COMMUNITY HEALTH CHOICE

Summary of Formulary Benefits

The information in this document will help you understand the prescription drug benefits offered under this plan and allow you to compare these benefits to those offered by other plans. Information in this summary will help you compare the value and scope of formulary benefits.

How to Find Information on the Cost of Prescription Drugs

This document and the drug list will help you understand your options. This document will answer questions about:

1. Covered medications under Community Health Choice plans formulary
2. Lower-cost medication options
3. Development of the formulary
4. Appeals
5. Medical management

Community Health Choice offers a web-based tool to determine cost sharing for drugs on Community Health Choice's formulary. Cost-sharing information reflects a consumer's share of the cost. This cost excludes any deductible requirement. It is calculated using the most current price of the drugs. This is based on the plan's actual cost-allowed amount.

A formulary is a list of brand and generic drugs that are covered by your plan. You can obtain more information about your pharmacy benefits by visiting our website at https://www.communityhealthchoice.org.

Community Health Choice requires Members to use generic medications when available. The Member will pay the applicable tier copay plus the cost difference between the brand and generic if a brand-name drug is dispensed when a generic is available. This is regardless of whether or not the doctor's prescription indicates the branded medication should be dispensed. This amount will not apply to the Member's deductible or maximum out of pocket. The Provider must submit a prior authorization for the medical necessity of branded medications when an equivalent generic alternative is available.

You can view a comparison of pharmacy benefits for each plan on our website at https://www.communityhealthchoice.org.

You can also view the summary and benefit, along with evidence-of-coverage documents for our plans, at https://www.communityhealthchoice.org.

Drugs by Cost-Sharing Tier

TIER NAME

TIER NAME	
1	13.4%
2	13.1%
3	9.1%
SP	16.9%
M	1.2%
$0	9.4%
NC	36.3%
EXC (excluded)	.6%

How Prescription Drugs are Covered

The Community Health Choice formulary is a closed formulary. This means some drugs are excluded or not covered. The formulary is developed and maintained by a Pharmacy and Therapeutics (P&T) Committee.

The Community Health Choice delegated P&T Committee meets quarterly to review new drugs and new information on existing drugs available in the market. The Committee consists of appropriate licensed clinicians. It includes medical professionals employed by Community Health Choice's delegated PBM Navitus, as well as those currently practicing in the community. The task of the Committee is to review scientific evidence balancing the effectiveness and side effects of the drugs. The Committee's review, recommendations, and approval are based on information presented through peer-reviewed journals and treatment guidelines. This evidence-based literature may come from private parties (e g. pharmaceutical companies) or public parties (e.g., government and/or medical associations).

The Committee evaluates the overall value of a medication to determine its placement on the formulary.

The committee may make a decision on:

1. Adding/removing a drug
2. Tier placement
3. Adding/removing utilization management (UM) rules such as step therapy (ST), quantity limits (QL), and prior authorization (PA).

The committee may also choose to exclude a medication from being covered in the formulary. All committee members are bound by a non-conflict-of-interest agreement that requires members to notify the committee if there is a financial stake that may affect their decisions.

Right to Appeal

Contact Community Health Choice at 713.295.2294 or 1.855.315.5386 if you need to make a complaint or file an appeal. If your issue or concern is not resolved by calling Community, you have the right to file a written appeal with Community. Please send the appeal request and related information from your doctor to:

MAIL
Community Health Choice, Inc., Attn: Appeals Coordinator
2636 South Loop West, Suite 125, Houston, TX 77054

FAX
Community Health Choice, Inc., 713.295.7033
Attn: Appeals Coordinator

Continuation of Coverage

New members will be permitted a one-time override if medically necessary for medications that require a PA (or ST). The override will be placed for 30 a day-supply while the prescriber requests a PA. The intent of the one-time override is to allow the Provider to submit a prior authorization request to Navitus for review.

Off-Label Drug Use

You have the right to seek review by an independent review organization if a claim is denied as being experimental or investigational. Refer to the Appeals, Complaints, and External Review Rights provision in the General Provisions section of this contract for more information.

Prescription Drug Exclusions: Unless expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Any drug prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature

2. Any drug, medicine or medication that is labeled either "caution limited by federal law to investigational use" or “experimental or investigational”

Cost Sharing

What you expect to pay depends on the type of drugs your doctor prescribes. Each drug is placed in a tier. Different tiers have different copay levels. Tier structures are developed to encourage you to use quality products at the most cost-effective option for you. The lower-cost option does not represent a lower-quality product. It is simply the best cost option considering covered products within that treatment category. You can be assured that drugs provided through your pharmacy benefit have gone through rigorous processes before being approved by the FDA.

The Gold 001 plan does not have a deductible. All our other plans have a combined pharmacy and medical deductible. Unless the plan allows for a drug to bypass deductible, the pharmacy deductible must be met in full before the plan will begin to pay for benefits.

- Tier 1 = Preferred generics and certain low-cost brands
- Tier 2 = Preferred brands and non-preferred generics
- Tier 3 = Non-preferred brands and some high-cost, non-preferred generics
- Tier 4 (listed as SP) = Specialty medications
- Tier 5 (listed as M) = Drugs typically covered through medical benefit
- Tier 6 (listed as $0) = $0 Cost-share preventive drugs

The mail-order service allows you to receive up to a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is voluntary.

Generics First Requirement

Community Health Choice requires Members to use generic medications when available. The Member will pay the applicable tier copay plus the cost difference between the brand and generic if a brand name drug is dispensed when a generic is available. This is regardless of if the doctor’s prescription indicates the branded medication should be dispensed. This amount will not apply to the Member’s deductible or maximum out of pocket. The Provider must submit a prior authorization for medical necessity of branded medications when an equivalent generic alternative is available.

Utilization Management Requirements

Drug coverage review is used to encourage appropriate and cost-effective use of prescription drugs by allowing coverage only when certain conditions are met. Some reasons for pre-certification include:

- Compliance with dosing guidelines
- Avoiding duplicate therapies
- Helping healthcare providers check medically accepted criteria that help ensure high efficacy and low side effects

Community Health Choice implements approval criteria based on FDA-approved labeling, national guidelines, and current standards of care.

Clinical Prior Authorization (PA): PA criteria assess requirements such as appropriateness of indication, age, dose, lab values, and others for that specific prescription drug.

Quantity Limits (QL): Community Health Choice limits the quantity and dosing of certain drugs to be consistent with recommended doses approved by the U.S. Food & Drug Administration (FDA). The quantity limit can include limits on the number of doses per day, maximum daily dose based on labeled dosing, and quantity over time. This may include the number of prescription fills per month or year.

Step Therapy (ST): Step Therapy promotes the appropriate use of effective but lower-cost drugs first. Prerequisite drugs are FDA-approved to treat the same condition as the corresponding step-therapy drugs.

Restricted to Specialist (RS): Limits prescribing of certain high-cost or high-risk drugs to certain prescribers who specialize in treating the associated disease states.
Some pre-certification processes are automated. If we have your complete information for review in our system, the prior-authorization approval may be issued automatically at the pharmacy.
When the information we have for you does not meet approval criteria, your pharmacy may notify your doctor of the rejection and the PA requirement, in which case your doctor may choose either to make changes to obtain coverage for a similar drug OR request a prior approval of that specific drug.
The most common automated PA is the step-therapy requirement. This is when the pharmacy system checks for a previously filled drug that meets the requirement.
Coverage determinations will be issued by mail within 72 hours from the time of request for the first level of standard determination request (or within 24 hours for expedited requests). If approved, the corresponding tier copayment will apply for that specific drug. If denied, you may still fill the prescribed drug, but you will have to pay the complete cost of the drug. Community Health Choice's Pharmacy Benefit Manager (Navitus Health Solutions) performs our initial precertification drug reviews.

DrugName	Special Code	Tier
ANTISEPTICS & DISINFECTANTS Cont.		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
DESCOVY TAB	PA	$0
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	$0
didanosine DR cap (VIDEX EC equiv)	-	1
lamivudine soln (EPIVIR equiv)	-	1
lamivudine tab (EPIVIR equiv)	-	1
nevirapine tab (VIRAMUNE equiv)	-	1
STAVUDINE CAP	-	1
stavudine cap (ZERIT equiv)	-	1
zidovudine cap (RETROVIR equiv)	-	1
zidovudine syrup (RETROVIR equiv)	-	1
zidovudine tab (RETROVIR equiv)	-	1
CIMDUO TAB	-	2
DOVATO TAB	-	2
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	2
NEVIRAPINE ER TAB	-	2
nevirapine ER tab (VIRAMUNE XR equiv)	-	2
ritonavir tab (NORVIR equiv)	-	2
TIVICAY PD TAB	-	2
TIVICAY TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters		**BRANDS** =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
TMSP	Available through Specialty Network	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ISENTRESS (HD) TAB	-	3
ISENTRESS CHEW TAB	-	3
ISENTRESS POWDER PACK	-	3
NORVIR CAP	-	3
NORVIR POWDER PACK	-	3
NORVIR SOLN	-	3
ATRIPLA TAB	-	NC
BIKTARVY TAB	-	NC
CABENUVA IM SUSP	-	NC
COMBIVIR TAB	-	NC
EMTRIVA CAP	-	NC
EPIVIR SOLN	-	NC
EPIVIR TAB	-	NC
EPZICOM TAB	-	NC
GENVOYA TAB	-	NC
KALETRA SOLN	-	NC
LEXIVA TAB	-	NC
NORVIR TAB	-	NC
ODEFSEY TAB	-	NC
RETROVIR CAP	-	NC
RETROVIR SYRUP	-	NC
RETROVIR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
TMSP	Available through Specialty Network	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
REYATAZ CAP	-	NC
RUKOBIA ER TAB	-	NC
STRIBILD TAB	-	NC
SUNLENCA TAB	-	NC
SUSTIVA CAP	-	NC
SUSTIVA TAB	-	NC
SYMFI (LO) TAB	-	NC
SYMTUZA TAB	-	NC
TRIUMEQ PD TAB	-	NC
TRIUMEQ TAB	-	NC
TRIZIVIR TAB	-	NC
TYBOST TAB	-	NC
VIRAMUNE SUSP	-	NC
VIRAMUNE TAB	-	NC
VIRAMUNE XR TAB	-	NC
VIREAD TAB	-	NC
VOCABRIA TAB	-	NC
ZERIT CAP	-	NC
ZIAGEN SOLN	-	NC
ZIAGEN TAB	-	NC
abacavir soln (ZIAGEN equiv)	-	SP
abacavir tab (ZIAGEN equiv)	-	SP

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters		**BRANDS** =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
TMSP	Available through Specialty Network	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
abacavir/lamivudine tab (EPZICOM equiv)	-	SP
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	SP
APTIVUS CAP	-	SP
APTIVUS SOLN	-	SP
atazanavir cap (REYATAZ equiv)	-	SP
COMPLERA TAB	-	SP
CRIXIVAN CAP	-	SP
darunavir tab (PREZISTA equiv)	-	SP
DELSTRIGO TAB	-	SP
DIDANOSINE DR CAP, VIDEX EC CAP	-	SP
EDURANT TAB	-	SP
EFAVIRENZ CAP	-	SP
efavirenz tab (SUSTIVA equiv)	-	SP
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	SP
emtricitabine cap (EMTRIVA equiv)	-	SP
EMTRIVA SOLN	-	SP
etravirine tab (INTELENCE equiv)	-	SP
EVOTAZ TAB	-	SP
fosamprenavir tab (LEXIVA equiv)	-	SP
FUZEON INJ	TMSP	SP
INTELENCE TAB	-	SP
INVIRASE CAP	-	SP

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters		**BRANDS** =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
TMSP	Available through Specialty Network	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
INVIRASE TAB	-	SP
JULUCA TAB	-	SP
KALETRA TAB	-	SP
lamivudine/zidovudine tab (COMBIVIR equiv)	-	SP
LEXIVA SUSP	-	SP
lopinavir/ritonavir soln (KALETRA equiv)	-	SP
lopinavir/ritonavir tab (KALETRA equiv)	-	SP
maraviroc tab (SELZENTRY equiv)	-	SP
NEVIRAPINE SUSP	-	SP
PIFELTRO TAB	-	SP
PREZCOBIX TAB	-	SP
PREZISTA SUSP	-	SP
PREZISTA TAB	-	SP
RESCRIPTOR TAB	-	SP
REYATAZ POWDER PACK	-	SP
SELZENTRY SOLN	-	SP
SELZENTRY TAB	-	SP
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	SP
VIDEX EC CAP	-	SP
VIDEX SOLN	-	SP
VIRACEPT TAB	-	SP
VIREAD TAB	-	SP

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
TMSP	Available through Specialty Network	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.