2021 Select Prescription Drug Plan

Your prescription drug benefit program is administered by Express Scripts.

Your Choices

If you are enrolled in any of the District medical plan options, you are eligible for prescription drug coverage. If you are not enrolled in the district's "Select Plan", please see the separate prescription (Rx) summary plan description (SPD) posted on the *HISD Benefits Office* web site at www.hisdbenefits.org.

When you need prescription drugs, you must use:

- A retail network pharmacy, or
- Express Scripts mail order pharmacy

Retail Pharmacy Program

Participating pharmacies have agreed to be part of Express Scripts retail pharmacy network. To locate a participating retail pharmacy in your area, access the Pharmacy Locator on www.express-scripts.com or call Express Scripts at 855.712.0331. You must use a network pharmacy to receive plan benefits. The plan doesn't cover prescriptions purchased at out-of-network pharmacies.

The retail pharmacy program is typically for the purchase of short-term use medications that you need to purchase immediately, such as antibiotics or certain pain medications. You may receive up to a 30-day supply of medication at a time. You must present your Express Scripts ID card to the pharmacist when purchasing a prescription. This ID Card is mailed to your home address upon initial enrollment in the plan, and is also available online at www.express-scripts.com. The amount of your copay depends on whether you purchase generic, preferred brand, non-preferred brand, or specialty drugs. Ask your doctor to consider prescribing an equivalent generic drug whenever possible since you can get the same quality as a brand-name drug at a lower cost.

Express Scripts Mail Service Program

The mail order program can save you money if you have a condition that requires maintenance medication, if you take regular medication, or you have a long-term illness. Through this program, you may purchase up to a 90-day supply of most prescribed medications. The amount of your copay again depends on whether you purchase generic, preferred brand, or non-preferred brand drugs. Your copay applies to each prescription you and your dependents purchase.

If you have paid for your prescription out of pocket and need to submit a paper claim, you can find the claim form on the web site, www.Express Scripts.com, and then submit it along with the receipts to:

Express Scripts, Inc.
PO Box 14711
Lexington, KY 40512-4711

Express Scripts Smart90 Program

For long-term and maintenance medications, the Smart90 Program allows you to receive a 90-day supply of your medication in two ways – either through the Express Scripts Mail Service Pharmacy (online, by phone or through mail) or at a Smart90 retail pharmacy near you. No matter which option you choose, your copay remains the same. You must obtain a 90-day prescription from your physician. 90-day maintenance prescriptions can be picked up locally at Costco, HEB, Kroger, Randall's, Kelsey-Seybold, and Walmart or through mail order. Refer to www.express-scripts.com or call Express Scripts at 855-712-0331 for the most current network information.

For new long term drug prescriptions, you can get two 30-day supplies of your medication at any network retail pharmacy for the retail copay, but after that, you will need to use the Smart 90 Program described above or you will have to pay 100% of the cost to receive a 30-day supply at any network retail pharmacy. Ordering a 90-day supply through Express Scripts Mail Service Pharmacy or a Smart90 retail pharmacy (retail location or mail order) will result in substantial savings to you for long-term and maintenance medications.

Express Script's Formulary

For 2021, the Select prescription drug plan includes Express Scripts High Performance formulary. A formulary is a list of generic and brand name drugs that are preferred by your health plan for certain conditions. If you choose drugs that aren't on the list, you may be responsible for the full cost, which can be significantly higher. To avoid this issue, please print the High Performance Formulary *Drug List* found at www.express-scripts.com to review with your doctor when deciding on your medications. In order to access the list, members should log into www.express-scripts.com, register and authenticate

themselves to determine drug coverage and alternatives under their plan. Please check the www.express-scripts.com web site frequently for the most recent list available, as medications on the list do change periodically.

What is Covered

The amount you pay for prescription drug coverage depends on whether you purchase generic, preferred brand, non-preferred (brand-name), or specialty drugs. Your copay(s) apply to each prescription you and your dependents purchase. Once you reach your combined medical and pharmacy annual out-of-pocket maximum, your eligible prescriptions are paid at 100% for the remainder of the plan year.

2021 Prescription Drug Benefits Through Express Scripts – Select Plan		
Plan Features	Retail	Mail Order/Smart90
	Express Scripts Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	Express Scripts Mail Service Pharmacy/Smart 90 Network For long-term medications (Up to a 90-day supply)
Annual deductible – pharmacy	None	None
Annual out-of-pocket maximum[1]	$4,900 individual $9,800 family	$4,900 individual $9,800 family
Generic Medications (copay)[2] Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	$20 for a generic prescription	$50 for a generic prescription
Preferred Brand-Name Medications (copay)[2] If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	$50 High Performance Formulary for a preferred brand-name prescription	$125 High Performance Formulary for a preferred brand-name prescription
Non-Preferred Brand-Name Medications (copay) You will pay the most for medications not on your plan's preferred drug list.	$70 High Performance Formulary for a non-preferred brand-name prescription	$175 High Performance Formulary for a non-preferred brand-name prescription
Specialty Medications Dispensed from Accredo with a 30 day supply limit.	$150 copay	

[1] All Rx prescription copays and coinsurance count toward the annual out-of-pocket maximum. For 2021, the annual out-of-pocket maximum for prescription drug coverage and medical are combined.

[2] Generic drugs will be dispensed whenever possible. Brand-name drugs will be dispensed only when:

- There is no equivalent generic drug available for substitution, or
- If a brand drug is filled when a generic is available, you will pay the brand name drug copay plus the difference in the cost between the generic and the brand name drug.

Discount Rx Program

Employees who waive HISD-sponsored medical coverage may enroll in the Discount Rx program. Eligible employees can enroll in this benefit by (1) signing up via the HISD portal or, (2) calling the HISD Benefits Service Center anytime from 7 AM - 7 PM, Monday through Friday, at 877-780-HISD (4473). Eligible employees can do that at initial eligibility, annual enrollment or during a qualifying life event change.

The program entitles you to a cash discount through Express Scripts participating pharmacies and mail service. The Discount Rx card is not insurance, and you do not have a copay amount. You are responsible for paying 100% of the discounted Express Scripts price and any dispensing fee. It is simply a discount program. Express Scripts will provide you an ID card when you choose to enroll.

Waived Generic Copay(s)

A comprehensive program has been designed for you if you have chronic conditions including hypertension, hyperlipidemia (high cholesterol) or diabetes. The HISD prescription drug plan provides generic drugs for hyperlipidemia, hypertension and diabetes as well as injectable insulin for $0 copay. In order to receive these generic drugs at $0 copay(s), you must use the Smart90 Program described on page 1 of this document. So take your prescribed medications and refill them on time to effectively manage your chronic condition.

Health Care Reform and No-Cost Care

Your prescription benefit plan will pay 100 percent of the cost of certain contraceptive products and preventive related medications. Please check www.express-scripts.com or call Express Scripts at 855-712-0331 for drug specific cost information.

Specialty Products and Pharmacy Services

Specialty products refer to injectable and non-injectable drugs and must require a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required, and must meet at least one of the following four characteristics: 1) produced through DNA technology or biological process; 2) target chronic or complex disease; 3) route of administration could be inhaled, infused, or injected; or 4) unique handling, distribution and/or administration requirements.

Specialty pharmacy services provide clinical support and ongoing interaction and education that enable patients to manage and live with their chronic or complex condition resulting in optimal outcomes and reduced overall healthcare costs. Accredo Health Group, Inc., and Express- Scripts Specialty Pharmacy Services provide end to end support of physicians and participants – hassle-free benefits verification, patient-centric care and engagement, improved adherence, access to over 99% of all specialty medications and understands the unique needs of patients.

Accredo Health Group, Inc., Express Script's Specialty pharmacy, is a unique service model designed to help patients manage complex conditions and their associated treatments. Medicines handled by a specialty pharmacy may be 1) injectable and infused, 2) high-cost, and 3) require special delivery and storage requirements (e.g. refrigeration). Prescriptions are limited to a 30-day supply.

Central to the Express Scripts model are the clinician-led teams, which are experts in your condition and specialty therapies. Each Therapeutic Resource Center is comprised of pharmacists, member service representatives, and depending on the therapy – nurses. The Therapeutic Resource Center communicates and coordinates care with your prescriber. They regularly contact patients to assess, educate and provide focused support, including:

- Educating members on how to take their medications correctly
- Review proper medication storage and handling
- Help with any injection-related issues
- Discuss how to manage side effects to ensure members stay on therapy
- Help members manage adherence to their treatment
- Reinforce proper treatment guidelines for the members condition
- Coordinate delivery of your medications

The Patient Care Representatives will contact you to arrange for the delivery of your specialty medications. Medications can be mailed to the location (e.g. home, office) you choose in a timely manner wrapped in secure, nondescript, temperature-controlled packaging.

If you have questions, you can call a pharmacist 24 hours a day, 365 days a year. Call Accredo Health Group, Inc. at 1-800-803-2523 for questions related to Specialty therapies and services. You can also find information related to Specialty Pharmacy Services at www.accredo.com.

What's Not Covered

HISD's prescription benefit plan will not cover medications excluded from the formulary unless approved by the health plan as medically necessary. Your doctor can request an exception to prescribe excluded medications by calling Express Scripts Prior Authorization Unit toll-free at 1-855-712-0331. In most cases, there is a formulary alternative your doctor can use. If Express Scripts does not approve the medical exception and you still choose to get excluded prescription, then you are responsible for the full cost of the drug.

Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.

The prescription drug plan does not cover certain products because they are either: 1) covered under the medical plan, 2) intended solely for cosmetic appearance, 3) self-care products, or 4) available over-the-counter (OTC). Please check www.express-scripts.com or call Express Scripts at 855-712-0331 for drug specific cost information.

About Generic, Preferred Brand, and Non-preferred Brand Drugs

A generic drug includes the same active ingredients as its brand-name equivalent, but at a lower cost. A generic drug is named for its contents, while a brand-name drug is named by the manufacturer for marketing purposes.
A preferred brand drug is a brand-name drug that has been selected for its clinical appropriateness (i.e. safety and efficacy) and cost effectiveness.
Non-preferred brand drug are those which generally have generic equivalents and/or have one or more preferred brand name drugs within the same therapeutic category. These medications are typically covered at the highest copay.
Drug manufacturers must comply with Food and Drug Administration (FDA) standards, whether they are producing brand-name or generic drugs. These standards guarantee that generics are equivalent to their brand-name counterparts in substance and body absorption rates.

Understanding Express Scripts Clinical Programs

Managed Drug Limitations (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. 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. Refer to www.express-scripts.com or call Express Scripts at 855-712-0331 for drug specific information.

Prior Authorization Required

Express Scripts prior authorization drives plan savings by monitoring the dispensing of high-cost medications and those with the potential for misuse. Our program ensures drug coverage consistent with the client's intent for the prescription benefit, while maintaining member and physician satisfaction. Twenty-four hours a day, personnel specially trained on our PA program's diseases, drugs, and coverage criteria provide review services, giving physicians and pharmacists quick, easy access to information and ensuring effective treatment by monitoring patient response to therapy. Refer to www.express-scripts.com or call Express Scripts at 855-712-0331 for drug specific information.

Step Therapy Required

The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of sale. Coverage for back-up therapies (second/third step) is determined at the patient level based on the presence or absence of front-line drugs or other automated factors in the patient's claims history. Our systems' capability supports automatic concurrent review of patients' claims profile for use of front-line alternatives. Only claims for patients whose histories do not show use of first-step products are rejected for payment at the point of sale. Refer to www.express-scripts.com or call Express Scripts at 855-712-0331 for drug specific information.

Express Script's Reviews & Appeals Overview

A plan sponsor ("Plan Sponsor") of a pharmacy benefit plan ("Plan") may elect to delegate final claims and appeal authority for the Plan to Express Scripts. In that case, Express Scripts, acting on behalf of the Plan Sponsor, will provide the following claims and appeals review services:

- Clinical Coverage Review Request
- Administrative Coverage Review Request
- Standard Pre-Service Claims and
- Standard Post-Service Claims.
- Urgent Claims

Definitions

The following terms are used herein to describe the claims and appeals review services provided by Express Scripts:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the application of a utilization review or on a determination of a plan member's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.

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.

Claim – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of the member, member's family, or provider.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-authorization – Express Script's pre-service review of a member's initial request for a particular medication. Express Script will apply a set of pre-defined criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product.

Initial Coverage Review – The first request for coverage. Express Scripts reviews both clinical and administrative coverage review requests.

Express Scripts Reviews and Appeals Process

How to Request An Initial Coverage Review

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing Pharmacist may call the Express Scripts Coverage Review Department at 1 800-753-2851 or the prescriber may submit a completed coverage review form to Fax 1 877- 329-3760. Forms may be obtained online at www.express-scripts.com/services/physicians/. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing to Express Scripts Attn: Benefit Coverage Review Department - PO 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:

<table>
<tr><td>Type of claim</td><td>Decision Timeframe:

Decisions are completed as soon as possible from receipt of request but no later than:</td><td colspan="2">Notification of Decision</td></tr>
<tr><td></td><td></td><td>Approval</td><td>Denial</td></tr>
<tr><td>Standard Pre-Service*</td><td>15 days (Retail)

5 days (home delivery)</td><td rowspan="2">Patient:
Automated call (letter if call not successful)

Prescriber:</td><td rowspan="2">Patient:
Letter

Prescriber:
Fax (letter if fax not successful)</td></tr>
<tr><td>Standard Post-Service*</td><td>30 days</td></tr>
</table>

		Fax (letter if fax not successful)	
Urgent	72 hours**	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: 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.

Level 1 Appeal - 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. The review of a member's Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of ERISA and any related laws. Members will be accorded all rights granted to them under ERISA and any related laws

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: Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588. Fax 1 877- 852-4070

  Administrative review Requests: Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

An urgent 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 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 an Express Scripts Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or 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: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		

Urgent*	72 hours	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: 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: Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588. Fax 877-852-4070

Administrative review Requests: Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587 Fax 1 877-328-9660

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 an Express Scripts Pharmacist, Physician, panel of clinicians or 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: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: Automated call and letter Prescriber:	Patient: Live call and letter Prescriber:

		Fax (letter if fax not successful)	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.

Authority as Claims Fiduciary:

Express Scripts shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. Express Scripts shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties.

Express Scripts is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO.

Express Scripts Federal External Review Services

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 mailed or faxed to: MCMC llc Attn: Express Scripts Appeal Program, 300 Crown Colony Drive. Suite 203, Quincy, MA 02169-0929. Phone: 1 617- 375- 7700 ext. 28253 Fax: 1 617- 375- 7683 and 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).

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) and 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 randomly be assigned 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.

Confidentiality

- All participant and Client appeal documentation is handled in a confidential manner and in accordance with applicable statutes and regulations to protect the participant's identity and their prescription history.

How to File a Claim

To get a prescription filled at a retail pharmacy, you can find a participating retail pharmacy by going to www.express-scripts.com, or by calling Express Scripts Patient Care Advocates. At the network pharmacy, you should present your ID card and prescription. The pharmacist will look up the benefit information online, verify coverage, and dispense the prescription to you. No claim needs to be filed.

To get a prescription filled through Express Scripts Mail Service, you can complete an Express Scripts Mail Service Order Form (also available through the web site or by calling Customer Care at 1-855-712-0331) and mail it along with your prescription for a 90 day supply to Express Scripts. You can provide payment information when you place the order (either by check, money order, or credit card) and expect to receive the medicine in approximately 10 to 14 days. Refills can be submitted online or by mail.

If you have paid for your prescription out of pocket and need to submit a paper claim, you can find the claim form on the web site, www.express-scripts.com, and then submit it along with the receipts to:

Express Scripts
Attn: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

How to Use this Document

We are pleased to provide you with this Plan Description. This document describes your prescription drug benefits under the Houston ISD prescription drug plans. These prescription drug benefits are part of the Houston Independent School District Welfare Benefit Plan, and there is a single enrollment and single contribution for this combined Medical / Prescription drug Plan.

Your eligibility and rights within this Plan are described in the medical plan documents. Please refer to these documents for plan information related, but not limited to:

- When coverage begins
- Initial, Open, and Special enrollment periods
- When coverage ends
- COBRA continuation
- General legal provisions

Plan Description

Name of plan: Houston Independent School District Employee Benefit Plan

Name, Address, and Telephone Number of Plan Sponsor:

Houston Independent School District
4400 W. 18th Street
Houston, TX 77092
713-556-6655

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 746001255

IRS Plan Number: Non-Federal Governmental Plan

Effective Date of Plan: January 1, 2021

Type of Plan: Group health care coverage plan

Name, Business address, and Business Telephone Number of Plan Administrator:

Houston Independent School District
4400 W. 18th Street
Houston, TX 77092
713-556-6655

Claims Administrator: The company which provides certain administrative services for the Plan:

Express Scripts
PO Box 14711
Lexington, KY 40512-4711

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a provider network established by Express Script, Inc. The named fiduciary of the Plan is Houston Independent School District, the Plan Sponsor.

Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid by the Plan Sponsor. Any required employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposed of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Plan Sponsor

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw, or add Benefits or terminate this Plan or this Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and condition, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan description issued by the Plan Sponsor, including this document.