IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Express Scripts Prescription Drug Plan

Summary Plan Description

Effective January 1, 2025

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Introduction

This booklet describes the common features and administrative information pertaining to the Iowa State University of Science and Technology ("Iowa State University" or "ISU") Prescription Drug Plan, administered by Express Scripts, Inc., as in effect January 1, 2025. The information in this SPD applies to eligible active employees, COBRA participants, and pre-Medicare retirees who are enrolled in either the Iowa State University of Science and Technology-sponsored Employee Blue HMO Plan or the Employee Blue PPO Plan, both administered by Wellmark Blue Cross and Blue Shield of Iowa.

For information on the medical benefits available to you through the Iowa State University-sponsored Medical Plan option you have chosen, refer to your Medical Plan SPD available at **https://hr.iastate.edu/medical-plan**.

This SPD contains a summary of the provisions of the Plan as of the date of publication. We encourage you to read this SPD carefully and share it with your family members. If you have any questions about your benefits, please contact Express Scripts, the prescription drug administrator, at 1-800-987-5248.

No provision of the Iowa State University Medical Plan or the Prescription Drug Plan is to be considered a contract of employment between you and Iowa State University.

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Welcome

Prescription drug coverage is provided under the Plan as part of your medical benefits. When you enroll in either the Iowa State University Employee Blue HMO or Employee Blue PPO medical plans administered by Wellmark, you automatically receive prescription drug coverage through Express Scripts, Inc.

You may purchase prescriptions through a national network of participating retail pharmacies, through the Express Scripts Mail Order Service, or through a retail pharmacy of your choice. See the "**Overview of the Prescription Drug Plan**" section for detailed information about how the Prescription Drug Benefit works.

Highlights of the Prescription Drug Plan

Plan Feature	Summary
Eligibility	You are eligible for coverage if you are an active employee or COBRA participant who is enrolled in an ISU-sponsored Medical Plan. If you have enrolled your eligible dependents for medical coverage, they will also be eligible for prescription drug benefits.
Enrollment	You are automatically enrolled for prescription drug coverage when you enroll in an ISU-sponsored Medical Plan. There is no separate enrollment required for prescription drug coverage.
Contributions for Coverage	Contributions for your prescription drug coverage are included in your medical plan contributions. In addition, you pay a portion of the cost for each prescription purchased. Your out-of-pocket prescription drug costs are limited to an annual out-of-pocket maximum.
Out-of-Pocket Cost of Prescriptions	The cost of the prescription drugs you purchase will depend on whether you choose a generic, a preferred brand, or a non-preferred brand name drug and whether you have met the out-of-pocket maximum for your ISU Pharmacy Plan.
How to Get the Most from the Prescription Drug Plan	Here are a few tips: • **Use generic drugs.** They are therapeutically equivalent to their brand name counterpart and less expensive. • **Go in-network.** Otherwise, you pay the full cost of your medication and have to file a claim for reimbursement. • **Using ongoing medication? Get a 90-day supply and save.** You can use mail order or go to a participating pharmacy that offers a 90-day supply and pay less than at retail. • **Understand the prescription formulary,** what's covered and any special features of the Plan. • **Use this booklet as a reference** and contact Express Scripts for detailed information and questions.

Questions? Here's How to Reach Express Scripts

Prescription Drug Plan	Telephone Numbers and Website Address
Member Services	1-800-987-5248 (TDD: 1-800-759-1089) **www.express-scripts.com**
Prior Authorization	1-800-753-2851
Submitting Claims	Log into **www.express-scripts.com** to electronically submit claims. Or, call Member Services at 1-800-987-5248 to request a claim form.
Express Scripts Mobile App	Free from Android and Apple App Stores: • Download the app from **www.express-scripts.com/mobileapp** or search for "Express Scripts" in your app store.

Eligibility and Participation

Eligible Employees

You are eligible to participate in the Prescription Drug Plan if you are an active employee of Iowa State University, a COBRA participant, or a pre-Medicare retiree and are enrolled in an ISU-sponsored Medical Plan.

Eligible Dependents

Your eligible dependents can also participate in the Prescription Drug Plan if you elect coverage for them under an ISU-sponsored Medical Plan. Eligible dependents include:

- Your legal spouse
- Your domestic partner
- Your or your spouse/domestic partner's dependent children until December 31 of the year they turn age 26. If covering a dependent child over age 26, they must be an unmarried, full-time student (student status verification is required). Children include:
  - Biological child
  - Adopted child or child placed with you for adoption
  - Stepchild
  - Foster child
  - Child for whom you are the legal guardian
  - Biological child eligible for coverage under a Qualified Medical Child Support Order
- Your dependent children over age 26 if unmarried and a full-time student. Student status verification is required.
- Your or your spouse/domestic partner's unmarried dependent child(ren), regardless of age, who are mentally or physically disabled and incapable of earning their own living. The child must have been disabled before age 26 or while a full-time student. Documentation of disabled status is required.

When Prescription Drug Coverage Begins

Prescription drug coverage begins when your medical coverage begins. When you enroll in an ISU-sponsored Medical Plan, you are automatically enrolled for prescription drug coverage. The timeline for enrollment in a medical option varies by your employment status, as shown in the chart below.

Employment Status	Timeline to Enroll	When Coverage Begins
Newly-hired/newly-benefits-eligible employees	31 days from date of hire or date of eligibility	Effective on your date of benefit eligibility, provided you enroll within 31 days of eligibility
Current active eligible employees or COBRA participants	Annual Enrollment period	January 1 of the following calendar year

Coverage Levels

The level of coverage you elect under an ISU-sponsored Medical Plan option will apply to the Prescription Drug Plan as well. In other words, if you elect medical coverage for yourself under one of the Medical Plan options, you will have individual coverage under this Prescription Drug Plan. If you elect to cover yourself and your family members under one of the Medical Plan options, you and your covered family members will be covered under the Prescription Drug Plan.

Paying for Prescription Drug Coverage

The cost of the Prescription Drug Plan is included in the cost of the Medical Plan option you elect. You and ISU share in the cost of your medical (including prescription drug) coverage. Your contributions are deducted from your paycheck on a pre-tax basis. If you are employed on other than a 12-month basis, any premiums in arrears will be collected from your next paycheck to maintain coverage for the off-duty period (e.g., if you do not receive Summer Salary, a deduction will be made from your August paycheck for the missed premiums in June and July). COBRA participants are billed directly by ASI COBRA for COBRA premiums.

If You Do Not Enroll for Medical Coverage

You may opt out of medical coverage (including prescription drug coverage) sponsored by ISU if, for example, you have coverage elsewhere, such as through a spouse's employer plan. Keep in mind that if you opt out of medical coverage, you are also opting out of prescription drug coverage.

Making Changes During the Year

Because you are contributing before-tax dollars to the ISU-sponsored Medical Plan, you may make changes during the year only if you have a change in your family or employment status (referred to as a "coverage change event") or if you experience a different event permitting a mid-year election change. Any changes you make to your medical coverage will apply to your prescription drug coverage.

Approved qualified coverage change events under this Plan include, but are not limited to:

- A change in your legal marital status (such as marriage, divorce, death of spouse, legal separation, and annulment)
- The start or termination of a domestic partnership
- A change in the number of your dependents (such as through birth, death, adoption, placement for adoption, appointment as child's legal guardian, placement of a foster child in your home, or addition of a biological child by court order)
- Exhaustion of COBRA coverage
- Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *Hawki* plan in Iowa)
- Eligibility for premium assistance under Medicaid or CHIP
- A change in employment status of you, your spouse, or your domestic partner
- Your child resumes student status

Any election change you make during the year as a result of a qualified coverage change event must be consistent with the event. An election change is consistent with the qualified coverage change event only if the change is on account of, and corresponds with, an event that affects eligibility for either you, your spouse/domestic partner, or your dependent child under this Plan or under the plan of your spouse's or domestic partner's employer.

Note:

Please refer to your Medical Plan SPD for details on qualified coverage change events and how to make changes in your coverage during the year.

HIPAA Special Enrollment Rights

Loss of Eligibility for Other Medical Coverage

The Prescription Drug Plan is considered a group health plan under the law and, as such, the same enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would enable you to make enrollment changes during the year if you lose other medical coverage will apply. Because the Prescription Drug Plan is included as part of your medical plan coverage, any resulting changes you make to your Medical Plan election will also apply to your prescription drug coverage. For more details, please refer to your Medical Plan Certificate.

Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid

If you (the employee) are eligible for, but not enrolled in, an ISU-sponsored Wellmark Medical Plan (or your dependent is eligible for, but not enrolled in, a Wellmark Medical Plan), you (and your dependent) may enroll in a medical plan (and automatically receive coverage under this Prescription Drug Plan) or switch medical benefit options in certain situations if there is a loss or gain of eligibility for a State Children's Health Insurance Program (CHIP) (*Hawki* in Iowa) or Medicaid. Please refer to your medical plan Certificate for information on special enrollment periods provided.

When Participation Ends

In general, coverage under this Prescription Drug Plan will end when your ISU-sponsored medical coverage ends. Please refer to your medical plan Certificate to see when your medical coverage ends.

If you lose your ISU-sponsored Medical Plan coverage (and, as a result, your prescription drug coverage under this Plan), you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the "**Continuation Coverage Rights Under COBRA**" section. If you elect to extend your Medical Plan coverage through COBRA, your coverage under the Prescription Drug Plan is also extended.

You also may be able to continue coverage under this Plan if you are on military leave (see the "**Continuation of Coverage If You Go on Military Leave**" section) or if you are on an approved Family and Medical Leave Act (FMLA) leave (see the "**Continuation of Coverage If You Go on FMLA Leave**" section).

Overview of the Prescription Drug Plan

Your prescription drug benefits will be paid based on a copay for generic drugs, or coinsurance for preferred brand and non-preferred brand name drugs. There is no deductible to meet; benefits are paid from the first prescription you order. See "**Summary of Your Prescription Drug Benefits**" for information.

What you pay for prescription drugs depends on the following factors:

- Whether you have met the prescription drug out-of-pocket maximum for the year, which is the most you have to pay for covered prescription drug expenses during any calendar year;
- Where you get your prescription filled: a network participating pharmacy, an out-of-network pharmacy, or the Express Scripts Mail Order Service or Express Scripts participating pharmacy; and
- The type of drug you request: Preventive drugs, Generic drugs, Preferred brand name drugs, Non-preferred brand name drugs, or Specialty drugs.

Note:

If you go to a non-participating pharmacy (also referred to as an "out-of-network pharmacy"), you will have to pay the full cost of the prescription at that time and then submit a claim for reimbursement. Once your claim has been approved, the Prescription Drug Plan will reimburse you for what you paid for the eligible prescription less your regular share of the cost as shown in the "**Summary of Your Prescription Drug Benefits**" chart.

Your out-of-pocket cost for prescription drugs is lower when you use generic and preferred brand-name prescription (formulary) drugs. Express Scripts has contracts with most chain and independent pharmacies nationwide. You can also have maintenance medications (medications used to treat an ongoing health condition) filled through the mail order program or at a local Express Scripts participating retail pharmacy for up to a 90-day supply at a lower cost than at retail.

Summary of Your Prescription Drug Benefits

	Blue HMO or Blue PPO Plan		
	Retail (Up to a 30-day supply)	**Mail Order** (Up to a 90-day supply)	
		Participating Retail Pharmacy (Retail 90)	**Express Scripts Mail Order**
Prescription Drug Plan Deductible	None	None	None
Annual Prescription Drug Out-of-Pocket Maximum *Once your prescription drug expenses reach this amount, the Prescription Drug Plan will cover 100% of your eligible expenses for the remainder of the plan year*	$2,000 per employee $4,000 employee + spouse/partner/child/family		
Preventive Drugs	Plan pays 100% of preventive drugs required by Affordable Care Act		
• **Generic (Tier 1)**	$15 copay/ prescription	$0 copay/ prescription	$0 copay/ prescription
• **Preferred Brand (Tier 2)**	30% coinsurance, up to $125 maximum copay/prescription	25% coinsurance, up to $300 maximum copay/prescription	25% coinsurance, up to $300 maximum copay/prescription
• **Non-Preferred Brand (Tier 3)**	50% coinsurance, up to $250 maximum copay/prescription	33% coinsurance, up to $600 maximum copay/prescription	33% coinsurance, up to $600 maximum copay/prescription

Diabetic Bundling Copay rule:

Bundled copays – Diabetic medications/supplies: Includes insulin, oral anti-diabetic agents, syringes/needles, and diabetic supplies. When one of these items is dispensed, the member will be charged the appropriate copay for that prescription, and then the copay is waived for all additional items included on the list that are dispensed on the same day.

Express Scripts Specialty Pharmacy Services

Specialty Medications

Specialty medications are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, cancer, and hemophilia. These medications often require special handling, preparation, or refrigeration. Under the Prescription Drug Plan, all of your specialty medications must be filled through the Accredo Specialty Pharmacy starting with the first prescription you order. To access Accredo, call 1-800-803-2523.

When you fill specialty prescriptions through Accredo, you also receive a variety of specialized services:

- **Convenient medicine delivery:** Accredo will schedule and quickly ship all of your specialty medications, including those that require special handling such as refrigeration. Most supplies, such as syringes, will be provided with your medication.
- **Patient counseling:** Specialty-trained pharmacists and nurses are available 24 hours a day, seven days a week to answer your questions and help you manage your condition.
- **Patient education:** Clinicians and disease-specific educational materials are available 24/7.
- **Refill reminders:** Accredo will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through **www.express-scripts.com**.
- **Language assistance:** Translation services are available for non-English speaking patients.

As an Express Scripts participating pharmacy, Accredo can access your prescription information on file at all Express Scripts pharmacies to monitor for potential drug interactions and side effects of your medications.

Paying for Specialty Medications

The copayment or coinsurance you pay will be based on the type of drug you are requesting (generic, preferred brand-name drug, non-preferred brand-name drug). If you do not go through the Accredo Specialty Pharmacy, you will pay the full cost of your prescription. Prescriptions are generally filled for up to a 90-day supply on select specialty medications. Contact Accredo for information. There are no grace fills for specialty medications, which means you must use the Accredo Specialty Pharmacy starting with your first specialty prescription or you will be responsible for the full cost.

It's a Fact!

Specialty drugs must be filled through the Accredo Specialty Pharmacy or there is no coverage.

Copay Assistance

Specialty medications are costly. Your plan includes a copay assistance benefit administered by Save On SP, LLC (SaveOnSP). Under this copay assistance benefit, certain specialty prescription drugs on the formulary have been classified as non-essential health benefits (NEHBs). An NEHB classification does not mean these drugs are not important to you, this is a classification under the Affordable Care Act. A list of these specialty prescription drugs and the applicable coinsurance can be accessed at **www.saveonsp.com/iastate**. This list will change from time to time.

If your physician prescribes you one of these NEHB drugs, SaveOnSP will contact you to participate in the Plan's copay assistance benefit. Once you enroll in the available manufacturer copay assistance or support program (or attempt to enroll and are denied through no fault of your own) and provide SaveOnSP with consent to monitor your pharmacy account, your cost could be as low as $0.

In the event you fail to enroll in the applicable manufacturer copay assistance or program (or are denied as a result of your acts or omissions), and/or you do not provide consent to SaveOnSP to monitor your pharmacy account, you will be responsible for the full required coinsurance for the NEHB drugs even after your out-of-pocket maximum has been satisfied. Any coinsurance paid for these medications (either paid by you or by the manufacturer copay assistance or support program) will not apply to your out-of-pocket maximum. Additionally, as a result of the NEHB classification, the coinsurance will continue even after you've met your Plan's out-of-pocket maximum.

Out-of-Pocket Protection Program

Your Plan limits your out-of-pocket prescription expenses to an annual out-of-pocket maximum. Once you reach the maximum, the Plan will pay 100% of your prescription drug expenses for the remainder of the plan year. If you are using manufacturer-funded copay assistance/patient assistance, the value of that assistance will not be considered a true out-of-pocket cost for members and may not apply to your out-of-pocket prescription drug maximum.

How the Prescription Drug Plan Works

When You Need to Fill a Prescription

When you need to fill a prescription, you can choose to go to a participating retail pharmacy or, for home delivery, use the Express Scripts Mail Order Service. You also have the option of picking up a 90-day supply of maintenance medication at an Express Scripts participating pharmacy. See "**Maintenance Medications – Home Delivery or Retail Pick-Up – Your Choice**" below for information.

If your prescription is for a 30-day supply of a medication or less, you must fill at retail. If you are filling a maintenance medication that you are expecting to take for a longer period of time, you must get your prescription filled for a 90-day supply at an Express Scripts participating retail pharmacy or through the mail order service.

Retail Pharmacies

Express Scripts has contracted with thousands of retail pharmacies, including most major drug stores. These retail pharmacies in the Express Scripts network are referred to as "participating retail pharmacies."

For short-term medicine needs, a participating retail pharmacy is your most convenient option. For filling prescriptions that you need immediately, you should use a local pharmacy to fill a prescription of up to 30 days. When you go to a participating retail pharmacy, present the pharmacist with your Express Scripts ID card. When you go to a non-participating (out-of-network) retail pharmacy, you have to pay the full cost of the prescription.

Finding a Participating Retail Pharmacy

To find an Express Scripts participating retail pharmacy near you, please register at **www.express-scripts.com**. You can visit this site or call Express Scripts at 1-800-987-5248 to find a participating retail pharmacy and check your drug coverage/costs. You can also ask your local pharmacy if it participates in your Express Scripts program.

If you use a non-participating retail pharmacy to fill a covered prescription, you will be responsible for the full cost of the medication at the pharmacy. You will then need to submit a claim to Express Scripts for reimbursement. Reimbursement will be based on the type of medication and the copayment or coinsurance you must pay.

Maintenance Medications – Home Delivery or Retail Pick-Up – Your Choice

If you are taking maintenance medications, which are prescriptions for managing ongoing health conditions, like high blood pressure, asthma, diabetes, or high cholesterol, the Plan offers you choice and savings. You can go to a local Express Scripts participating retail pharmacy or use the Express Scripts

Mail Order Service. With both options, you can get up to a 90-day supply of medication at the lower, mail order copay or coinsurance.

You are required to fill maintenance medications at a participating retail pharmacy or through our home delivery pharmacy, and at a 90-day supply. You can get two 30-day courtesy fills before making the switch to a 90-day supply. After courtesy fills are exhausted, if you are not filling for 90-days you will be required to pay the full cost of the medication.

Express Scripts Mail Order Service	Express Scripts Participating Retail Pharmacy
Convenient home delivery	Pick up medication at a time convenient for you
Receive your prescriptions in private, tamper-resistant and (when needed) temperature-controlled packaging	Enjoy same-day prescription availability
Talk to a pharmacist by phone	Talk to a pharmacist in person

Tips for Using the Mail Order Service

You can request prescriptions through the mail order service online, by mail, or by having your doctor send the prescription by fax or electronically.

- To get started, ask your doctor to write a prescription for a 30-day supply and fill it immediately at your local pharmacy. Then, go online to **www.express-scripts.com** to complete your registration. Once complete, follow the prompts to have Express Scripts contact your doctor to order a 90-day supply.
- By mail, simply get an order form from Express-Scripts by visiting **www.express-scripts.com** or by calling 1-800-987-5248. Follow the instructions and return the completed form to the address indicated along with the appropriate payment and the written prescription. Generally, your prescription will be delivered to you, postage-paid, within 5-7 days from when your order is received.
- Alternatively, your doctor can call 800-987-5248 to order a prescription, fax the prescription to 1-877-251-5896, or electronically send a new prescription for a 90-day supply directly to Express Scripts Rx Home Delivery to get the convenience and cost savings of the mail order program.
- ePrescribe: For fastest service ask your doctor to submit prescriptions electronically to Express Scripts Home Delivery. Online/mobile app: Log in to express-scripts.com/rx or the Express Scripts® mobile app, choose the medicine you want delivered, add it to your cart, then check out.

Refills are even easier. You can order a refill by mail, call the phone number on your prescription label, or visit **www.express-scripts.com**. You can use your credit card or Flexible Spending Account to pay.

Prescriptions can be filled in senior-friendly, child-resistant bottles. Each new prescription will include an informative insert about the medication.

In general, you pay less for generic and certain formulary brand-name drugs and more for non-formulary brand-name drugs.

Your ID Card

Express Scripts will provide new members, and existing members who need a replacement Prescription ID Card, digitally. You will receive an email from express-scripts@mail.express-scripts.com welcoming you to Express Scripts and requesting that you register on the Express Scripts member portal via the link provided in the Welcome email (express-scripts.com). Once you have registered, you can locate your

digital Prescription ID card from the home page by selecting Prescription ID card from the menu under Account. You can also view your digital ID card on your mobile device via the Express Scripts mobile app. Your Prescription ID Card is located on the app's home screen under Prescription ID Card.

If you require a physical ID card, you can contact Express Scripts Customer Service at 800-987-5248 at any time to request one be sent to you via US mail.

If you need to fill a prescription but you have not yet received your welcome email (and your coverage has taken effect), please have the pharmacy call Express Scripts Member Services at 1-800-987-5248 to verify your coverage.

Your digital prescription drug ID card is separate from your Medical Plan ID card. It is important to remember to use your Prescription Drug Plan ID card at the pharmacy rather than your Medical Plan insurance card.

The Express Scripts Mobile App

You can use the Express Scripts mobile app to manage your prescriptions. Go to your smartphone's mobile app store and search for "Express Scripts" and download the app for free. Then log in with your online express-scripts.com User ID and password to open.

With the app you can:

- Refill and renew mail order service prescriptions for yourself and your family.
- Track your home delivery prescription orders.
- Look up potential lower cost prescription options available under your plan and discuss them with your doctor – even while you're in the office.
- Review your personalized alerts to help ensure that you are following your treatment plan as prescribed by your doctor.
- View your medicines and set reminders for when to take them or notify you when you are running low.
- Get personalized alerts if there's a potential health risk related to your medicines.
- Display a virtual ID card that you can use at the pharmacy.

Covered Medications

The Plan generally covers generic and brand name medications including, but not limited to, the following drugs:

- Federal legend drugs, which are drug products bearing the legend, "Caution: Federal law prohibits dispensing without a prescription."
- Insulin
- Specialty medications, through Accredo Specialty Pharmacy only

To find out if a specific drug is covered under the Prescription Drug Plan, go to the "Price a Medication" application on the Express Scripts website, **www.express-scripts.com**. That application will indicate whether a drug is covered, what it will cost, and if any limitations or exclusions apply.

Preventive Drugs Covered at 100%

To comply with the Affordable Care Act (ACA), the Prescription Drug Plan covers certain drugs at 100% with no deductible or copay. The ACA preventive drug list is subject to change as ACA guidelines are updated or modified. Currently, the ACA preventive drug list includes the following:

- Aspirin (generic only)
- Oral fluorides (generic), for children age 6 months through 16 years (covers prescription and over-the-counter)
- Folic acid (generic only) (prescription and over-the-counter)
- Tobacco cessation products (if on the Express Scripts formulary), for individuals age 18 and older to quit smoking; limited to a 180 day supply within a 365-day period. Prescriptions processed after 180 days will be subject to a copay
- Certain immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP); routine vaccines only, does not include non-routine vaccines
- Bowel prep products used to prepare for colonoscopy, ages 45 to 75
- Contraceptive drugs and devices; over-the-counter contraceptives require a prescription
- Risk reducing breast cancer medication, adults age 35 and over
- Statins to prevent serious heart disease in adults age 40-75 (generic only)
- Preexposure prophylaxis (PrEP) for the prevention of HIV infection (generic only)

Coverage of preventive drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. Coverage of any medication requires a prescription from a licensed health care provider. For information about the preventive drugs covered, contact Express Scripts at 1-800-987-5248 or visit **www.express-scripts.com**.

What Is Not Covered

The Prescription Drug Plan does not cover certain prescription drugs, some of which are listed below. Please call Express Scripts Member Services to confirm whether or not your prescription drug will be covered.

- Charges for prescription drugs that were incurred before you were covered under the Plan or after you are no longer covered under the Plan
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for diabetes management), support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use
- Any over-the-counter medication, unless otherwise specified
- Blood products, blood serum
- Experimental or investigational drugs
- Drugs used for cosmetic purposes
- Nutritional supplements
- Abortifacients

- Drugs to treat impotency in individuals under age 18
- Fertility agents
- Drugs intended for weight loss
- Drugs that are dispensed to you while in a hospital, either as an inpatient or as an outpatient, or while a patient in your doctor's office (such medications may be covered under your Medical Plan, not the Prescription Drug Plan).

Special Features of the Prescription Drug Plan

The Prescription Drug Formulary

A formulary is a list of FDA-approved, generic and brand-name prescription drugs that are covered by a health plan. The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the Prescription Drug Plan, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's formulary. The Plan uses the Express Scripts National Preferred Formulary. The Plan's formulary is updated periodically and is subject to change.

Drugs that are excluded from the Plan's formulary are not covered under the Plan unless approved in advance as being (1) medically necessary and essential to the patient's health and safety and/or (2) all formulary drugs comparable to the excluded drug have been tried by the patient. If your physician believes that an excluded drug meets the requirements described above, your physician should contact Express Scripts at 1-800-753-2851 to initiate a request for review.

The formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing formulary tier.
- Additional drugs may be excluded from the formulary.
- A restriction may be added on coverage for a formulary-covered drug (e.g., prior authorization).
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the formulary. Certain drugs, even if covered on the formulary, will require prior authorization in advance of receiving the drug. Other formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step-therapy. As with all aspects of the formulary, these requirements may also change from time to time.

If you are taking a drug that becomes excluded from the formulary or moves from preferred to non-preferred status, you will receive a notification from Express Scripts including a list of alternative medications to discuss with your doctor. You can check formulary status of a medication and available preferred alternatives at **www.express-scripts.com**.

Prior Authorization/Coverage Review Programs Applicable to Certain Drugs

The Plan has three programs in place to ensure your medications are taken safely, to avoid uncovered costs and help ISU to continue providing affordable health care options: prior authorization, drug quantity management, and step therapy.

Prior Authorization

A prior authorization will be needed if you are currently taking a medicine that is not on the formulary and in some other situations. Examples of medicines that require a prior authorization include growth hormones and drugs to treat multiple sclerosis, cancer, arthritis, and skin conditions. For these and certain other medications, the Prescription Drug Plan requires "prior authorization" by Express Scripts before benefits will be paid. The review will determine whether the Plan covers your prescribed medication based on medical necessity. This review uses Plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. You may need approval for coverage of the drug or for coverage of additional quantities of the drug.

To find out whether a medication requires prior authorization, go to **www.express-scripts.com** and select "Price a Medication" from the drop-down menu under "Prescriptions." After you look up the medicine's name, click "View coverage notes." Or, call 1-800-987-5248 for information.

Prior authorizations, when approved, are typically approved for a one year period, unless otherwise noted.

Your physician may call Express Scripts at 1-800-753-2851 to request a prior authorization approval.

Please note:

Certain medications may require qualification by previous drug history before they can be covered by the Plan. Log on to **www.express-scripts.com** for more details.

Drug Quantity Management

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. Currently, the days' supply limit in place is a 30-day supply at retail and, for maintenance drugs, a 90-day supply by mail or a participating ESI retail pharmacy. You may obtain information on maximum dispensing limits by either visiting **www.express-scripts.com** or by contacting Express Scripts at 1-800-987-5248.

Step Therapy Requirements

Step therapy is a program designed to help you save money by using the most cost-effective treatments if you have certain health conditions that require maintenance medications. It requires that you try one or more specified drugs (generally generic drugs) to treat a particular condition before the Plan will cover another (usually more expensive) drug that your doctor may have prescribed. If it turns out that the Step 1 medicine is not a good choice for you, your doctor can request prior authorization to determine if a Step 2 medicine will be covered by your plan. Step therapy is intended to reduce costs to you and the Plan by encouraging the use of medications that are less expensive, but can still treat your condition effectively.

The medications requiring step therapy are subject to change. Express Scripts will monitor your claims throughout the year and may make additional recommendations on programs.

For up to date information on coverage of specific drugs, or medications that require step therapy, prior authorization, or coverage review, please call Express Scripts Customer Service at 1-800-987-5248. Participants should confirm coverage prior to filling a prescription.

Additional Prescription Drug Program Benefits

Omada for Prevention

Omada for Prevention is a virtual care program offered at no charge for sustainable behavior change that targets two of the nation’s biggest health risks and cost drivers: heart disease and diabetes. Omada Diabetes Prevention combines an evidence-based curriculum, one-on-one personalized coaching, and a virtual peer support community to empower members to take control of their health and avoid a chronic condition diagnosis. Targeted members are invited to check eligibility to determine if they qualify for the program. If qualified, you will receive an email confirmation letting you know when you can expect to receive your device and when your program will begin.

How to File a Claim for Reimbursement

In-network

If you go to a pharmacy that is in the Express Scripts network, you simply show your ID Card and pay your share of the cost when you buy the drug.

Out-of-network

If you purchase your prescription at a non-participating pharmacy, you must pay the full cost of your prescription at the time of purchase, then file a claim for reimbursement with Express Scripts. Claims must be filed within 365 days of the date of purchase. You will need your receipt if you are filing a claim for reimbursement. Contact Member Services at 1-800-987-5248 for information and claim forms.

Note:

If you do not receive the prescription drug benefits you feel you are entitled to, you may file an appeal with Express Scripts. See the following section "**Filing a Claim Appeal**" for information.

Filing a Claim Appeal

Claim Appeal Procedures

To appeal a decision for denied prior authorization claims under the Prescription Drug Plan, contact Express Scripts (See "**Questions? Here's How to Reach Express Scripts**"). Your concern will be investigated, and you will be contacted. If you are not satisfied, you can appeal the decision, as described in this section.

You have the right to request an initial review for a medication that is not covered at point of sale at either retail or home delivery pharmacies to be covered or to be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called the initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

- **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.

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 by faxing it to 1-877-328-9660. Forms may be obtained online at **www.express-scripts.com**. Home delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filing the prescription.

To request an initial administrative coverage review, you, your doctor, or your dispensing pharmacist must submit specific information in writing to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of an "urgent situation" 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 in which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy, or the patient may experience severe pain that cannot be adequately managed without the medication 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 the provider by phone at 1-800-753-2851.

How a Coverage Review Is Processed

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 his or her request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	*Patient:* Automated call (letter if call not successful) *Prescriber:* Electronic or Fax (letter if fax not successful)	*Patient:* Letter *Prescriber:* Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours**	*Patient:* Automated call and letter *Prescriber:* Electronic or Fax (letter if fax not successful)	*Patient:* Live call and letter *Prescriber:* Electronic or 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.

Denial Process

An initial coverage/administration review will be denied if the necessary information needed to make a determination is not received from the prescriber within 45 days of the decision timeframe or the information received does not meet the approval standards. An appeal request for further review can be initiated at that point.

How to Request Appeals After Coverage Review Has Been Denied

Level 1 Appeal

Upon receipt of a denial notice, a covered member or authorized representative can request a Level 1 appeal with Express Scripts within 180 days from receipt of a denial notice. 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
- Description of why the claimant disagrees with the denial

For **clinical** appeal requests, call/fax/mail to:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

Phone: 1-800-753-2851

Fax: 1-877-852-4070

Download Claim Form from **www.express-scripts.com**.

For **administrative** appeal requests, call/fax/mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

Phone: 1-800-946-3979

Fax: 1-877-328-9660

Download Claim Form from **www.express-scripts.com**.

If the patient's situation meets the definition of an "urgent situation" 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 in which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy, or the patient may experience severe pain that cannot be adequately managed without the medication 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 the provider by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a phone call or fax identifies the appeal as urgent.

Type of Request	Phone	Fax
Urgent clinical appeals	1-800-753-2851	1-877-852-4070
Urgent administrative appeals	1-800-946-3979	1-877-328-9660

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 a pharmacist, physician, 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	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service	15 days	***Patient:*** Automated call (letter if call not successful) ***Prescriber:*** Electronic or Fax (letter if fax not successful)	***Patient:*** Letter ***Prescriber:*** Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	***Patient:*** Automated call and letter ***Prescriber:*** Electronic or Fax (letter if fax not successful)	***Patient:*** Live call and letter ***Prescriber:*** Electronic or 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 together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 Appeal

If a Level 1 appeal is denied, also called an adverse benefit determination, a request for a Level 2 appeal may be submitted by the member or authorized representative to Express Scripts within 90 days from receipt of notice of the Level 1 appeal denial. You should submit required information to the appropriate address.

Important:

To initiate a Level 2 appeal, follow the same appeal process as in Level 1 above.

How a Level 2 Appeal or Urgent Appeal Is Processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions may be made by a pharmacist, physician, panel of clinicians, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	***Patient:*** Automated call (letter if call not successful) ***Prescriber:*** Electronic or Fax (letter if fax not successful)	***Patient:*** Letter ***Prescriber:*** Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	***Patient:*** Automated call and letter ***Prescriber:*** Electronic or Fax (letter if fax not successful)	***Patient:*** Live call and letter ***Prescriber:*** Electronic or 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 together with an opportunity to respond prior to issuance of any final adverse determination.

Standard External Appeals

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 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.

The request for an external review must be received within 4 months of the date of the final 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 a Level 2 External Review Is Processed

Standard External Review

An independent third party selected by Express Scripts will review the request for an external review within 5 business days. The plan will notify you of your eligibility for an external appeal within one business day of completing the review.

If eligible, the request will be randomly assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of the assignment.

The IRO will notify the claimant in writing that is has received the request for an external review. If the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information for consideration within 10 business days.

Any additional information submitted 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 the receipt of the request, and will notify the claimant, the Plan, and Express Scripts of its decision in writing. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Reviews

Once an urgent external review request is submitted, the claim will be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one in which, in the opinion of the patient's provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, 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 eligible, the request will be randomly 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 of receipt of the request and will send a written notice of its decision to the claimant.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is later than 180 calendar days after you are notified of the denial or rescission. You may file a Level 2 appeal within 90 days of receiving notice of the Level 1 appeal denial. External appeals must be filed within four months of notice of an adverse benefit determination.

Other Rules that Apply to the Prescription Drug Plan

National Medical Support Notice (NMSN)

The Medical (including Prescription Drug) Plan will comply with all the terms of a National Medical Support Notice (NMSN). A National Medical Support Notice is an order or judgment from a court or administrative body that directs the Plan to cover a child of a participant under the health plan. A National Medical Support Notice must meet certain form and content requirements to be considered an appropriately completed National Medical Support Notice.

If the Plan Administrator determines that the NMSN has been appropriately completed, your dependent will be permitted to immediately enroll in the same medical/prescription drug coverage you have. If you have any questions or would like to receive a copy of the written procedure for determining whether a national medical support order has been appropriately completed, contact **benefits@iastate.edu**.

Your Right to Privacy

The Department of Health and Human Services has issued comprehensive federal regulations that give individuals broad protections over the privacy of their health records. These regulations are part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Provision, which in part governs the transmission of health care transactions, privacy, and security. The purpose of this law is to standardize and safeguard the transmission of protected health information, protect the privacy of your health information, and allow you access to your medical records. HIPAA protection applies to the medical, dental, vision, prescription drug, Employee Assistance Program (EAP), and health care flexible spending account programs.

By providing privacy protections at a federal level, all employees, no matter which state they live in, will be covered by a national base of privacy. Compliance with state law and other federal laws will be included as part of ISU's total compliance program.

These regulations apply to your health care providers, such as doctors and hospitals, as well as to the ISU-sponsored Medical Plans (including prescription drug coverage), which is in compliance with the HIPAA privacy and security regulations. A copy of the HIPAA Notice of Privacy Practices is available **benefits@iastate.edu**.

Subrogation and Right of Reimbursement

The purpose of this Plan is to provide prescription drug coverage for qualified prescription drug expenses that are not covered by a third party. Therefore, you or a covered dependent shall reimburse the Plan for related Plan benefits received out of any funds or monies you or your covered dependent recovers from any third party as a result of receiving Plan benefits related to prescription drug expenses (1) that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy, or any other plan of benefits, or

(2) arising through an act or omission of another person and paid by a third party — whether through legal action, settlement, or for any other reason.

The Plan has a right to subrogation and reimbursement. Please contact the medical or prescription drug Plan Administrator for more information on the Plan's rights.

How You May Lose Benefits

Under certain circumstances, Plan benefits may be denied or reduced from those described in this SPD. For instance:

- You provide insufficient documentation to support a claim for reimbursement
- You purchase a drug without getting prior authorization when required
- You purchase a drug that is not covered under the Plan

Rescission

Rescission of coverage is cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions. For example, rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with a written notice at least 30 days before the date of rescission.

Continuation of Prescription Drug Coverage

If you lose coverage under an ISU-sponsored Medical Plan, you will also lose prescription drug coverage under the Plan. You may be able to continue that coverage under certain conditions through COBRA as described below. Other federal or state laws similar to COBRA may apply if COBRA does not. See the Medical Certificate for your medical plan for more information. You also may want to consider your coverage options in the Health Insurance Marketplace, which may provide a more cost-effective alternative for you.

Continuation Coverage Rights Under COBRA

COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage is a continuation of Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." If you experience a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and lose coverage because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect.

Keep Your Plan Informed of Address Changes

In order to protect your rights as well as the rights of your spouse and dependent children, you should keep the Plan Administrator informed of any address changes for your spouse and/or dependent children. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Plan Contact Information

For questions about COBRA coverage, please call ASI COBRA at 877-388-8331 or visit their website at **www.asicobra.com** for more information.

Continuation of Coverage If You Go on Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (that is, Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights, and benefits associated with the position held at the time employment was interrupted, plus any additional seniority, rights, and benefits that you would have attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your prescription drug coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of (1) 24 months after the leave begins or (2) the period running from the day the leave begins through the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your prescription drug coverage while on military leave, you are entitled to reinstated prescription drug coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage If You Go on FMLA Leave

Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of unpaid leave for certain family and medical situations and continue your elected prescription drug coverage benefits during this time. The Company is required to maintain group health plan coverage for an employee on FMLA leave: a) if you had that coverage before taking the leave, and b) on the same terms as if you had continued to work. If applicable, you may need to make arrangements to pay your share of group health plan contributions while on leave. In some instances, the Company may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Important Plan Information

Plan Administration/Interpretation

The administration of the Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the Plan, including eligibility, coverage, and benefits.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to the interpretation and operation of the Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Iowa State University's Right to Amend or Terminate the Plan

ISU has the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension, or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the Plan to the extent permitted by law.

ISU's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modification to the Plan.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else. However, you may assign your rights to benefits under the Plan to the health provider who provided the medical/prescription drug services.

Your Employment

This SPD provides detailed information about the Prescription Drug Plan and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Plan should not be interpreted as an implied or express contract or guarantee of employment. ISU's employment decisions are made without regard to benefits to which you are entitled upon employment.

Plan Administration

The following information is about the administration of the Plan. While you should not need these details on a regular basis, the information may be useful if you have specific questions about the Plan.

Details About Plan Administration	
Plan Sponsor/Plan Administrator	Iowa State University of Science and Technology
Employer Identification Number	42-6004224
Official Plan Name	Iowa State University HMO Plan; Iowa State University PPO Plan
Plan Number	501
Plan Year	January 1 – December 31
Type of Plan	Group health plan providing prescription drug benefits
Agent for Service of Legal Process	Iowa State University of Science and Technology Department of Human Resource Services Benefits Office 3770 Beardshear Hall Ames, IA 50011-2033 1-515-294-4800 Legal process can also be served on the Plan Administrator
Pharmacy Benefit Manager	Express Scripts, Inc. One Express Way St. Louis, MO 63121 1-800-987-5248 **www.express-scripts.com**
Plan Funding	The Prescription Drug Plan is self-funded. Benefits from this Plan are paid from employee contributions, as applicable, and from the general assets of ISU, as needed. ISU has contracted with a third-party administrator to administer this Plan.

Important Terms

The following terms will help you understand the features and benefits of the Prescription Drug Plan. For more information, contact Express Scripts at 1-800-987-5248 or go online to **www.express-scripts.com**.

Annual out-of-pocket maximum. The most you will pay out-of-pocket for covered prescription drugs each year under the Plan. The amount includes your copayments and your coinsurance. The annual out-of-pocket maximum does not include your payroll contributions for coverage and any amounts provided through a copay assistance plan. After you reach the out-of-pocket maximum, the Plan pays 100% of any remaining eligible charges for that year.

Brand Name drug. A drug that has been patented and is produced by only one manufacturer.

Claims Administrator/Third-Party Administrator. The third party contracted by ISU who is responsible for administering the Plan and paying claims. The Claims Administrator/Third-Party Administrator for the Prescription Drug Plan is Express Scripts.

Coinsurance. The percentage you and the Plan pay toward the prescription drugs you receive.

Copayment (or "copay"). The flat dollar amount you must pay for generic prescription drugs.

Experimental or investigative treatment, drug, or device. Medical, surgical, and psychiatric procedures, treatments, devices, drugs, and drug treatments not approved by governmental agencies such as the Food and Drug Administration (FDA) and not accepted as standard, tested, and accepted effective practice by the medical community at large at the time the service, treatment, or drug is provided, as determined by the health care company.

Formulary. A formulary is a clinically based drug list that contains the generic, brand name, and specialty medications covered by the Plan. It is created and maintained by Express Scripts, as amended from time to time. The Prescription Drug Plan has a drug-tier structure, known as an open formulary, for prescription drug coverage. Your coinsurance/copayment is determined by the tier of your medication.

Generic drug. A drug that does not bear the trademark of the original manufacturer. It must have the same active ingredients as its brand name drug counterpart. Generic drugs usually cost less than brand name drugs.

In-Network Pharmacy (also called a "participating pharmacy"). A retail pharmacy that participates in the Express Scripts Network subject to an agreement between the pharmacy and Express Scripts.

Maintenance Prescription Drug. Prescription drugs commonly used to treat conditions that are considered chronic or long term. These conditions usually require regular use. Examples include medications to treat high blood pressure, heart disease, asthma, and diabetes.

Prescription Drug. A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must have a message on its original packing label that says: "Caution: Federal law prohibits dispensing without a prescription."

Specialty drug. Typically, high cost drugs that are injected or infused in the treatment of acute or chronic diseases, such as multiple sclerosis and rheumatoid arthritis. Specialty medications often require special handling, preparation, or refrigeration. Most specialty drugs require preauthorization to be considered medically necessary.

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IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Express Scripts Prescription Drug Plan
Summary Plan Description
Effective January 1, 2025