CONROE INDEPENDENT SCHOOL DISTRICT

SUMMARY PLAN DESCRIPTION

Conroe Independent School District
Pharmacy Benefits Program

Effective September 1, 2021

Prescription Drug Plan

Your prescription drug benefit program is administered by OptumRx

Your Choices
If you are enrolled in any of the District medical plan options, you are eligible for prescription drug coverage.

When you need prescription drugs, you must use:

- A retail network pharmacy, or
- OptumRx Home Delivery

Retail Pharmacy Program
Participating pharmacies have agreed to be part of OptumRx' retail pharmacy network. To locate a participating retail pharmacy in your area, access the Pharmacy Locator on www.optumrx.com or call OptumRx at 1-844-722-1702. You must use a network pharmacy to receive plan benefits. The plan does not 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 health plan 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.optumrx.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. If your doctor prescribes, or you request, a brand-name drug when a generic equivalent is available, you must pay the difference in cost (if any) between the brand-name drug and the generic drug, plus the applicable copayment/coinsurance.

OptumRx 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 for the cost of a 60-day supply. The amount of your copay again depends on whether you purchase Tier 1 (mostly generic), Tier 2 (mainly preferred brand names), or Tier 3 (highest cost). 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.optumrx.com, and then submit it along with the receipts to:

OptumRx Claims Department
PO Box 650540,
Dallas, TX 75265-0540

OptumRx Pharmacy Drug List
The prescription drug plan includes drugs listed on OptumRx's Pharmacy Drug List (PDL), also known as a 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 Pharmacy Drug List found on www.optumrx.com to review with your doctor when deciding on your medications. In order to access the list, members should log into www.optumrx.com to determine drug coverage and alternatives under their plan. Please check the www.optumrx.com web site frequently for the most current list, as medications on the list change periodically.

What is Covered
Prescription drug costs vary by plan. The amount you pay for prescription drug coverage depends on whether you purchase Tier 1, Tier 2, or Tier 3 drugs, as well as certain Specialty drugs. Your copay or coinsurance amount applies to each prescription you and your covered dependent(s) 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.

2021-2022 Prescription Drug Benefits Through OptumRx			
Plan Features	**Charter Kelsey-Seybold OR Nexus ACO R Memorial Hermann (Plan Year 9/1 – 8/31)**	**Choice Plus HDHP (Plan Year 1/1 – 12/31)**	
	In-Network	In-Network	Out-of-Network
Annual Prescription Deductible[1,2]	$200 per individual, per plan year	N/A	N/A
Prescriptions (RETAIL)			
Tier 1 (mostly generic)	$15 copay	30%, after deductible	Not covered
Tier 2 (mainly preferred brand name)	$60 copay	30% after deductible	Not covered
Tier 3 (highest cost)	$120 copay	30% after deductible	Not covered
Prescriptions (SPECIALTY)			
Must use Optum Specialty Pharmacy for specialty medications (limit 30-day supply)	$250 copay	30% after deductible	Not covered
Prescriptions (MAIL ORDER)			
Tier 1 (mostly generic)	$30 copay	30% after deductible	Not covered
Tier 2 (mainly preferred brand name)	$120 copay	30% after deductible	Not covered
Tier 3 (highest cost)	$240 copay	30% after deductible	Not covered

[1] The prescription deductible only applies once per year per person, and is waived for Tier 1 medications.

[2] All prescription deductibles, copays, and coinsurance count toward the annual out-of-pocket maximum. The annual out-of-pocket maximum for prescription drug coverage and medical services are combined.

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.

Health Care Reform and No-Cost Care

Your prescription benefit plan will pay 100% of the cost of certain contraceptive products and preventive-related medications. Please check www.optumrx.com or call OptumRx at 1-844-722-1702 for drug specific cost information.

Specialty Products and Pharmacy Services

Specialty products refer to injectable and non-injectable drugs and typically 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.

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. Call Optum Specialty Pharmacy toll-free 1-877-838-2907 for additional information and assistance.

What is Not Covered

This prescription drug plan does not cover medications excluded from the Pharmacy Drug List (PDL) unless approved by the health plan as medically necessary. Your doctor can request an exception to prescribe excluded medications by calling the OptumRx Prior Authorization Unit toll-free at 1-844-722-1702. In most cases, there is a formulary alternative your

doctor can use. If OptumRx does not approve the medical exception and you still choose to get the excluded medication, then you are responsible for the full cost of the drug.

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.optumrx.com or call OptumRx at 1-844-722-1702 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 drugs 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 out-of-pocket cost to the member.
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 OptumRx Clinical Programs

Quantity Limits Required

The Quantity Limits 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. OptumRx 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.optumrx.com or call OptumRx at 1-844-722-1702 for drug specific information.

Prior Authorization Required

OptumRx prior authorization drives plan savings by monitoring the dispensing of high-cost medications and those with the potential for misuse. The 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 the prior authorization 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.optumrx.com or call OptumRx at 1-844-722-1702 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.optumrx.com or call OptumRx at 1-844-722-1702 for drug specific information.

OptumRx 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 OptumRx. In that case, OptumRx, acting on behalf of the Plan Sponsor, will provide the following claims and appeals review services:

- Clinical Coverage Review Request
- Urgent Claims

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

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.

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 the medication, service, or product is not solely for the convenience of the member, member's family, or provider.

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

Urgent Request– A Claim for a medication 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.

Appeals Process

Level 1 Appeal:
How to Request a Level 1 Appeal or Urgent Appeal After an Initial Prior Authorization Review Has Been Denied

When an initial coverage review has been denied (prior authorization denial) the member will receive a letter with appeal information. 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.

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:
OptumRx
Attn: Appeals Coordinator
P O Box 25184, Santa Ana, CA 82799

Phone: 1-888-403-3398
Fax: 1-877-239-4565

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 or fax. 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

OptumRx 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 OptumRx Pharmacist, Physician, panel of clinicians, and trained prior authorization staff member.

How to Request a Level 2 Appeal After a Level 1 Appeal Has Been Denied

When a level 1 appeal has been denied, 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 denial. 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: (same as 1st level appeal)

OptumRx
Attn: Appeals Department Appeals Coordinator
P O Box 25184, Santa Ana, CA 82799

Phone: 1-888-403-3398
Fax: 1-877-239-4565

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 1-888-403-3398. 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

OptumRx completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an OptumRx 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 level 1 & 2 Pre-Service	30 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)
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)
Independent Review	45 days	Patient & Prescriber: letter	Patient & Prescriber: letter

*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:
OptumRx 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. OptumRx shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties.

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

External Review Services

When and How to request an External Review

The right to request an independent external review may be available for excluded products. All internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) 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:

OptumRx
C/O Appeals Department
Appeals Coordinator
P O Box 25184, Santa Ana, CA 82799

The request must be received within four (4) months of the date of the final internal adverse benefit determination (if the date that is four (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: OptumRx will review the external review request within five (5) business days to an Independent Review Organization (IRO).

The request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within five (5) business days of OptumRx receiving the information. 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 OptumRx 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: If the claim is eligible for urgent processing, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within two (2) business days of OptumRx receiving the information. 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. 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.myuhc.com, or by calling OptumRx at 1-844-722-1702. 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 OptumRx Mail Service, you can complete an OptumRx Mail Service Order Form (also available at www.optumrx.com or by calling Customer Care at 1-844-722-1702) and mail it along with your prescription for a 90-day supply to OptumRx at the address listed on the form. 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 either:

- Go to www.optumrx.com and file a claim online
  Information Center – Forms – Claim Forms – Online Claim form – Start New Request

- Find the claim form on the website, www.OptumRx.com, and submit it along with the receipts to:

OptumRx Claims Department
PO Box 650540, Dallas, TX 75265-0540

How to Use this Document

We are pleased to provide you with this Plan Description. This document describes your prescription drug benefits under the Conroe ISD prescription drug plans. These prescription drug benefits are part of the Conroe Independent School District Health 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: Conroe Independent School District Employee Health Plan

Name, Address, and Telephone Number of Plan Sponsor:

Conroe Independent School District
3205 W. Davis St.
Conroe, TX 77304
936-709-7808

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): 74-6000556

IRS Plan Number: Non-Federal Governmental Plan

Effective Date of Plan: September 1, 2021

Type of Plan: Group health care coverage plan

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

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 OptumRx. The named fiduciary of the Plan is Conroe 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 purpose of maintaining Plan's fiscal records: Plan year shall be a twelve-month period ending August 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.