Blue Cross & Blue Shield of Rhode Island (BCBSRI) Mental Health Parity and Addiction Equity Act - NQTL Comparative Analysis

The Consolidated Appropriations Act, 2021 ("CAA") requires group health plans and health insurance issuers to make available to the applicable State authority or the Secretaries of the Departments of Health and Human Services, Labor, and the Treasury (the "Secretaries"), upon request, the comparative analysis and information outlined below (the "NQTL Comparative Analysis").

The Mental Health Parity and Addiction Equity Act ("MHPAEA") Final Rules outline the elements that an NQTL Comparative Analysis must include for each NQTL. Specifically, they must include:

1. A description of the non-quantitative treatment limitation ("NQTLs");
2. Identification and definition of the factors used to design or apply the NQTL;
3. A description of how factors are used in the design and application of the NQTL;
4. A demonstration of comparability and stringency, as written;
5. A demonstration of comparability and stringency, in operation; and
6. Findings and conclusions.

BCBSRI (the "Plan")] [or Issuer Name] has completed the NQTL Comparative Analysis below, based on the content elements required under the MHPAEA Final Rules.

Prescription Drug Analysis

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply prescription drug coverage, for mental health or substance use disorder ("behavioral health") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the coverage for medical surgical ("M/S") benefits.

Steps		Medical/Surgical & Behavioral Health
1	A description of the non-quantitative treatment limitation ("NQTLs")	Specific plan and coverage terms related to the pharmacy benefit from the Subscriber Agreement are attached below as Appendix A. The drug formulary has coverage tiers as follows • Tier 1: low cost generic drugs • Tier 2: higher cost generic drugs and preferred brand name drugs • Tier 3: highest cost generic drugs and non-preferred brand name drugs • Tier 4: Specialty drugs Prescription drug preauthorization, prior authorization, is the advance approval that must be obtained before BCBSRI provides coverage for certain prescription drugs Step Therapy is a type of prior authorization process which requires that one drug be used in treatment prior to another drug being allowed for coverage. The intention is that a member has tried or been treated with the first drug and a documented treatment failure or adverse reaction has occurred. BCBSRI limits the quantity of certain prescription drugs that can be obtained at one time for safety, cost-effectiveness and medical appropriateness reasons. Our clinical criteria for quantity limits are subject to our periodic review and modification

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Steps		Medical/Surgical & Behavioral Health
		Pharmacy management procedures and formulary development policy outlines the BCBSRI prescription drug management program and how the formulary is structured. Specific drug coverage information and the current formulary can be found on the BCBSRI.com website. The policy outlines the procedures for managing prescription drugs under the Blue Cross & Blue Shield of Rhode Island (BCBSRI) plan, including coverage, quantity limits, pharmacy types, payment structures, and preauthorization processes. The prescription drug benefit is administered by the Pharmacy Benefit Manger (PBM). The Pharmacy & Therapeutics (P&T) Committee oversees formulary development and maintenance, implementing updates twice a year, with members notified 30 days in advance of changes affecting out-of-pocket expenses or coverage. The volume and volatility of marketplace activity and the need to respond in a timely manner to the real-time drug claim processing system create challenges. Given the limited schedule of P&T meetings, it became necessary to develop and adopt a process authorized by the Committee to allow the clinical staff to implement formulary actions outside of the normal committee review. These guidelines are referred to as the Formulary Guiding Principles. These guidelines provide directions to update the claims system based upon a standard set of principles. On a twice annual basis, all decisions regarding new drugs to market and the action taken since the last formulary update are reviewed by the full P&T Committee. Policies and documents: The formulary and which specific drugs are subject to Prior authorization, Step therapy, Medical necessity, and/or Quantity limits are identified here: Pharmacy | Blue Cross & Blue Shield of Rhode Island (bcbsri.com) Pharmaceutical Management Procedures Formulary Guiding Principles Pharmacy and Therapeutics Committee Charter 2025 Formulary Decision Grid Template Example P&T Committee Agenda CTL designation description Sample member notification of negative change letter template
2	Identification and definition of the factors used to design or apply the NQTL	The formulary includes a tiered copayment structure and preauthorization requirements. Quantity limits are set for safety and cost-effectiveness, with restrictions on the number of prescriptions per period or provider. The plan uses retail, mail order, and specialty pharmacies. The payment structure varies between retail and specialty pharmacies, with certain drugs not subject to tiered copayments. Rhode Island law mandates generic substitution unless specified otherwise by the physician. Preauthorization is required for certain drugs, with processes for obtaining preauthorization and expedited reviews, as well as coverage exceptions for non-formulary drugs. The document details procedures for appealing denied requests and provides contact information for the PBM. Step therapy requires trying

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Steps		Medical/Surgical & Behavioral Health
		one drug before another is covered, verified through the pharmacy claim system. Exclusions include experimental drugs, cosmetic drugs, and non-FDA approved compounds. The development of the formulary is an ongoing and dynamic process that is under constant evaluation in response to marketplace events. New drug entities come to market every day, some in the form of FDA approvals of new products, reformulations of existing products, repackaged products, or drugs that are sold from one manufacturer to another. There is similar activity for both brand drugs and generic drugs across both behavioral health and medical/surgical medication categories. Drug products are also being removed from the market, some voluntarily and some by order of the FDA. The formulary process evaluation also includes monitoring of drug shortages and reacting to this by adjusting the claims processing system in some cases to allow coverage of the brand product that has been excluded under the Blue Cross & Blue Shield of Rhode Island Formulary, as an example.
3	Description of How the Factors are Used in the Design and Application of the NQTL	One critical component of formulary development and maintenance is the corporate Pharmacy & Therapeutics (P&T) Committee. This Committee is made up of local and independent physicians and pharmacists that provide clinical input and oversight to the content and structure of the Plan Formulary. Pharmacy & Therapeutics Committee Title Qualifications & Specialty PharmD Specialty Pharmacist MD Cardiologist MD GI Specialist MD Psychiatrist MD Rheumatologist MD Oncologist MD Primary Care MD Primary Care MD Pulmonologist MD Endocrinologist

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Steps		Medical/Surgical & Behavioral Health
		MD Medical Director In addition, it is the responsibility of the P&T Committee to conduct therapeutic class reviews on a revolving basis throughout the year to validate formulary coverage and review utilization within the class. The Committee also considers any updated and applicable clinical guidelines produced by nationally recognized compendia and academic review organizations such as the CDC, NHLBI, NCCN, and ASCO, ADA or similar groups In preparation for the formal P&T Committee meeting, the clinical staff of both the Plan and PBM, along with BCBSRI Medical Director develops a meeting agenda of topics for consideration by the Committee. The agenda will include regularly scheduled therapeutic class reviews, identified opportunities for formulary changes, reaction to marketplace changes including price volatility, new drugs to market or significant changes in drug utilization The following factors are applicable for formulary status of both M/S and MH/SUD medications (inclusion on the formulary, the cost sharing tier, as well as any medical management or utilization management including Prior Auth, Step Therapy, and/or Quantity Limits): Topics that are applicable for formulary status discussion/review by the P&T committee Impending generic availability – impact on existing products in class. Release of new clinical studies involving an important therapeutic class. Contracting opportunities presented by PBM from manufactures for preferred status Present information from a utilization review of drug classes suggesting the need for management in the form of a PA or Quantity Limit. Identify a therapeutic class that has not been the subject of a full class review in the past 24 months and include it for the next scheduled P&T meeting. Review of marketplace pricing updates to identify generics to be placed at tier 2 or moved to tier 1 in response to pricing declines. FDA approvals of new drugs to market and expected patterns of use Participating provider recommendations for additions or deletion of drugs to the formulary Whether the medication is generic or brand The cost effectiveness and comparative expenses of the medication Bioavailability data Cost comparisons against other drugs available to treat the same medical condition(s) Current therapeutic guidelines Dosage ranges by route and age Patient risk factors relative to contraindications, warnings, and precautions

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Steps		Medical/Surgical & Behavioral Health
		Pharmacokinetic data Pharmacologic considerations (e.g. drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-to-drug interaction potential, and clinical advantages over other products in the specific drug class) Risks versus benefits regarding clinical efficacy and safety of a particular drug relative to other drugs with the same indication Special monitoring or medication administration requirements Findings of clinical effectiveness of the medication. Availability of direct generic equivalent drugs. Federal and state statutory and regulatory requirements This information can be sourced from the following resources which are leveraged for both M/S and BH medications when applicable Findings from governmental agencies and regulatory body publications (Federal Drug Administration, Centers for Disease Control and Prevention, the National Institute of Health, Centers for Medicare and Medicaid, etc.), Medical and pharmaceutical associations including the American Pharmacists Association (APhA), American Medical Association (AMA), American College of Cardiology, American College of Allergy, and Asthma and Immunology; Medical literature and clinical trials; Clinical guidelines produced by nationally recognized compendia and academic review organizations such as the Centers for Disease Control and Prevention, The National Heart, Lung, and Blood Institute, National Comprehensive Cancer Network, and American Society of Clinical Oncology, American Diabetes Association or similar groups. Off-label uses (the use of currently available and marketed medications but for an indication that has never received Food and Drug Administration (FDA) approval when the use has been supported by one or more citations in recognized medical literature sources (e.g. DRUGDEX Information System or American Hospital Formulary Service Drug information (AHFS)); Rhode Island General laws and regulations and requirements from the Office of the Health Insurance Commissioner, Federal laws and regulations. BCBSRI claims and utilization data; Recommendations from participating providers, for additions or deletions to the formulary (experiential information). Primary consideration is given to FDA approval. A drug must be approved by the FDA for coverage. All other factors listed above become secondary considerations. This is the same for both M/S and BH medications. The mission of FDA is to enforce laws enacted by the U.S. Congress and regulations established by the Agency to protect the consumer's health, safety, and pocketbook. *The Federal Food, Drug, and Cosmetic Act* is the basic food and drug law of the U.S. The law is intended to assure the consumer that drugs and devices are safe and effective for their intended uses. The Code of Federal Regulation (CFR) provides regulations for Investigational New Drugs (INDs), New

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Steps		Medical/Surgical & Behavioral Health

		Drug Applications (NDAs), Abbreviated New Drug Applications (ANDAs) and Biologics License Applications (BLAs). Laws, Regulations, Policies and Procedures for Drug Applications | FDA
		
		The DEA provides instruction on drug scheduling. Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs have a high potential for abuse and the potential to create severe psychological and/or physical dependence. As the drug schedule changes-- Schedule II, Schedule III, etc., so does the abuse potential-- Schedule V drugs represent the least potential for abuse. A listing of drugs and their schedule are located at Controlled Substance Act (CSA) Scheduling or CSA Scheduling by Alphabetical Order. Drug Scheduling. These lists describe the basic or parent chemical and do not necessarily describe the salts, isomers and salts of isomers, esters, ethers and derivatives which may also be classified as controlled substances. These lists are intended as general references and are not comprehensive listings of all controlled substances.
		The same is applied equally to both MH/SUD and M/S medication categories.
		
		The Pharmacy and Therapeutics Committee meets quarterly. Each drug is presented to the committee as follows
		• Indication
		• Class and Mechanism of action
		• Dose and administration
		• Similar products by indication
		• Clinical Trial
		  ○ Trial Design
		  ○ Key baseline characteristics
		  ○ Efficacy results
		  ○ Safety
		  ▪ Warnings and precautions
		  ▪ Adverse effects
		• Place in Therapy
		  ○ FDA review
		  ○ Clinical guidelines produced by nationally recognized compendia and/or academic review organizations
		• Summary of presented information
		• Recommendation for CTL, formulary placement, and utilization management
		• Voting and discussion
		  ○ Majority vote required to pass CTL, formulary placement, and utilization management
		
		"Formulary Guiding Principles" describes the criteria for the formulary tiering process. The BCBSRI Pharmacy & Therapeutic Committee reviews a comprehensive formulary document twice a year.

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Steps		Medical/Surgical & Behavioral Health
4.	Demonstration of Comparability and Stringency as Written	The same group considers medications used for Medical/Surgical and Behavioral Health. The BCSRI P&T Committee's voting membership reflects the appropriate expertise. It consists of local practitioners and pharmacists. The committee members include of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing health care professionals who are licensed to prescribe drugs. The physician members include a minimum of five contracted and board-certified physicians, one of which is a primary care physician (PCP), and at least three specialists. Current voting membership includes a specialist in behavioral health. Upon completion of the Pharmacy and Therapeutics committee meeting a decision grid is created (see attached) to track and document any formulary changes. This decision grid captures the type of review, the formulary drug monograph chapter and section, brand vs generic availability, the chemical name, the brand name, dosage form, drug strength, GPI number, the decision, the effective date of the decision, CTL designation, the clinical rational of the placement recommendation, the cost and any comments related to the drug or the decision. (see attached for sample template). The same decision grid is used for both behavioral health and Medical/Surgical drugs. Evidence-based criteria is mainly sourced from national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies, criteria from professional associations, and federal authorities. The Committee considers any updated and applicable clinical guidelines produced by nationally recognized compendia and academic review organizations such as the CDC, NHLBI, NCCN, and ASCO, ADA or similar groups. Factors for copay tier designation are whether the medication is generic or brand, and brands with demonstrated effectiveness established by adequate and well controlled clinical trials and approved by the FDA are placed in no less advantaged level than other brands designated as preferred, brands with lower costs may qualify to be designated as preferred. Preferred drugs are formulary drugs deemed clinically comparable to similar drugs but that provide the best economic value in each drug class, exclusive of generic alternatives. The purpose of the preferred drug list is to identify the most clinically appropriate and cost-effective medications. There is no difference in tier decision placement factors for Medical/Surgical and Behavioral Health products. Primary consideration is given to FDA approval. A drug must be approved by the FDA for coverage. All other factors listed become secondary considerations. Utilization management edits are implemented to ensure appropriate use of designated drugs consistent with FDA approved use and/or diagnosis. UM seeks to encourage generic drug use and the use of preferred drugs as first line treatment prior to the selection of a non-preferred drug. The Pharmacy and Therapeutics committee oversees the establishment of the utilization management criteria. As part of the drug review process, select drugs are identified for the potential application of UM. The recommendations for coverage criteria will be included in the drug review. The requirements for coverage are outlined including current diagnosis, trial and failure of other generic or preferred drugs, history of a members' prior adverse reactions that preempt use of the preferred product. The materials presented for review will include evidence showing how preferred drugs produce similar or better results for a most members than other pharmaceuticals in the same class. The suggested criteria are presented on a drug by drug basis and the committee will review and approve criteria specific to a drug or class of drugs. This process is the same for criteria for M/S medications and BH medications. Prescription drugs requiring preauthorization are initially reviewed by pharmacists and authorized personnel based on medical necessity. If the criteria are met, the request may be approved at this stage. Requests that might be denied are reviewed by a physician for a final decision. Approval is granted only if clinical guidelines are met, ensuring the drug is appropriate and cost-effective for the diagnosis for which it has been prescribed. There is no difference in the prior authorization process for Medical/Surgical and Behavioral Health Products. If a request results in a denial, the determination response will include the criteria upon which the request did not met standard for approval. The response will also include an outline of the internal and external appeal process for when a request has not been approved, this process is the same for both Behavioral Health and Medical/Surgical drugs.

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<table>
<tr><th colspan="2">Steps</th><th>Medical/Surgical & Behavioral Health</th></tr>
<tr><td>5.</td><td>Demonstration of comparability and stringency, in operation;</td><td>
Drugs to treat behavioral health conditions are more likely to be on lower cost sharing tiers (the generic and preferred brand tiers). As of January 1, 2025: For behavioral health drugs, 82% are on the lowest tier and 15% on the next lowest (together, 97% of the drugs to treat a behavioral health condition) and fewer percentage of drugs on the higher tiers; comparatively for drugs for a medical condition, 63% are on the lowest tier and 26% are on the next lowest tier (together 89%) and a higher percentage of drugs on the higher tiers.

A very small subset of medications to treat Behavioral Health conditions are subject to utilization management (prior authorization or step therapy). As of May 2024: 2678 unique products are subject to some form of utilization management, of these, 98% are for medical/surgical conditions and 2% for behavioral health services. The behavioral health services ones are:

• Atypical Anti-Psychotics (step from generic to brand)
• Brand Anti-Depressants (step from generic to brand)
• Vraylar (prior authorization for the specific medication for treatment of bi-polar disorder)
• Invega Trinza (prior authorization for the specific medication (long term anti-psychotic injectable))
• Zurzuvae (prior Authorization for the specific medication for treatment of post-partum depression)

The utilization management process is the same for these medications for behavioral health conditions as for the medications to treat medical conditions.

A review of outcomes data illustrates the favorable coverage and utilization management applied to medications for behavioral health conditions.

• Prior Authorization is applied to 0.12% of the medication for Behavioral Health, compared to 7.04% for medical surgical conditions (low numbers of requests distort the percentages of denials/appeals reported below).

• Step Therapy is applied to 1.21% of the medication for Behavioral Health, compared to 0.74% for medical surgical conditions (and denial/approval on appeal rates are substantially more favorable for Behavioral Health).

• Quantity Limits are applied to 21.11% of the medication for Behavioral Health, compared to 22.39% for medical surgical conditions.

<table>
<tr><th colspan="4">Prior Authorization – 2024 (All Commercial)</th></tr>
<tr><th></th><th>M/S</th><th>MH/SUD</th><th></th></tr>
<tr><td>Total # of Prior Authorization (“PA”) Requests</td><td>10939</td><td>42</td><td></td></tr>
<tr><td>Total # of PA Requests Approved</td><td>8034</td><td>36</td><td></td></tr>
<tr><td>Total # of PA Requests Denied</td><td>2905</td><td>5</td><td></td></tr>
</table>
</td></tr>
</table>

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Steps	Medical/Surgical & Behavioral Health			
	Denial Percentage Rate	**26.56%**	**11.9%**	
	Total of PA Requests Appealed	**1685**	**4**	
	Appeal Percentage Rate (appeal rights' time period is 18 months, extending into subsequent year, some appeals apply to prior year's denials)	**58.0%**	**80%**	
	Total # Approved on Appeal	**777**	**2**	
	Overturn Percentage Rate	**46.11%**	**50%**	
	Drugs that Require Prior Authorization			
		M/S	**MH/SUD**	
	# of Generic Brand Drugs (T1/T2)	**702**	**0**	
	# of Condition Care Brand Drugs	**0**	**0**	
	# of Preferred Brand Drugs (T3)	**117**	**5**	
	# of Non-Preferred Brand Drugs (T4)	**1460**	**0**	
	Total # of Drugs Subject to PA	**2442**	**5**	
	Total # of Drugs Reviewed	**34646**	**3949**	
	% of Drugs Subject to PA	**7.04%**	**0.12%**	
	Step Therapy 2024 (All Commercial)			
		M/S	**MH/SUD**	
	Total # of Step Therapy Requests	**709**	**151**	

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Steps	Medical/Surgical & Behavioral Health			
	Total # of Step Therapy Requests Approved	**451**	**140**	
	Total # of Step Therapy Requests Denied	**258**	**11**	
	Denial Percentage Rate	**36.39%**	**7.28%**	
	Total # of Step Therapy Requests Appealed	**169**	**23**	
	Appeal Percentage Rate (appeal rights' time period is 18 months, extending into subsequent year, some appeals apply to prior year's denials)	**65.50%**	**209.8%**	
	Total # Approved on Appeal	**98**	**23**	
	Overturn Percentage Rate	**57.99%**	**100%**	
	Drugs that Require Step Therapy			
		M/S	**MH/SUD**	
	# of Generic Brand Drugs	**43**	**1**	
	# of Condition Care Brand Drugs	**0**	**0**	
	# of Preferred Brand Drugs	**139**	**47**	
	# of Non-Preferred Brand Drugs	**1**	**0**	
	Total # of Drugs Subject to Step Therapy	**183**	**48**	
	Total # of Drugs Reviewed	**34646**	**3949**	
	% of Drugs Subject to Step Therapy	**0.74%**	**1.21%**	

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<table>
<tr><th colspan="2">Steps</th><th>Medical/Surgical & Behavioral Health</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="4">Drugs that Require Quantity Limits</th></tr>
<tr><th></th><th>M/S</th><th>MH/SUD</th><th></th></tr>
<tr><td># of Generic Brand Drugs</td><td>6118</td><td>763</td><td></td></tr>
<tr><td># of Condition Care Brand Drugs</td><td>0</td><td>0</td><td></td></tr>
<tr><td># of Preferred Brand Drugs</td><td>376</td><td>71</td><td></td></tr>
<tr><td># of Non-Preferred Brand Drugs</td><td>1134</td><td>0</td><td></td></tr>
<tr><td>Total # of Drugs Subject to Quantity Limits</td><td>7758</td><td>834</td><td></td></tr>
<tr><td>Total # of Drugs Reviewed</td><td>34646</td><td>3949</td><td></td></tr>
<tr><td>% of Drugs Subject to Quantity Limits</td><td>22.39%</td><td>21.11%</td><td></td></tr>
</table>
</td></tr>
<tr><td>6</td><td>Findings and conclusion</td><td>The same policies and practices apply to formulary design for medications for both behavioral health and medical/surgical conditions. All applicable clinical guidelines produced by nationally recognized compendia and academic review organizations are reviewed to determine a medications formulary status. The P&T committee is appropriately staffed and resourced, with representation that includes a behavioral health specialist. The resulting formulary and utilization management practices treat medications for the treatment of behavioral health conditions with appropriate comparability, if not more favorably, than for medical conditions.

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement rates to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement rates to M/S benefits; and (2) the [Plan or Issuer] complies with the relevant data requirements under the MHPAEA Final Rules.</td></tr>
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See Policy PH 7.01

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)	**11/6/2025**	**Implementation Date: 1/1/2026**
Analysis Performed By:	**David Dunn** Signed by: 20643044BFC7406... **Director, Pharmacy Services**	**Bethany Spadaro** Signed by: Bethany Spadaro EC86817B55034AD... **Director, Pharmacy Services**
I certify that this analysis was reviewed/approved by BCBSRI's Mental Health Parity Governance Committee on the above-mentioned date.	**X** Signed by: Sonia Worrell Asare 096289BA3644F5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE: 11/6/2025**

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SECTION 11: PRESCRIPTION DRUG BENEFITS

The Summary of Pharmacy *Benefits* only applies to prescription drugs purchased at a retail, mail order, or specialty, pharmacy. For information about our pharmacy *network*, visit our website or call our Customer Service Department.

Required Preauthorization

Prescription drugs for which *preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy *Benefits*.

For details on how to obtain prescription drug *preauthorization*, see *Preauthorization* in Section 5 for details. If *preauthorization* is not obtained, you will be required to pay for the prescription drug at the pharmacy. You can ask us to consider reimbursement after you receive the prescription drug by following the prescription drug *preauthorization* process. For a list of prescription drugs that require *preauthorization*, visit our website or call our Customer Service Department.

Five-Tier Copayment Structure

This prescription drug *plan formulary* has a five-tiered *copayment* structure. The *copayment* for a prescription drug will vary by tier. The tier placement of a prescription drug on our *formulary* is subject to change. For more information about our *formulary*, and to see the tier placement of a particular prescription drug, visit our website or call our Customer Service Department.

Below indicates the tier structure for this *plan* and the amount that you are responsible to pay. You will be responsible for paying the lowest cost of either *y*our *copayment*, the retail cost of the drug, or the *pharmacy allowance*.

We reserve the right not to accept manufacturer coupons, discount *plan* payments or other cost share assistance program payments for prescription drug *copayments* and/or *deductibles*. **DN: Insert for HSA plans:** If prescription drug manufacturer coupons, discount *plan* payments or other cost share assistance program payments for prescription drug *copayments* are accepted they may not be counted towards your *deductible* (if applicable) or your *maximum out-of-pocket expense* limit.

DN: Not applicable for HSA products

Copayment Solution Program

BCBSRI's *copayment* solution program is designed to help both you and this *plan* save money on certain *specialty prescription drugs* by obtaining *copayment* assistance from drug manufacturers when it is available. If you are taking a qualifying prescription drug, a representative will contact you to participate in program services. With this program, a variable *copayment* may apply, which takes into account coupon assistance available to pay your cost for the prescription drug. The *copayment* for program prescription drugs may be set to the maximum of either the *copayment* associated with the tier placement of the prescription drug on our *formulary,* or the amount determined by the manufacturer-funded *copayment* assistance program. We reserve the right not to apply manufacturer or *provider* cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the *deductible* or *out-of-pocket maximums*. Participation in this program is voluntary and choosing not to participate will not affect your *benefits*.

Insulin Prescription Drugs

In accordance with RIGL § 27-20.8-3, *copayments* for insulin *prescription drugs* will not exceed $40 for each thirty-day supply and are not subject to a *deductible*.

EpiPen Prescription Injectors

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In accordance with RIGL § 27-18.94, this *plan* covers one two-pack epinephrine auto-injector kit, with no *copayment,* per *plan year,* as indicated on our *formulary*. Please contact our Customer Service Department for details.

Summary of Pharmacy Benefits

Covered Benefits	**Network Pharmacy**	**Non-network Pharmacy**
(+) Preauthorization is required for this service. Please see Preauthorization in Section 5 for more information.	**You Pay**	**You Pay**
Prescription Drugs, other than Specialty Prescription Drugs, and Diabetic Equipment and Supplies (which includes Glucometers, Test Strips, Lancet and Lancet Devices, Needles and Syringes, and Miscellaneous Supplies, calibration fluid):		
When purchased at a Retail or Specialty Pharmacy:	Tier 1: $x - After *deductible*	Not Covered
For maintenance and non-maintenance prescription drugs, a *copayment* applies for each 30-day period (or portion thereof) within the prescribed dosing period.	Tier 2: $x - After *deductible*	Not Covered
	Tier 3: $x - After *deductible*	Not Covered
Prorated *copayments* for a shorter supply period may apply for *network pharmacy* only. See Prescription Drug section for details.	Tier 4 and Tier 5: See *specialty prescription drug* section below.	Not Covered
For tiers 1, 2, and 3: Up to a 90-day supply of maintenance and non-maintenance prescription drugs is available at certain *network* retail pharmacies and a 365-day supply for contraceptive prescription drugs		

and devices is available at all *network* retail pharmacies. A copayment will apply for each 30-day supply. For more information about pharmacies offering this option, visit our website.		
When purchased at a Mail Order Pharmacy: Up to a 90-day supply of maintenance and non-maintenance prescription drugs.	Tier 1: $x - After *deductible*	Not Covered
	Tier 2: $x - After *deductible*	Not Covered
	Tier 3: $x - After *deductible*	Not Covered
	Tier 4 and Tier 5: See *specialty prescription drug* section below.	Not Covered
Specialty Prescription Drugs (+) Prorated copayments for a shorter supply period may apply for *network pharmacy* only. See Prescription Drug section for details.		
When purchased at a Specialty Pharmacy(+): For maintenance and non-maintenance prescription drugs, a *copayment* applies for each 30-day period (or portion thereof) within the prescribed dosing period.	Tier 4: $x - After *deductible*	Not Covered
	Tier 5: $x - After *deductible*	Not Covered
When purchased at a Retail Pharmacy(+): For maintenance and non-maintenance prescription drugs, a *copayment* applies for each 30-day period (or portion thereof) within the prescribed dosing period. *Specialty Prescription Drugs* purchased at a r*etail* pharmacy may require a higher out of pocket expense than if purchased from a	Tier 4: x% up to $150 - After *deductible*	Not Covered
	Tier 5: x% up to $150 - After *deductible*	Not Covered

Specialty Pharmacy. Our reimbursement is based on the pharmacy allowance.		
When purchased at a Mail Order Pharmacy:	Not Covered	Not Covered
Infertility Prescription Drugs (+) - Three (3) in-vitro cycles will be covered per *plan year* with a total of eight (8) in-vitro cycles covered in a *member's* lifetime.		
When purchased at a Specialty, Mail Order, or Retail Pharmacy	Tier 1: x% - After *deductible*	Not Covered
	Tier 2: x% - After *deductible*	Not Covered
	Tier 3: x% - After *deductible*	Not Covered
When purchased at a Specialty Pharmacy(+)	Tier 4: x% up to $150 - After *deductible*	Not Covered
	Tier 5: x% up to $150 - After *deductible*	Not Covered
When purchased at a Retail Pharmacy (+):	Tier 4: x% up to $150 - After *deductible*	Not Covered
Specialty Prescription Drugs purchased at a retail pharmacy may require a higher out of pocket expense than if purchased from a Specialty Pharmacy. Our reimbursement is based on the pharmacy allowance.	Tier 5: x% up to $150 - After *deductible*	Not Covered
When purchased at a Mail Order Pharmacy:	Not Covered	Not Covered

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Contraceptive Methods - when covered as a preventive care service as described in Section 3. Coverage includes barrier method (diaphragm or cervical cap), hormonal method (birth control pill), and emergency contraception. For all other contraceptive prescription drugs and devices the amount you pay will depend on the tier placement of the contraceptive prescription drug or device. See above for those *copayment* details.		
When purchased at a Retail Pharmacy: Up to a 365-day supply of contraceptive prescription drugs and devices is available at all *network* retail pharmacies. For more information about this option, visit our website.	$0	Not Covered
When purchased at a Mail Order Pharmacy: Up to a 90-day supply.	$0	Not Covered
Over-the-counter (OTC) Preventive Drugs		
When purchased at any pharmacy: Must be prescribed by a physician. See Prescription Drug section for details.	$0	Not Covered

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Nicotine Replacement Therapy (NRT) and Smoking Cessation Prescription Drugs		
When purchased at any pharmacy: Must be prescribed by a physician. See Prescription Drug section for details.	Tier 1 Preventive: $0 Tier 1 Non-preventive: $x- After *deductible*	Not Covered
	Tier 2 Preventive: $0 Tier 2 Non-preventive: $x - After *deductible*	Not Covered
	Tier 3: $x - After *deductible*	Not Covered
	Tier 4 and Tier 5: NRT and Smoking Cessation drugs are only placed in Tier 1, Tier 2, or Tier 3. See above.	Not Covered
When purchased at a Mail Order Pharmacy:	Not Covered	Not Covered
DN: Insert highlighted rows for all VB, and NEHP (NB AND BC) plans		
Diabetes, Asthma, and COPD Prescription Drugs		
For maintenance and non-maintenance prescription drugs, a *copayment* applies for each 30-day period (or portion thereof) within the prescribed dosing period. For tiers 1, 2, and 3: Up to a 90-day supply of maintenance and non-maintenance prescription drugs is available at certain retail pharmacies. For a 90-day supply; three retail *copayments* apply. For more information about pharmacies offering this option, visit our website.	$2	Not Covered
Prescription Drugs Administered by a Provider (other than a Pharmacy).	See the Summary of Medical *Benefits*.	See the Summary of Medical *Benefits*.

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Prescription Drugs

This *plan* covers prescription drugs and diabetic equipment or supplies. When they are purchased from a pharmacy, prescription drugs and diabetic equipment or supplies are covered as a pharmacy *benefit*. In most cases, when the prescription drug requires administration by a *provider* other than a pharmacist (or the FDA approved recommendation is administration by a *provider* other than a pharmacist), the prescription drug is covered as a medical *benefit* referred to as "*medical prescription drugs*". See subsection B: Medical Benefits - Prescription Drugs Administered by a Provider (other than a pharmacist) below for further information.

Please see Pharmacy *Benefits* subsection A and Medical *Benefits* subsection B below for information about how these prescription drugs are covered.

Prescription drugs and diabetic equipment or supplies are covered when dispensed using the following guidelines:

- the prescription must be *medically necessary*, consistent with the *physician's* diagnosis, ordered by a *physician* whose license allows him or her to order it, filled at a pharmacy whose license allows such a prescription to be filled, and filled according to state and federal laws;
- the prescription must consist of *legend drugs* that require a *physician's* prescription under law, or compound medications made up of at least one *legend drug* requiring a *physician's* prescription under law;
- the prescription must be dispensed at the proper place of service as determined by our Pharmacy and Therapeutics Committee. For example, certain prescription drugs may only be covered when obtained from a specialty pharmacy; and
- the prescription is limited to the quantities authorized by your *physician* not to exceed the quantity listed in the Summary of Pharmacy *Benefits*.

Prescription Drug Quantity Limits

We limit the quantity of certain prescription drugs that you can get at one time for safety, cost-effectiveness and medical appropriateness reasons. Our clinical criteria for quantity limits are subject to our periodic review and modification.

Quantity limits may restrict:

- the amount of pills dispensed per thirty (30) day period;
- the number of prescriptions ordered in a specified time period; or
- the number of prescriptions ordered by a *provider*, or multiple *providers*.

HIV Prevention Prescription Drug Coverage

This *plan* covers treatment of pre-exposure prophylaxis (PrEP) for the prevention of HIV and post-exposure prophylaxis (PEP) to prevent HIV infection in accordance with RIGL § 27-18-91. Under this law, certain PrEP and PEP prescription drugs are covered with no *copayment* as indicated on our *formulary.* These prescription drugs also do not require *preauthorization* or step therapy. Please see our website or contact our Customer Service Department for details.

Designated Prescription Drug Prescribers and Pharmacies

We may limit your selection of a pharmacy to a single pharmacy location and/or a single prescribing *provider* or practice. Those *members* subject to this designation include, but are not limited to, *members* that have a history of:

- being prescribed prescription drugs by multiple *providers*;
- having prescriptions drugs filled at multiple pharmacies;
- being prescribed certain long acting opioids and other controlled substances, either in combination or separately, that suggests a need for monitoring due to:

- o quantities dispensed;
- o daily dosage range; or
- o the duration of therapy exceeds reasonable and established thresholds.

Prescription Drug Coverage Exception Process
When a prescription drug is not covered, you can request that this *plan* cover the drug as an exception.

To request a coverage exception, complete a Coverage Exception form (located on our website), contact our Customer Service Department, or have your prescribing *provider* submit a request for you. We will respond to you with a determination within seventy-two (72) hours following receipt of the request. For standard exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the prescription, including refills.

How to Request an Expedited Prescription Drug Coverage Exception Review
You may request an expedited review if a delay could significantly increase the risk to your health or your ability to regain maximum function, or you are undergoing a current course of treatment with a drug not on our *formulary*. Please indicate "urgent" on the Coverage Exception form or inform Customer Service of the urgent nature of your request. We will respond to you with a determination within twenty-four (24) hours following receipt of the request. For expedited exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the exigency.

For both standard and expedited exception reviews, if we grant your request for a prescription drug coverage exception, the amount you pay will be the *copayment* at the highest pharmacy prescription drug tier in your *plan* as shown in the Summary of Pharmacy *Benefits*. For *Medical Prescription Drugs* the amount you pay will be the prescription drugs *copayment* shown in the Summary of Medical *Benefits*. Other applicable *benefit* requirements, such as step therapy, are not waived by this exception and must be reviewed separately.

If we deny your request for a prescription drug coverage exception, we will notify you with information on how to appeal our decision, including external appeal information.

A. Pharmacy Benefits - Prescription Drugs and Diabetic Equipment or Supplies from a Pharmacy
This *plan* covers prescription drugs listed on our *formulary* and diabetic equipment or supplies purchased from a pharmacy as a pharmacy *benefit*.

Our *formulary* includes a tiered *copayment* structure and indicates if a prescription drug has a quantity limit or requires *preauthorization*. If a prescription drug is not on our *formulary*, it is not covered. For specific coverage information or a copy of the most current *formulary*, please visit our website or call our Customer Service Department.

DN: Insert for LG if applicable
This *plan* covers prescription drugs such as sildenafil citrate (e.g., Viagra), therapeutic equivalents, or any other pharmaceuticals up to **[Insert # of pills covered]** pills per month, when used to treat physiological dysfunctions.

Types of Pharmacies
Prescription drugs and diabetic equipment or supplies can be purchased from the following types of pharmacies:
- Retail pharmacies. These dispense prescription drugs and diabetic equipment or supplies.
- Mail order pharmacies. These dispense maintenance and non-maintenance prescription drugs and diabetic equipment or supplies.
- Specialty pharmacies. These dispense *specialty prescription drugs*, defined as such on our *formulary*.

For information about our *network* retail, mail order, and specialty pharmacies, visit our website or call our Customer Service Department.

The Amount You Pay for Prescription Drugs
Our *formulary* includes a tiered *copayment* structure, which means the amount you pay for prescription drugs purchased at a pharmacy will vary by tier. See the Summary of Pharmacy *Benefits* for your *copayment* structure, *benefit limits* and the amount you pay.

When you buy covered prescription drugs and diabetic equipment and supplies from a retail *network pharmacy*, you will be responsible for the *copayment* and *deductible* (if any) at the time of purchase. You will be responsible for paying the lower of your *copayment*, the retail cost of the drug, or the *pharmacy allowance*.

Specialty prescription drugs are generally obtained from a specialty pharmacy. If you buy a *specialty prescription drug* from a retail *network pharmacy*, you will be responsible for a significantly higher out of pocket expense than if you purchased the specialty drug from a specialty pharmacy.

The amount you pay for the following prescription drugs purchased at a pharmacy is not subject to the tiered *copayment* structure:
- Contraceptive methods covered as a *preventive care service*;
- Over-the-counter (OTC) drugs covered as a *preventive care service*;
- Nicotine replacement therapy (NRT) and smoking cessation prescription drugs;
- Other prescription drugs covered as a *preventive care service* as indicated on our *formulary*;
- Infertility *specialty prescription drugs*; and
- Covered diabetic equipment or supplies purchased at a *network pharmacy*.

Not all contraceptive drugs or devices are listed on our *formulary* or are covered as a *preventive care service*. If you or your *provider* decide that you need a different contraceptive drug or device than those listed on our *formulary* or those covered as a *preventive care service*, you or your *provider* may request an exception using our Contraceptive *Copayment* Waiver form. For more information, please visit our website or call our Customer Service Department.

See the Summary of Pharmacy *Benefits* for *benefit limits* and the amount you pay.

DN: Insert for LG when applicable
Over-the-counter (OTC) Options Program
This program allows a *member* to buy specifically designated OTC drugs at no cost. To participate in this program, you must agree to use the alternative OTC drug instead of the prescription drug. The OTC drug must be purchased at a *network* retail pharmacy. The OTC drug is subject to the *benefit limits* shown in the Summary of Pharmacy *Benefits*. A current list of the prescription drugs included in the OTC options program is available by visiting our website or calling our Customer Service Department.

This *plan* allows for medication synchronization in accordance with R.I. General Law §27-18-50.1. This means a prorated *copayment* may be applied to qualifying covered prescription drugs used for chronic long-term conditions, when prescribed for less than a thirty (30) day supply and dispensed by a *network pharmacy*.

B. Medical Benefits - Prescription Drugs Administered by a Provider (other than a pharmacist)

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This *plan* covers prescription drugs as a medical *benefit*, referred to as "*medical prescription drugs"*, when the prescription drug requires administration (or the FDA approved recommendation is administration) by a licensed healthcare *provider* (other than a pharmacist). Please note: Certain prescription drugs meeting these requirements or recommendations may be designated as a specialty prescription drug and will be covered as a pharmacy *benefit* and not a medical *benefit*. When this occurs, these specialty *prescription drugs* will be listed on our *formulary*.

These *medical prescription drugs* include, but are not limited to, medications administered by infusion, injection, or inhalation, as well as nasal, topical or transdermal administered medications. For some of these *medical prescription drugs*, the cost of the prescription drug is included in the *allowance* for the medical service being provided, and is not separately reimbursed.

Administration Services
When a *medical prescription drug* is administered by infusion, the administration of the prescription drug may be covered separately from the prescription drug. See Infusion Therapy - Administration Services in the Summary of Medical *Benefits* for *benefit limits* and the amount you pay.

Prescription drugs that are self-administered are not covered as a medical *benefit* but may be covered as a pharmacy *benefit*. Please see Pharmacy Prescription Drugs and Diabetic Equipment or Supplies – Pharmacy Benefits section above for additional information.

Site of Care Program
For some *medical prescription drugs*, after the first administration, coverage may be limited to certain locations (for example, a designated *outpatient* or ambulatory service facility, *physician's* office, or your home), provided the location is appropriate based on your medical status. For a list of *medical prescription drugs* that are subject to this Site of Care Program, visit our website.

Preauthorization may be required to determine *medical necessity* as well as appropriate site of care. If we deny your request for *preauthorization*, or you disagree with our determination for the appropriate site of care, you can submit a medical appeal. See Appeals in Section 5 for information on how to file a medical appeal.

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