To learn if your medication is subject to Step Therapy requirements, visit **www.HealthSelectRx.com** and click on Prescription Drug List or call Express Scripts at **(800) 935-7189** toll-free.

Note on Utilization Management: If you are unable to take the Generic or therapeutic equivalent of a Covered Drug or Supply due to a medical condition or complication and the Utilization Management requirements cannot be met you may be eligible to obtain coverage of the Brand-name Drug if certain Clinical Criteria are met. For more information about the Utilization Management exceptions process, call Express Scripts at **(800) 935-7189** toll-free.

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Table 2 below contains the Program's Network Copays, Annual Prescription Drug Deductible, and Total Network Out-of-Pocket Maximum for Covered Drugs or Supplies under the Program.

TABLE 2 – Network Benefits for Covered Drugs or Supplies

Program Features	Amount
Network Annual Deductible (per Calendar Year)[1] Network and Non-Network Covered Drugs and Supplies apply to the Annual Prescription Drug Deductible	$50 per Participant

Network Retail Pharmacy: Up to a 30-Day Supply

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Per Prescription fill of Non-Maintenance Medication (refills allowed as prescribed)[2]	$10 Copay	$35 Copay	$60 Copay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	$10 Copay	$45 Copay	$75 Copay
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) [2 and 5] Annual Prescription Drug Deductible does not apply.	No charge	No charge	$10 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Certain oral contraceptives eligible for a 12 month supply* (refills allowed as prescribed) Annual Prescription Drug Deductible does not apply. *Subject to supply availability at pharmacy	No charge	No charge	$10 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.			
■ Insulin (refills allowed as prescribed)[2] Annual Prescription Drug Deductible does not apply	$10 Copay	$25 Copay	$25 Copay
■ Diabetic oral agent (refills allowed as prescribed)[2]	$10 Copay	$35 Copay	$60 Copay
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher [2 and 8] Annual Prescription Drug Deductible does not apply. Limited to one free glucose meter annually through the Free Glucose Meter Program. See *Diabetes Supplies and Insulin* in Section 6, "*Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	No charge	No Charge	No charge
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	Generic not available	$35 Copay	$60 Copay
■ Preferred glucose meter purchased at a Network Retail Pharmacy without Voucher	$10 Copay	$35 Copay	$60 Copay

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Preferred blood glucose test strips[2 and 8] Annual Prescription Drug Deductible does not apply. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge	No charge
■ Non-preferred blood glucose test strips	$10 Copay	$35 Copay	$60 Copay
■ Lancets and lancing devices, disposable insulin syringes and needles Annual Prescription Drug Deductible does not apply.	No charge	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	$10 Copay	$35 Copay	$60 Copay

Network Mail Order Pharmacy

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	$30 Copay	$105 Copay	$180 Copay
■ Certain preventive medications, including contraceptives (refills allowed as prescribed)[2 and 5] Annual Prescription Drug Deductible does not apply.	No charge	No charge	$30 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies	Generic not available	$35 Copay	$60 Copay
■ Lancets and lancing devices, disposable insulin syringes and needles Annual Prescription Drug Deductible does not apply.	No charge	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	$30 Copay	$105 Copay	$180 Copay

Network Extended Days' Supply (EDS) Retail Pharmacy

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	$30 Copay	$105 Copay	$180 Copay
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) 2 and 5 Annual Prescription Drug Deductible does not apply.	No charge	No charge	$30 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug
■ Certain oral contraceptives eligible for a 12 month supply (refills allowed as prescribed) Annual Prescription Drug Deductible does not apply. *Subject to supply availability at pharmacy	No charge	No charge	$30 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Certain oral contraceptives eligible for a 12-month supply (refills allowed as prescribed) Annual Prescription Drug Deductible does not apply. *Subject to supply availability at pharmacy	No charge	No charge	$30 Copay plus the difference in cost between the Brand Name Drug and the equivalent Generic Drug
Diabetes-related Covered Drugs and Supplies *Please see Section 6, Details for Covered Drugs or Supplies,* under the heading **Diabetes Supplies and Insulin** for more details about coverage.			
■ Insulin (refills allowed as prescribed)[2] Annual Prescription Drug Deductible does not apply	$25 Copay	$75 Copay	$75 Copay
■ Diabetic oral agent (refills allowed as prescribed)[2]	$30 Copay	$105 Copay	$180 Copay
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher [2 and 8] Annual Prescription Drug Deductible does not apply. Limited to one free glucose meter annually through the Free Glucose Meter Program. See *Diabetes Supplies and Insulin* in Section 6, "*Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	No charge	No charge	No charge
■ Preferred glucose meter purchased at a Network Mail Order Pharmacy without Voucher	$10 Copay	$35 Copay	$60 Copay
■ Preferred blood glucose test strips [2 and 8] Annual Prescription Drug Deductible does not apply. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge	No charge
■ Non-preferred blood glucose test strips	$30 Copay	$105 Copay	$180 Copay

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *Details for Covered Drugs or Supplies* for more details about covered diabetes supplies.			
■ Insulin (refills allowed as prescribed)[2] Annual Prescription Drug Deductible does not apply	$30 Copay	$75 Copay	$75 Copay
■ Diabetic oral agent (refills allowed as prescribed)[2]	$30 Copay	$105 Copay	$180 Copay
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher [2 and 8] Annual Prescription Drug Deductible does not apply. Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, "*Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	No charge	No charge	No charge
■ Preferred blood glucose meter purchased at a Network EDS Pharmacy without voucher	$10 Copay	$35 Copay	$60 Copay
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies	Generic not available	$35 Copay	$60 Copay
■ Preferred blood glucose test strips [2 and 8] Annual Prescription Drug Deductible does not apply. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	No charge	No charge	No charge
■ Non-preferred blood glucose test strips	$30 Copay	$105 Copay	$180 Copay

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Lancets and lancing devices, disposable insulin syringes and needles Annual Prescription Drug Deductible does not apply.	No charge	No charge	No charge
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	$30 Copay	$105 Copay	$180 Copay

Total Network Out-of-Pocket Maximum[1]

Total Network Out-of-Pocket Maximum (per Calendar Year)[7]	
Program Features	**Amount**
■ Participant, per Calendar Year (CY)	CY 2024: $7,500 CY 2025: $8,050
■ Family, per Calendar Year (not to exceed the applicable Individual amount per Participant for Network Benefits)[6]	CY 2024: $15,000 CY 2025: $16,100

[1] The Annual Prescription Drug Deductible and Total Network Out-of-Pocket Maximum are per Calendar Year (January 1 - December 31).

[2] Copays only apply after the Annual Prescription Drug Deductible has been met.

[3] If the cost of your Covered Drug or Supply is less than the applicable Copay, you pay the cost of the drug instead of the Copay.

[4] If a Generic Drug is available and you choose to buy the Brand-name Drug, you will pay the Generic Tier 1 Copay plus the difference in cost between the Brand-name Drug and the Generic Drug. (This is referred to as the Dispense as Written Penalty.)

[5] Certain preventive medications (including certain contraceptives) may be covered without any Participant cost share dependent upon Generic availability. Under the Affordable Care Act, certain contraceptive methods for women with reproductive capacity are paid at 100% (i.e., at no cost to the Participant). In some cases, you will be responsible for payment (for example, if you choose a Tier 3 drug when a Tier 1 drug is available.)

[6] No one individual within the family will pay more than the Per Participant Total Network Out-of-Pocket Maximum.

[7] The Total Network Out-of-Pocket Maximum includes Copays, Coinsurance (medical only), and the Annual Prescription Drug Deductible for both medical and Prescription Drug Network Benefits.

[8] The blood glucose meters and test strips available under this benefit are subject to change. You can find

a list of covered glucometers and test strips at **www.HealthSelectRx.com** or call **(800) 935-7189** (TTY 711).

Table 3 below contains the Program's Non-Network Copays, Coinsurance, and the Annual Prescription Drug Deductible for Covered Drugs or Supplies. ***Note:*** There is no Total Out-of-Pocket Maximum for Non-Network Benefits in the HealthSelect of Texas Prescription Drug Program.

TABLE 3 – Non-Network Benefits for Covered Drugs or Supplies

Program Features	Amount
Non-Network Annual Deductible (per Calendar Year)[1] Network and Non-Network Covered Drugs and Supplies apply to the Annual Prescription Drug Deductible	$50 per Participant

Non-Network Retail Pharmacy

Percentage of Predominant Reimbursement Rate Payable by the Participant

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Per Prescription fill of Non-Maintenance Medication (refills allowed as prescribed)[2]	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	40% after paying a $10 Copay	40% after paying a $45 Copay	40% after paying a $75 Copay
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) [2 and 5]	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $10 Copay plus the difference in cost between the Brand name Drug and the equivalent Generic Drug

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Certain oral contraceptives eligible for a 12 month supply (refills allowed as prescribed) Annual Prescription Drug Deductible does not apply. *Subject to supply availability at pharmacy	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $10 Copay plus the difference in cost between the Brand name Drug and the equivalent Generic Drug
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.			
■ Insulin (refills allowed as prescribed)[2]	$25 Copay	$25 Copay	$25 Copay
■ Diabetic oral agent[2] (refills allowed as prescribed)	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher[2 and 6] Annual Prescription Drug Deductible does not apply Limited to one free glucose meter annually through the Free Glucose Meter Program See *Diabetes Supplies and Insulin* in Section 6, "*Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	No charge	No charge	No charge

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 30-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■Preferred blood glucose meter purchased at a Non-Network Retail Pharmacy without Voucher	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies	Generic not available	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Preferred blood glucose test strips[2 and 5] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	40%	40%	40%
■ Non-preferred blood glucose test strips	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Lancets and lancing devices, disposable insulin syringes and needles	40%	40%	40%
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay

Non-Network Mail Order Pharmacy

Percentage of Predominant Reimbursement Rate Payable by the Participant

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Per Prescription fill of Maintenance Medication (refills allowed as prescribed)[2]	40% after paying a $30 Copay	40% after paying a $105 Copay	40% after paying a $180 Copay

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Certain preventive medications, including contraceptives (refills allowed as prescribed) [2 and 5]	40% after paying a $30 Copay	40% after paying a $105 Copay	40% after paying a $180 Copay plus the difference in cost between the Brand name Drug and the equivalent Generic Drug
■ Certain oral contraceptives eligible for a 12-month supply (refills allowed as prescribed) Annual Prescription Drug Deductible does not apply. *Subject to supply availability at pharmacy	40% after paying a $30 Copay	40% after paying a $105 Copay	40% after paying a $180 Copay plus the difference in cost between the Brand name Drug and the equivalent Generic Drug
Diabetes-related Covered Drugs and Supplies See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.			
■ Insulin (refills allowed as prescribed)[2]	$75 Copay	$75 Copay	$75 Copay
■ Diabetic oral agent (refills allowed as prescribed)[2]	40% after paying a $30 Copay	40% after paying a $105 Copay	40% after paying a $180 Copay
■ Preferred blood glucose meter obtained through the Free Glucose Meter Program with Voucher [2 and 6] Annual Prescription Drug Deductible does not apply. Limited to one free glucose meter annually through the Free Glucose Meter Program. See *Diabetes Supplies and Insulin* in Section 6, "*Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	No charge	No charge	No charge

Copays[2,3] (Copay is per Prescription Order or Refill)			
Covered Drugs or Supplies (up to a 90-day supply)	**Tier 1** You will pay	**Tier 2** You will pay	**Tier 3**[4] You will pay
■ Preferred blood glucose meter purchased at a Non-Network Mail Order Pharmacy without Voucher	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Continuous Glucose Monitors (CGMs) include Dexcom, Eversense, and Freestyle Libre. See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies	Generic not available	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Preferred blood glucose test strips [2 and 6] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for the list of preferred blood glucose test strips covered under this Benefit and more details about covered diabetic supplies.	40%	40%	40%
■ Non-preferred blood glucose test strips	40% after paying a $10 Copay	40% after paying a $35 Copay	40% after paying a $60 Copay
■ Lancets and lancing devices, disposable insulin syringes and needles	40%	40%	40%
■ Other covered diabetic supplies (glucagon emergency kits, alcohol wipes and swabs, etc.)[2] See *Diabetes Supplies and Insulin* in Section 6, *"Details for Covered Drugs or Supplies"* for more details about covered diabetes supplies.	40% after paying a $30 Copay	40% after paying a $105 Copay	40% after paying a $180 Copay

[1] The Annual Prescription Drug Deductible is per Calendar Year (January 1 - December 31)

[2] Copays only apply after the Annual Prescription Drug Deductible has been met.

[3] If the cost of your Covered Drug or Supply is less than the applicable Copay, you pay the cost of the drug instead of the Copay.

[4] If a Generic Drug is available and you choose to buy the Brand -name Drug, you will pay the Tier Copay and Coinsurance plus the difference in cost between the Brand-name Drug and the Generic Drug. (This is referred to as the Dispense as Written Penalty.)

[5] Certain preventative medications (including certain contraceptives) may be covered without any Participant cost share dependent upon Generic availability if they are provided by a Network Pharmacy. Any preventative medications filled at a Non-Network Pharmacy will be subject to the Non-Network Annual Deductible and Coinsurance amounts.