INSURED Pharmacy Benefit Summary for Blue Essentials/Blue Premier/Blue Premier Access HMO
NON-GRANDFATHERED & GRANDFATHERED
NON-STANDARD

ACCOUNT INFORMATION	
Legal Group Name: SSCP Management & Affiliates	Anniversary Date: 01/01
Account # TX436693	Benefit Agreement # 0004
New – Original Effective Date: 01/01/2026	
Grandfathered Status: Non-Grandfathered	
Retiree Only Plan: No	
Prepared by: Tracy Marshall	

Comment	PHARMACY BENEFIT PROGRAM	
	Administered by Prime Therapeutics (applies to Retail and Mail-Service)	
	Product: Blue Essentials	
	Drug List:	Performance (UM package for this drug list will automatically apply)
	Accums Integration (Pharmacy-Medical)	
	Calendar Year	
	Yes **Shared Prescription Drug Out-of-Pocket Maximum** *Applies to retail and mail service.* ***NOTE:*** Annual OPX limits cannot exceed the current IRS maximums. In-network $6600 Individual $13200 Family ***NOTE:*** • In-network RX accums update in-network only (standard). • If Pharmacy deductible is integrated with Medical, three-month deductible carryover is not available. • Blue Essentials Plans 20-39 cannot have deductible or coinsurance. These are copay or % copay driven plans.	
	RETAIL PHARMACY	
	Member Pays the Difference to Brand Name Drugs (was MAC) Does Member Pays the Difference penalty apply to brand name drugs when there is a generic drug available?: Yes Will Member Pays the Difference Penalty apply if prescriber indicates brand medically necessary No (was MAC II)	

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	NOTE: The intent of the MPTD Penalty Waiver program is to have criteria to waive the MPTD penalty when a prescriber provides documentation to support that a member cannot tolerate a generic equivalent drug.				
	Pharmacy Retail Network Selection:	Broad Advantage If 90-day supply selected, ESN network would apply			
	Preferred Pharmacy Retail Network Differential: ***NOTE:*** Choose a differential only if *Preferred* Pharmacy Retail Network was selected above.	N/A – (*Select if not using the Preferred Pharmacy Retail Network)*			
	Retail Maximum Day Supply (including ESN Pharmacies): Up to 30 days at retail. 31 to 90 days at ESN. 1 copay per 30 days (standard)Up to 30 days at retail. 31 to 90 days at ESN. 1 copay per 90 days (used with percentage copays and when ESN copay same as Mail Order copay)	**Mail Order Maximum Day Supply:** 90 day supply with 1 copay per 90 days			
	Pharmacy Plan Design Tiers ***NOTE:*** The tier differential between preferred generic and preferred brand should be at least $30, non-preferred brand copay should be at least $25 more than the preferred brand copay with two specialty tiers, a differential of at least $50 is recommended.	Four-tier (generic/preferred brand/non-preferred brand/specialty)			
	Member Share *For each of the following drug types, indicate copay amount or coinsurance percentage.*	**Member Share Network** ***NOTE*: Standard ESN copay should match the copay for a 30-day supply at Retail. If following Mail copays, then copays should match Mail copay.**			
		Retail Pharmacy (30, 34 day)	**Mail Order (90, 102 day)**	**Extended Supply Network (ESN) (90, 102 day)**	**Specialty**
	Generic: (includes Preferred Generic for applicable tiers)	$20 Copay	$50 Copay	$20 Copay	Not Applicable
	Non-preferred Generic:	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Brand: (includes Preferred Brand for applicable tiers)	$50 Copay	$125 Copay	$50 Copay	Not Applicable
	Non-preferred Brand:	$85 Copay	$212.5 Copay	$85 Copay	Not Applicable
	Specialty: (includes Preferred Specialty for applicable tiers) ***NOTE:*** 4-tier Optimal plans enter same copay/% as Non-preferred Brand entry.	Not Applicable	Not Applicable	Not Applicable	$250 Copay
	Non-preferred Specialty:	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Specialty Drugs: ***NOTE:*** Mail order does not dispense specialty drugs.	Specialty Drugs are not covered unless obtained through a participating specialty pharmacy provider (no option).			
	Non-Standard Pharmacy Offerings (applies to Retail and Mail-Service) Indicate coverage selections:				

Comment	PHARMACY BENEFIT PROGRAM	
	Diabetic Medication and Supplies: ***NOTE:*** • Continuous glucose monitors, Omnipod insulin pump, and oral Diabetic medications are covered. • Other glucometers and pumps are usually not covered under Pharmacy, they are covered under Medical DME benefits. • For Performance, Performance Select, and Balanced drug list, coverage is based on the drug list. Customization is not allowed.	Full Benefit (standard)– includes test strips, lancets and lancet devices, visual reading strips, urine testing strips and tablets which test for glucose, ketones, and protein, insulin and insulin analog preparations, injection aids, insulin syringes, biohazard disposable containers, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and glucagons emergency kits.
	• **Proton Pump Inhibitors:** ***NOTE:*** For Performance drug list, coverage will be based on the drug list. Customization is not allowed.	Generics coverage only (standard)
	Prescribed over-the-counter (OTC) medications:	Not covered Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion). Cover Omeprazole 20 mg: Yes ***NOTE:*** ACA OTCs nicotine products, aspirin, folic acid, iron, prenatal and fluoride are standardly covered for Non-Grandfathered plans due to ACA with no cost share with a prescription from a provider.
	Compound Drugs: Compound limit is $300 and does not include coverage for non-FDA approved ingredients.	Not covered (standard)
	Non-sedating Antihistamine (NSA) Drugs and Combination Medications containing an NSA and Decongestant: ***NOTE:*** For Performance and Balanced drug list, coverage is based on the drug list. Customization is not allowed.	Exclude prescription strength NSA's (standard)
	Comments:	