**Prescription Drug Rider for Certain Drugs**

*{Drafting Note: Use this rider for plans that provide large group coverage that do not include prescription drug coverage.}*

This Rider amends Your Certificate to provide benefits for the Covered Services described below.

**A. Covered Prescription Drugs.**

We Cover Medically Necessary Prescription Drugs listed below that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

* Required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription”;
* FDA-approved;
* Ordered by a Provider authorized to prescribe and within the Provider’s scope of practice;
* Prescribed within the approved FDA administration and dosing guidelines;
* [On Our Formulary;] and
* Dispensed by a licensed pharmacy.

*{Drafting Note: Insert the formulary bullet for plans that use a closed formulary to list covered prescription drugs. The bullet may be omitted for plans with an open formulary.}*

We Cover the following Prescription Drugs:

1. Prescription drugs for the detoxification or maintenance treatment of substance use disorder (“SUD Medications”) that are FDA-approved for the treatment of substance use disorder, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid overdose reversal medication, including when dispensed over-the-counter.
2. Prescription Drugs prescribed in conjunction with Covered [infertility treatment,] in-vitro fertilization services or fertility preservation services.
3. [Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law.
   1. “Over-the-counter contraceptive products” means those products provided for in comprehensive guidelines supported by HRSA.
   2. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider. You may request an exception by having Your attending Health Care Provider complete the Contraception Exception Form and sending it to Us. Visit Our website [at XXX] or call [XXX; the number on Your ID card] get a copy of the form or to find out more about this exception process.]
4. [Prescription Drugs to treat diabetes, including insulin, oral hypoglycemics, and diabetic equipment and supplies if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under New York Education Law Title 8.]
5. Preventive Prescription Drugs (such as smoking cessation drugs), including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) or that have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”).
6. Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.

*{Drafting Note: Coverage for prescription drugs for infertility treatment other than IVF and fertility preservation is optional. For groups that meet the religious employer exception in New York Insurance Law Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A), the reference to contraceptive drugs, devices or other products may be removed. Diabetic drugs, equipment, and supplies may be covered under this Prescription Drug Rider if the cost-sharing is more favorable than under the medical benefits in the policy. The diabetes paragraph is optional when cost-sharing is more favorable under this Prescription Drug Rider.}*

[You may request a copy of Our Formulary.] [Our Formulary is also available on Our website [at XXX].] You may inquire if a specific drug is Covered under this rider by contacting us at [XXX; the number on Your ID card].

**B. Refills.**

We Cover Refills of Prescription Drugs only when dispensed at a retail [or] [mail order] pharmacy [and only after ¾ of the original Prescription Drug has been used]. Benefits for Refills will not be provided beyond one (1) year from the original prescription date.

*{Drafting Note: The bracketed language above is optional.}*

**C. Benefit and Payment Information.**

1. **Cost-Sharing Expenses.** Your Cost-Sharing for Prescription Drugs is as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **SUD MEDICATIONS; [AND] PRESCRIPTION DRUGS FOR [INFERTILITY TREATMENT,] IN VITRO FERTILIZATION AND FERTILITY PRESERVATION; PEP[; AND DIABETIC DRUGS, EQUIPMENT AND SUPPLIES]** | **[Preferred Provider Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** |
| **Retail Pharmacy** |  |  |  |
| 30-day supply  [Tier 1  Tier 2  Tier 3] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |
| **[Mail Order Pharmacy]** |  |  |  |
| [Up to a [90]-day supply  Tier 1  Tier 2  Tier 3] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [but no more than $100 for a 30-day supply of insulin] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |
| **[CONTRACEPTIVE DRUGS, DEVICES AND OTHER PRODUCTS]** |  |  |  |
| **[Retail Pharmacy]** |  |  |  |
| [Up to a 12-month supply  Tier 1  Tier 2  Tier 3] | [Covered in full]  [Covered in full]  [Covered in full] | [Covered in full]  [Covered in full]  [Covered in full] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |
| **[Mail Order Pharmacy]** |  |  |  |
| [Up to a 12-month supply  Tier 1  Tier 2  Tier 3] | [Covered in full]  [Covered in full]  [Covered in full] | [Covered in full]  [Covered in full]  [Covered in full] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |
| **PREVENTIVE PRESCRIPTION DRUGS (INCLUDING PrEP)** |  |  |  |
| **Retail Pharmacy** |  |  |  |
| 30-day supply  [Tier 1  Tier 2  Tier 3] | [Covered in full]  [Covered in full]  [Covered in full] | [Covered in full]  [Covered in full]  [Covered in full] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |
| **[Mail Order Pharmacy]** |  |  |  |
| [Up to a [90]-day supply  Tier 1  Tier 2  Tier 3] | [Covered in full]  [Covered in full]  [Covered in full] | [Covered in full]  [Covered in full]  [Covered in full] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost] |

[You have a one (1) tier plan design, which means that You will have the same out-of-pocket expenses for all Prescription Drugs.]

[You have a two (2) tier plan design, which means that You will have lower out-of-pocket expenses for [tier 1 drugs; Generic Drugs] and higher out-of-pocket expenses for [tier 2 drugs; Brand-Name Drugs].]

[You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.]

*{Drafting Note: Plans may include one, two or three tiers.}*

[For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an “ancillary charge,” may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your [or Your Provider’s] request and Our formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of the Certificate. [The request for an approval should include a statement from Your Provider that the Prescription Drug at the lower tier is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects.) We may also request clinical documentation to support this statement.] If We do not approve coverage for the Prescription Drug on the higher tier, the ancillary charge will [not] apply toward Your [In-Network] Out-of-Pocket Limit.]

*{Drafting Note: The paragraph above is optional. Insert the bracketed sentence regarding a statement and clinical documentation if applicable. Plans should indicate whether the ancillary charge counts towards the out-of-pocket limit in the last sentence.}*

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drugs, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

**Coupons and Other Financial Assistance.** We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your [In-Network] Deductible and [In-Network] Out-of-Pocket Limit. [However, if You have a high deductible health plan, We will apply the financial assistance towards Your [In-Network] Deducible and [In-Network] Out-of-Pocket Limit after You have met the minimum deductible amount required for high deductible health plans under the Internal Revenue Code.]

*{Drafting Note: Include the bracketed sentence for high deductible health plans.}*

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and 3) all Generic Drugs.

**2. Participating Pharmacies.** For Prescription Drugs purchased at a Participating Pharmacy, You are responsible for paying the lower of:

* The applicable Cost-Sharing; or
* The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

[In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug and cannot order the Prescription Drug within a reasonable time, You may, with Our prior [written] approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing [upon receipt of a complete claim form]. Contact Us at [XXX; the number on Your ID card] [or visit our website [at XXX]] to request approval.]

*{Drafting Note: The bracketed paragraph above is required for HMO and EPO coverage and optional for PPO coverage. Bracketed language within the paragraph (for example, “written”) is optional.}*

**3. Non-Participating Pharmacies.**  [We will not pay for any Prescription Drugs that You purchase at a Non-Participating Pharmacy other than as described above.] [If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.]

*{Drafting Note: Choose the appropriate bracketed provision depending on whether out-of-network coverage is provided.}*

**4.** [**Designated Pharmacies.** We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs for certain Prescription Drugs Covered by this Rider, including specialty Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, [You will not have coverage for that Prescription Drug] [Your coverage will be subject to the out-of-network benefit for that Prescription Drug].

*{Drafting Note: Plans may use either of the bracketed provisions, as applicable.}*

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

* Infertility].]

*{Drafting Note: Include if the plan uses designated pharmacies. Plans may add to or subtract from the list of drugs or conditions specified above.}*

[**5.**] [**Mail Order.** [Certain Prescription Drugs may be ordered through Our mail order pharmacy [[after an initial 30-day supply [, with the exception of contraceptive drugs or devices which are available for a 12-month supply]]. [We will only Cover drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy.] You are responsible for paying the lower of:

* The applicable Cost-Sharing; or
* The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

*{Drafting Note: The bracketed language regarding the initial 30-day supply is optional. If used, the language regarding contraceptives must also be inserted except for groups that meet the religious employer exception in Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A) of the Insurance Law.}*

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You [will; may] be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with [Us] [and; or] [Our vendor] in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website [at XXX] or by calling [XXX; the number on Your ID card].]

*{Drafting Note: Mail order drug coverage is optional. If mail order drug coverage is provided, the above language must be used.}*

[**6.**] **Formulary Changes.** [Our Formulary is subject to Our periodic review and modification. However, a Prescription Drug will not be removed from Our Formulary during the Plan Year, except when the FDA determines that such Prescription Drug should be removed from the market. Before We remove a Prescription Drug from Our Formulary at the beginning of the upcoming Plan Year, We will provide at least 90 days’ notice prior to the start of the Plan Year. We will also post such notice on Our website [at XXX].]

*{Drafting Note: Insert the bracketed paragraph above starting with “Our Formulary is . . .” for plans with a closed formulary.}*

We will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

*{Drafting Note: Insert the bracketed tier status paragraphs below for plans with a tiered formulary.}*

[**7.**] [**Tier Status.** A Prescription Drug will not be moved to a tier with a higher Cost-Sharing during the Plan Year, except a Brand-Name Drug may be moved to a tier with higher Cost-Sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time. Additionally, a Prescription Drug may be moved to a tier with a higher Copayment during the Plan Year, although the change will not apply to You if You are already taking the Prescription Drug or You have been diagnosed or presented with a condition on or prior to the start of the Plan Year which is treated by such Prescription Drug or for which the Prescription Drug is or would be part of Your treatment regimen.

Before We move a Prescription Drug to a different tier, We will provide at least 90 days’ notice prior to the start of the Plan Year. We will also post such notice on Our website [at XXX]. If a Prescription Drug is moved to a different tier during the Plan Year for one of reasons described above, We will provide at least 30 days’ notice before the change is effective. You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status on Our website [at XXX] or by calling [XXX; the number on Your ID card].]

[**8.**] **Formulary Exception Process.**

If a Prescription Drug in a category that is Covered under this Rider is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. [The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects.] If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of the Certificate;. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out more about this process.

*{Drafting Note: The bracketed sentence is optional.}*

**Standard Review of a Formulary Exception.** We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone [and in writing] no later than 72 hours after Our receipt of Your request. [We will notify You in writing within three (3) business days of receipt of Your request.] If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

*{Drafting Note: Plans should insert one of the two bracketed options regarding written notification.}*

**Expedited Review of a Formulary Exception.**  If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. [The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process.] We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone [and in writing] no later than 24 hours after Our receipt of Your request. [We will notify You in writing within three (3) business days of receipt of Your request.] If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

*{Drafting Note: The bracketed sentence is optional. Also note, plans must make a decision within 24 hours even if a statement from the prescribing health care professional is not included with the request. Plans should insert one of the two bracketed options regarding written notification.}*

[**9.**] **Supply Limits.** [Except for contraceptive drugs, devices or products,] We will pay for no more than a [30; 90]-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for [one (1) Cost-Sharing amount; up to three (3) Cost-Sharing amounts] for up to a [30; 90]-day supply. [However, for Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for [one (1) Cost-Sharing amount; up to three (3) Cost-Sharing amounts; one (1) Cost-Sharing amount for prescription drugs on tier 1 and three (3) Cost-Sharing amounts for Prescription Drugs on tier 2 and tier 3] for a 90-day supply at a retail pharmacy.]

*{Drafting Note: Include the bracketed language if the Plan covers a 90-day supply of maintenance drugs. Plans may insert one of the cost-sharing options from the brackets above. For groups that meet the religious employer exception in Insurance Law Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A), the reference to contraceptive drugs or devices in the first sentence may be removed.}*

[You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing [when provided by a Participating Pharmacy].]

*{Drafting Note: For groups that meet the religious employer exception in Insurance Law Sections 3221(l)(16)(A)(1) and 4303(cc)(1)(A), this paragraph may be removed.}*

[Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up toa 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of [one (1); two (2); two and a half (2.5); three (3)] Cost-Sharing amount[s] for a 90-day supply.]

*{Drafting Note: Include the bracketed language if mail order is available.}*

*{Drafting Note: The bracketed language below is optional.}*

[Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a [retail] [or] [mail order] pharmacy. You may access Our website [at XXX] or by calling [XXX; the number on Your ID card] for more information on supply limits for specialty Prescription Drugs.]

[Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month’s supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website [at XXX] or by calling [XXX; the number on Your ID card]. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of the Certificate.]

*{Drafting Note: The language above is optional.}*

**[10.] Emergency Refill During a State Disaster Emergency.** If a state disaster emergency is declared, You, Your designee, or Your Health Care Provider on Your behalf, may immediately get a 30-day Refill of a Prescription Drug You are currently taking that is Covered under this Rider. You will pay the Cost-Sharing that applies to a 30-day Refill. Certain Prescription Drugs, as determined by the New York Commissioner of Health, are not eligible for this emergency Refill, including schedule II and III controlled substances.

**D.** [**Medical Management.** This Rider includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

*{Drafting Note: The preauthorization paragraphs below are optional. If the preauthorization language is included, use one of the bracketed provisions in the second sentence of the first paragraph that explains how preauthorization works. Please note that the obligation to request preauthorization for prescription drugs is on the provider. In addition, include the first sentence in the second paragraph that explains how the member can determine which drugs require preauthorization.}*

[**1.**] [**Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, [We will contact Your Provider to determine if Preauthorization should be given] [ask Your Provider to complete a Preauthorization form] [Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug]. [Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.] Preauthorization is not required for SUD Medications, including opioid overdose reversal medications prescribed or dispensed to You.

For a list of Prescription Drugs that need Preauthorization, please visit Our website [at XXX] or call [XXX; the number on Your ID card]. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market. However, We will not add Preauthorization requirements to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns. Your Provider may check with Us to find out which Prescription Drugs are Covered.]

*{Drafting Note: The step therapy paragraph below is optional.}*

[**2.**] [**Step Therapy.** Step therapy is a process in which You may need to use one (1) [or more] type[s] of Prescription Drug before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of the Certificate. We will not add step therapy requirements to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.]

[**E.**] [**Limitations/Terms of Coverage.**

*{Drafting Note: The following limitations are permissible. A plan does not need to include all of the limitations. However, if a limitation is included, the language below must be used.}*

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain Prescription Drugs based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.
3. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of Prescription Drugs. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
4. Injectable drugs (other than self-administered injectable drugs) [and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment] are not Covered under this section but are Covered under other sections of the Certificate. [Your benefit for [diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs,] [diabetic supplies,] [and] [equipment] will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the [Certificate; Contract; Policy] than the Additional Benefits, Equipment and Devices section of the Certificate.]

*{Drafting Note: If the second sentence is used, omit “and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment” from the first sentence, as applicable.}*

1. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under other sections of the Certificate.
2. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in this Rider. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. [We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one (1) or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.]

*{Drafting Note: The bracketed language is optional.}*

1. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
2. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
3. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.
4. A pharmacy need not dispense a Prescription Order that, in the pharmacist’s professional judgment, should not be filled.]

[**F.**] **General Conditions.**

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. [You must include Your ID number on the forms provided by the mail order pharmacy from which You make a purchase.]

*{Drafting Note: Insert the bracketed language above as applicable.}*

[**2.** **Drug Utilization, Cost Management and Rebates.** [We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.]

[We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member’s utilization of Prescription Drugs. [Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members.] [Rebates [will not; may] change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.] [If a Prescription Drug is eligible for a rebate, most of the rebate will be used to reduce the Allowed Amount for the Prescription Drug. Your Deductible or Coinsurance is calculated using that reduced Allowed Amount. The remaining value of that rebate will be used to reduce costs for all Members enrolled in coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than Our estimate.]]

*{Drafting Note: The paragraph above is optional.}*

[**G.**] **Definitions.**

Terms used in this Rider are defined as follows. (Other defined terms can be found in the Definitions section of the Certificate).

1. **Brand-Name Drug:**  A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.
2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.
3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Rider. To determine which tier a particular Prescription Drug has been assigned, visit Our website [at XXX] or call [XXX; the number on Your ID card].
4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as “generic” by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.
5. [**Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.]

*{Drafting Note: Insert the definition of maintenance drug as applicable.}*

1. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide prescription drugs to Members. [We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.]

*{Drafting Note: Insert the bracketed language above as applicable.}*

1. **Participating Pharmacy:** A pharmacy that has:

* Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
* Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
* Been designated by Us as a Participating Pharmacy.

[A Participating Pharmacy can be either a retail or mail-order pharmacy.]

*{Drafting note: Include the bracketed sentence above if mail order is available.}*

1. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill [and is on Our Formulary]. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

*{Drafting Note: The bracketed language above is optional.}*

1. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, [We have agreed to pay Our Participating Pharmacies; as contracted between Us and Our pharmacy benefit manager] for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Rider includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

*{Drafting Note: Insert the appropriate language from the brackets depending whether the plan contracts directly with participating pharmacies or with a pharmacy benefit manager.}*

1. **Prescription Order or Refill:** The directive to dispense a prescription drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.
2. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

**H. Controlling Certificate.**

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this rider except where specifically changed by this Rider.