only the generic will be covered at 100% without a copay.

- OTC aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Select generic Statin preventive medication for adults 40 to 75 at high risk
- FDA-approved contraceptives for women of child-bearing age
- Generic fluoride supplements for children age 6-months to 5 years
- OTC Folic acid supplements for women who may become pregnant
- Select Iron supplements for children 6 to 12 months at risk for anemia.
- OTC Vitamin D supplements for adults 65 or older at risk of falls
- Select smoking cessation products for adults age 18 and older
- Select breast cancer preventive drugs for adults age 35 years and older at increased risk for breast cancer
- Select bowel preparations for colonoscopy procedures for adults age 50 to 75 years

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.

a. *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 or appeal process. You can also contact EpiphanyRx via mail at:

EpiphanyRx
Prior Authorizations and Appeals
PO Box 999
Appleton, WI 54912-0999

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.

b. *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.

c. *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.