INSURED Pharmacy Benefit Summary for PPO and HCA
NON-STANDARD

ACCOUNT INFORMATION	
Legal Group Name: SSCP Management & Affiliates	Anniversary Date: 01/01
Account # TX436693	Benefit Agreement # 0001
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: PPO	
	Drug List	Performance (UM package for this drug list will automatically apply)
	Accums Integration (Pharmacy-Medical)	
	Calendar Year	
	Yes **Accumulation Integration Option:** Traditional Rx accumulation integration – All applicable pharmacy claims apply toward in-network accumulators only. **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 $6500 Individual $13000 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.	
	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)	$0 Copay	$0 Copay	$0 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:	$100 Copay	$250 Copay	$100 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
	Out of Network coverage: *OON penalty is the same for all tiers.*	In addition to the copay/coinsurance amount the member pays an additional 50% of the allowable amount Other, explain:			
	Specialty Drugs: ***NOTE:*** Mail order does not dispense specialty drugs.	Mandatory Specialty applies (standard): Only available at in-network benefit level through the Preferred Specialty Pharmacy Network. All other pharmacies will be payable at the non-participating pharmacy benefit level.			
	Affordable Care Act (ACA) Preventive (including Vaccinations Obtained Through Pharmacies):	The group accepts all ACA Preventive categories (not optional for Non-Grandfathered)			

Comment	PHARMACY BENEFIT PROGRAM	
	Non-Standard Pharmacy Offerings (applies to Retail and Mail-Service) Indicate coverage selections:	
	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.	Full Benefit – 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:	Generics coverage only (standard)
	Prescription medications even if they have over-the-counter (OTC) equivalents:	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:	Not covered (standard)
	Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestants:	Exclude prescription strength NSA's (standard)
	Comments:	