DICK'S Sporting Goods, Inc. Health and Welfare Plan Prescription Drug Plan

For the Benefit of:

DICK's Sporting Goods, Inc.

Effective January 1, 2025

This Certificate only contains highlights of DICK'S Sporting Goods, Inc, Health and Welfare Plan Prescription Drug Plan (the Plan). While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. DICK'S Sporting Goods, Inc. intends to continue these programs but reserves the right to change or end them at any time. Participation in the programs does not imply a contract of employment.

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DICK’s Sporting Goods, Inc.

Health and Welfare Prescription Drug Plan introduction

This document is a description of the prescription drug plan (the Plan) offered through the DICK’S Sporting Goods, Inc. Health and Welfare Plan (the Health and Welfare Plan). The Plan is part of the Health and Welfare Plan and the provisions the Health and Welfare Plan’s medical coverage are incorporated by reference herein except where inconsistent with the provisions of the Plan. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain other expenses.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Teammates and their Dependents and is divided into the following parts:

Defined Terms. Defines those Plan terms that have a specific meaning.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies, and the types of charges covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Defined terms

The following terms have special meanings and when used in this Plan will be capitalized.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Teammate or Dependent who is covered under this Plan.

Teammate means a person who is an Active, regular Teammate of the Employer, regularly scheduled to work for the Employer in a Teammate/Employer relationship.

Employer is DICK's Sporting Goods, Inc.

Formulary means a list of prescription medications compiled by the third-party payer of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug, which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Medical Necessity means health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator (or designated third party):

- Required to diagnose or treat an illness, injury, disease or its symptoms;
- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, Physician or other health care provider;
- Not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your sickness, injury, condition, disease or its symptoms; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

Non-Formulary means a medication that is not included on the formulary listing of covered medications.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Plan means DICK'S Sporting Goods, Inc. Health and Welfare Plan, which is a benefits plan for certain; Teammates of DICK'S Sporting Goods, Inc. and is described in this document.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

How to submit a claim

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

In-Network
You do not need to file a claim for reimbursement when you use an in-network pharmacy or the home delivery Prescription Drug option. Except for the amount of your copay, which is required at the time of purchase, these expenses are paid directly by the Plan.

Out-of-Network
When you have an expense that is not paid directly by the Plan (for example a prescription drug filled at an out-of- network pharmacy), you should submit a claim form to Express Scripts in order to be reimbursed. You will be asked for information and documentation necessary to determine whether your claim qualifies for reimbursement. This information may include receipts and other information from the dispensing pharmacy and a written statement that the expense has not been reimbursed and is not reimbursable under any health insurance policy or other benefit plan.

Claims for reimbursement for costs incurred during a Plan Year should be submitted to Express Scripts no later than twelve (12) months after the date charges for the service were incurred. To request claim forms, contact Express Scripts at 1-866-283-2601 or log onto the Express Scripts website at www.express-scripts.com and select **Print forms** from the menu.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Pharmacy complete the provider's portion of the form.

(4) Send the above to the Claims Administrator at this address:

Express Scripts Pharmacy
PO Box 14711
Lexington, KY 40512
1-800-766-4695

When claims should be filed

Claims should be filed with the Claims Administrator no later than twelve (12) months after of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Claims procedure

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

- Notification to claimant of benefit determination 72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

- Notification to claimant, orally or in writing 24 hours
- Response by claimant, orally or in writing 48 hours
- Benefit determination, orally or in writing 48 hours

Ongoing courses of treatment, notification of:

- Reduction or termination before the end of treatment 72 hours
- Determination as to extending course of treatment 24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal must be requested by the provider by phone at 1-800-753-2851. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination 30 days
- Extension due to matters beyond the control of the Plan 15 days
- Extension due to insufficient information on the Claim 15 days
- Response by claimant following notice of insufficient information 45 days
- Review of adverse benefit determination 30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification must be requested by the provider by phone at 1-800-753-2851 followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 following an adverse benefit determination on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Claims Appeal Procedure

For all claims other than member submitted paper claims:

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes), a brief description of why you disagree with the initial adverse benefit determination and any additional information that may be relevant to your appeal. This information should be mailed or faxed to Express Scripts Pharmacy. For clinical appeal requests: Express Scripts Attn: Clinical appeals Department, PO Box 66588, St. Louis, MO 63166-6588. Fax 1-877-852-4070. For administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO 63166-6587. Fax 1-877-328-9660. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals

processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes), a brief description of why you disagree with the adverse benefit determination and any additional information that may be relevant to your appeal. This information should be mailed or faxed to Express Scripts Pharmacy. For clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St. Louis, MO 63166-6588. Fax 1-877- 852-4070. For administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO 63166-6587. Fax 1-877-328-9660. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility. 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 internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

The request must be received within 4 months of the date of the final Internal 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).
To submit an external review, the request must be mailed or faxed to:

Express Scripts
Attn: External Review Requests PO Box 66587
St. Louis, MO 63166-6587 Phone: 1- 800- 946- 3979
Fax: 1-877- 328- 9660

Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts' written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination as soon as possible, but no later than 72 hours from receipt of the request. In general, an urgent situation is one 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. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied. If the patient of provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-800-753-2851.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests must be requested via phone or fax. Urgent appeals submitted via mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent. If you or your physician believes that your situation is urgent, the expedited review must be requested via phone or fax: Clinical appeal requests: phone: 1-800-935-6103 fax: 1-877-852-4070. Administrative appeal requests: phone: 1-800-946-3979 fax: 1-877-328-9660. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding.

You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For member submitted paper claims:

Your Plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. To request reimbursement, you will send your claim to Express Scripts Pharmacy, P.O. Box 14711, Lexington, KY 40512. If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30-day period if additional information is needed to process the claim, and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the Prescription Drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) a brief description of why you disagree with the initial adverse benefit determination and any additional information that may be relevant to your appeal. This information should be mailed or faxed to Express Scripts Pharmacy. For clinical appeal requests: Express Scripts Attn: Clinical appeals Department, PO Box 66588, St. Louis, MO 63166-6588. Fax 1-877-852-4070. For administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO 63166-6587. Fax 1-877-328-9660.

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the plan provision on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the Prescription Drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) , a brief description of why you disagree with the adverse benefit determination and any additional information that may be relevant to your appeal. This information should be mailed or faxed to Express Scripts Pharmacy. For clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St. Louis, MO 63166-6588. Fax 1-877- 852-4070. For administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO 63166-6587. Fax 1-877-328-9660.

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

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 internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The request must be received within 4 months of the date of the final Internal 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).

To submit an external review, the request must be mailed or faxed to:
Express Scripts
Attn: External Review Requests PO Box 66587
St. Louis, MO 63166-6587 Phone: 1-800- 946- 3979
Fax: 1-877- 328- 9660

Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant’s right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claim’s administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts’ written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Limitations on action

Any plan participant, who has exhausted all of their appeal rights under this claim's procedure, must file a lawsuit within 24 months following the date of the first appeal denial. Any claim decision by the Plan or one of its delegated claim administrators shall not be reversed unless it is arbitrary and capricious.

Third party recovery provision

Right of subrogation and refund

When this provision applies. The Covered Person may incur Prescription Drug charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the Prescription Drug charges. Accepting benefits under this Plan for those incurred Prescription Drug expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-Prescription Drug charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred Prescription Drug expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred Prescription Drug expenses automatically assigns to the Plan the Covered Person's Third-Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for Prescription Drug charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorney's fees if the Plan needs to file suit in order to recover payment for Prescription Drug expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay Prescription Drug benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any Prescription Drug benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor Dependents. "Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect Prescription Drug charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for Prescription Drug expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for Prescription Drug benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for Prescription Drug charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

DICK'S Sporting Goods, Inc.
Health and Welfare Plan Prescription Drug Plan
Effective January 1, 2025

Prescription drug benefits

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the administrator of the pharmacy drug plan.

Verification of Eligibility
Express Scripts Pharmacy. 1-800-766-4695
Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

PLAN DESIGN FOR TRADITIONAL PPO AND CORE HRA (HEALTH REIMBURSEMENT ACCOUNT) PLANS

Non-Specialty Retail Pharmacy Option (up to 30-day supply)

Generic drugs	
Copayment	$10 copayment
Formulary Brand Name drugs	
Copayment	$40 copayment
Non-Formulary Brand Name drugs	
Copayment	$75 copayment

Non-Specialty Mail Order / Home Delivery Pharmacy Services (up to 90-day supply)

Generic drugs	
Copayment	$20 copayment
Formulary Brand Name drugs	
Copayment	$80 copayment
Non-Formulary Brand Name drugs	
Copayment	$150 copayment

Preventive Medications

Copayment	$0 copayment

Specialty Retail (up to 30-Day Supply)

Generic drugs	10% up to $100 maximum
Formulary Brand Name drugs	20% up to $250 maximum
Non-Formulary Brand Name drugs	10%

Specialty Mail Order / Home Delivery Pharmacy Services (up to 30-day supply)

Generic drugs	10% up to $100 maximum
Formulary Brand Name drugs	20% up to $250 maximum
Non-Formulary Brand Name drugs	10%

PLAN DESIGN FOR BASE HSA (HEALTH SAVINGS ACCOUNT) AND BUY-UP HSA (HEALTH SAVINGS ACCOUNT) PLANS

Non-Specialty Retail Pharmacy Option (up to 30-day supply)

Co-pay structure AFTER deductible has been met.

Generic drugs Copayment	$10 copayment after deductible
Formulary Brand Name drugs Copayment	$40 copayment after deductible
Non-Formulary Brand Name drugs Copayment	$75 copayment after deductible

Non-Specialty Mail Order / Home Delivery Pharmacy Services (up to 90-day supply)

Co-pay structure AFTER deductible has been met.

Generic drugs Copayment	$20 copayment after deductible
Formulary Brand Name drugs Copayment	$80 copayment after deductible
Non-Formulary Brand Name drugs Copayment	$150 copayment after deductible

Preventive Medications

Copayment	$0 copayment

Specialty Retail (up to 30-Day Supply)

AFTER deductible has been met.

Generic drugs	10% up to $100 maximum after deductible
Formulary Brand Name drugs	20% up to $250 maximum after deductible
Non-Formulary Brand Name drugs	10% after deductible

Specialty Mail Order / Home Delivery Pharmacy Services (up to 30-day supply)

AFTER deductible has been met.

Generic drugs	10% up to $100 maximum after deductible
Formulary Brand Name drugs	20% up to $250 maximum after deductible
Non-Formulary Brand Name drugs	10% after deductible

If you use an out-of-network pharmacy, you will pay the full cost of the Prescription Drug and need to submit a claim form to get reimbursement. (see section about How to Submit a Claim, Out-of-Network).

Type of Prescription

Following is a description of the three types of Prescription Drugs available through the Plan.

Generic drugs: the chemical equivalent of its brand name counterpart. The cost of a Brand Name drug includes research, patent and advertising expenses. When the patent expires, other manufacturers are able to duplicate the drug at a fraction of the cost. As a consumer, when you buy a Generic drug, you are buying the same formula as the Brand Name without helping to pay the overhead. The U.S. Food and Drug Administration (FDA) must certify that a Generic drug meets the same safety, strength and effectiveness standards as the original Brand Name drug. Your plan requires that if you fill a prescription for a Brand Name medication when a Generic is available you will be required to pay the difference in cost between the Brand Name drug and the Generic drug plus the copay.

Brand Name Formulary: A Brand Name drug that is on a preferred list. Formulary drugs are FDA approved and selected based on effectiveness and safety records. Typically, Express Scripts is able to negotiate a lower cost with the manufacturer for formulary drugs. That discount is passed on to you in the form of a lower copay. For the current list of formulary Prescription Drugs, log onto the Express Scripts website at www.express-scripts.com and check the list before you have a prescription filled and talk to you doctor about alternatives if a recommended drug isn't on the list. The list is subject to change periodically, so make sure you check it for updates.

Brand Name Non-formulary: a Brand Name drug that does not have a Generic equivalent and/or is not on the formulary list described above or a Brand Name drug that you choose even though a Generic and/or formulary equivalent is available.

Type of Pharmacy

Following is a description of the three types of pharmacies where your prescriptions may be filled.

In-Network Retail Pharmacy: for example, CVS, Rite-Aid and many other national and local retail pharmacies. To find out if your pharmacy is an Express Scripts participating pharmacy, you may call Express Scripts at 1-800-766- 4695 or log onto the Express Scripts website at www.express-scripts.com and select **Locate a Pharmacy** from the menu.

When you have a prescription filled at a participating pharmacy, present your member I.D. card to the pharmacist, who will verify your coverage and prescription cost. You may purchase up to a 30-day supply of most Prescription Drugs at an in-network pharmacy. There may be limitations on some prescriptions, such as controlled medications subject to state and federal dispensing limitations.

In an effort to broaden the reach of flu and other disease vaccinations, through the Retail Vaccination Program you may go to retail pharmacies for vaccinations. For more information you may contact Express Scripts at 1-800-766- 4695 or log onto the Express Scripts website at www.express-scripts.com.

Out-of-Network Retail Pharmacy: any licensed pharmacy that does not have an agreement with Express Scripts.

Mail Order / Home Delivery Pharmacy Services: The home delivery drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

If you require medication on an ongoing basis, you may pay significantly less if you use the Express Scripts home delivery service. You may order up to a 90-day supply of maintenance medications through the home delivery service; the minimum supply is 31 days, but you will pay the full home delivery order copay.

Also note that the actual quantity and/or days' supply may vary for each drug. Your doctor's instructions on how to take the medication, state and federal dispensing guidelines, or how the medication is packaged may impact the quantity and/or days' supply you can receive.

To get started, ask your doctor to write a new prescription for your plan's maximum days' supply of 90 days with refills up to 1 year, as appropriate. You may mail your prescriptions in the special envelope you receive with your enrollment materials or ask your doctor to call 1-800-766-4695 for instructions on how to fax them. If your order is faxed, your doctor must have your member number to complete the transaction. Your initial request may take 10 to 14 days to process. Home delivery refills maybe requested online or by phone. To avoid a lapse in your medication, you should place refill orders 7 to 10 days before your existing supply is finished. For your convenience, you may request an email reminder to order refills.

For home delivery forms or to request a refill, you may contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com and select **Print or download forms** from the **Getting Started** menu.

Worry Free Fills

With Worry Free Fills, the Express Scripts Home Delivery Pharmacy automatically delivers refills to you when the medication's supply is due to run out. Also, when your prescription is out of refills, Express Scripts will contact the doctor for a new prescription. This program helps avoid gaps in care that can affect your health.

Maintenance Medication Retail Programs

The below retail 90-day supply drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

ESI National Plus Network

You can fill your maintenance medications for 90 days at any retail pharmacy or through Express Scripts Home Delivery. For more information you may contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Specialty Pharmacy Services

If you are prescribed a specialty medication, you must obtain your prescription through Express Scripts' specialty pharmacy, Accredo. For more information you may contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

SMART 90:

With this program, you must fill your maintenance medications for 90 days at either Express Scripts Home Delivery or at a CVS or Walgreens network pharmacy. For any non-maintenance medications, you may continue to access a network pharmacy. For more information you may contact Express Scripts at 1.866.283.2601 or log onto the Express Scripts website at www.express-scripts.com.

Copayments

The copayment is applied to each covered pharmacy drug or home delivery drug charge and is shown in the Schedule of Benefits that will be charged by the participating Retail Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy to dispense any prescription order or refill. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one home delivery prescription is limited to a 90-day supply.
If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used refer to the section titled “How to Submit a Claim” for reimbursement.

SaveonSP - Specialty Pharmacy Copay Assistance Program (Applies to Traditional PPO and CORE HRA Plans Only)

If you are enrolled in the Traditional PPO Plan or CORE HRA Plan and taking certain specialty medications your cost share responsibility will be reduced to $0. Your prescriptions will still be required to be filled through Accredo, the specialty mail pharmacy.

Enrollment in the program is voluntary and members who qualify will be contacted directly by a SaveonSP representative.

Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.

Members with questions or concerns can contact SaveonSP at 1-800-683-1074.

Prior Authorization

For your health and safety, your Prescription Drug coverage under the Plan includes utilization review of Prescription Drug usage. Express Scripts will evaluate and certify a participant’s need for certain drugs, medicines and supplies, and may make formal assessments from time to time of the medical necessity, effectiveness, and appropriateness of Prescription Drug usage and treatment plans on a prospective, concurrent, or retrospective basis. Similar to healthcare plans that approve a medical procedure before it’s done to ensure the necessity of the test, if you’re prescribed a certain medication, that drug may need a prior authorization. This program makes sure you’re getting a prescription that is suitable for the intended use and covered by the Plan.

Certain drugs may require prior authorization by Express Scripts in order for the cost of such drugs to be paid or reimbursed under the Plan. Your own medical professionals are consulted since the Plan will cover a prescription only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see the Plan covers the drug. Only your physician can provide this information and request a prior authorization.

The Plan reserves the right to limit benefits under the Plan in order to prevent the over-utilization of drugs or medicines. If patterns of over-utilization or misuse of drugs is detected, Express Scripts will notify your doctor and pharmacist. Your physician may request that Express Scripts review a decision denying authorization at any time. For more information you may contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Covered Prescription Drugs

Covered Prescription Drugs include medications, products and devices that have been approved by the Food and Drug Administration and which can, under state law, be dispensed only by prescription. These medications are also referred to as legend drugs. Over the counter (OTC) are items that can be purchased through the pharmacy and in some cases without a prescription as identified below. Unless listed under the "Exclusions" heading, covered Prescription Drugs include:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- [OTC and Legend] Insulin Pump Supplies (Std)
- [OTC and Legend] ACA Merged Offering Bowel Prep Agents - Generics
- [OTC and Legend] Needles and Syringes (Std, All)
- Contraceptive Devices, Legend Eg Diaphragm/cervical Cap/iud
- Implantable Contraceptives (Std)
- Injectable Contraceptives (Std)
- [OTC and Legend] ACA Merged Offering Contraceptives - OTC, W/ X / Y Card and Direct: Emergency Contraceptives (Std)
- Card and Direct: Relenza/Tamiflu (Std)
- [OTC and Legend] Inhaler Assisting Devices (Std)
- Fertility Agents (Std, All) – Covered on the PPO Plan 3 only
- Synagis / Respigam (Std)
- Antihemophilia Agents (Std)
- Systemed Self Injectable Drug List (Std)
- [OTC and Legend] Diabetic Supplies/Insulin Needles, Syringes (Std)
- Androgenic Agents (Std, All)
- Specialty Pharmacy Drug List (Std)
- ACA Merged Offering Vaccines
- SPE524 Plus 100428
- [OTC and Legend] ACA Merged Offering Aspirin for Cardiovascular Disease
- [OTC and Legend] ACA Merged Offering Fluoride
- [OTC and Legend] RX to OTC Fluoride Vitaminss 2018
- Card and Direct: Plan B, through age 14
- Drugs to Treat Impotency Except Yohimbine (Std), for males only age 18 and over
- STD Specialty Limited Distribution List, up to a 30-day supply
- [OTC and Legend] HCR FOLIC ACID OTC GENERIC (child 154809), through age 50
- [OTC and Legend] HSA00111: IRON SUPPLEMENTS GENERIC & OTC, for infants only through 12 months old
- [OTC and Legend] HSA00234 & DC O: OTC HCR SMOKING CESSATION EXC CHAN age 18 and over
- [OTC and Legend] ACA Merged Offering Vitamin D and Calcium/Vitamin D age 65 and over

The above list is intended to represent the types of prescriptions covered under the Express Scripts plan. To find out if a particular medication is covered, or for information about limits on specific prescriptions, you may contact Express Scripts at 1-800-766-4695 or register and log onto the Express Scripts website at www.express-scripts.com and select **Price a medication** from the menu. Then search for a specific medication and then click on **View coverage notes** from the results page. Additionally, you may view a current list of covered prescriptions drugs by going to www. express-scripts.com

Preventive Medications

The plan covers the following prescription and over-the-counter (OTC) preventive medications at a $0 copayment. To receive these medications at a $0 copayment, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy. The preventive medication list can be found on the Express Scripts benefit website www.express-scripts.com.

- Aspirin – coverage of generic and OTC doses equal to or less than 325mg for Adults under 70 years of age for prevention of cardiovascular events and prevention of preeclampsia
- Bowel preparations - For adults beginning at age 50 years and continuing until age 75 years. This includes generic and over-the- counter medications only.
- Folic acid – OTC doses of 400 to 800 mcg/day for adults age 50 and younger.
- HIV Medications prescribed for pre-exposure prophylaxis (PrEP) of human immunodeficiency virus infection (HIV) for select patients.
- Oral fluoride – a prescription product to prevent dental cavities in children beginning at age 6 months through 5 years old
- Statins – Generic low to moderate dose statins for adults beginning at age 39 years and continuing through age 76 years. Includes all generic low/moderate does statins.
- Tobacco cessation products – all Food and Drug Administration tobacco cessation medications including Zyban (Brand and Generic), and Chantix, both prescription and over-the-counter medications) for adults age 18 and older, to a maximum of 180-day treatment regimen when prescribed by a health care provider without a prior authorization.
- Vaccinations through Express Scripts Pharmacy Vaccination Program - The following vaccinations are available through an Express Scripts participating retail pharmacy. Please contact your local pharmacy to verify the current vaccination schedule, availability, and any age restriction.

    - Influenza (Includes Flumist)
    - Pneumonia
    - Herpes zoster/shingles (Zostavax®)
    - Hepatitis
    - HPV
    - Childhood Vaccines (Measles, Mumps, Rubella, Varicella, Haemophilus Influenza, Poliomyelitis and Rotavirus)
    - Meningococcal
    - Rabies
    - Tetanus, Diphtheria, Pertussis
    - Travel vaccines/bioterrorism (Japanese Encephalitis, Typhoid, Yellow Fever, Anthrax and Smallpox)

- Women's contraception - All Food and Drug Administration approved contraceptive methods for women age 50 and younger with reproductive capacity subject to medical management rules. Including all over-the- counter contraceptive methods, all oral contraceptives (including emergency contraception), and all contraceptive devices.

Pharmacogenomic Testing

Pharmacogenomic testing empowers providers to use personalized medicine in their daily practice by using results of genetic tests that identify genetic variations in their patients. Testing results can offer important information about the right drugs and doses for their patients and help ensure that the patient derives maximum therapeutic benefit from the medication, and equally important, does not suffer potentially life-threatening adverse reactions. If you are taking any of the following Prescription Drugs, you are eligible for genetic testing that can offer important information about the right Prescription Drugs and doses in order to help ensure that you are receiving the maximum therapeutic benefit from the medication and equally important, you are not potentially suffering from life-threatening adverse reactions.

- Oncology drugs - currently Gleevac, Tasigna and Sprycel; other drugs may be added in time
- Immunology/Antiinfective drugs - currently Abacavir and Selzentry; other drugs may be added in time

SafeGuardRx®

Express Scripts SafeGuardRx® is a suite of programs designed to protect members against rising drug costs while providing access to specialized therapies and care. Prior authorization of certain medications may be required and if approved, members may be required to fill through ESI's home delivery pharmacy or through ESI's Accredo® specialty pharmacy. Some programs include specialized clinical support. Certain SafeGuardRx programs are further defined below due to specific requirements or program features. For more information contact Express Scripts at 1-800-766-4695 or log into www.express-scripts.com.

Diabetes Care Value Program

You are required to receive your diabetic medications with a 90-day supply through ESI's home delivery pharmacy or at a select retail pharmacy, including Walgreens or CVS. You may also receive personal assistance to help you stay on your course of treatment. Express Scripts also provides Diabetes remote patient monitoring and connected glucose meters. Members enrolled in this program will receive meters and a smartphone application from Express Scripts free of charge. Data is sent securely to clinicians who will track blood glucose levels, analyze trends and conduct proactive interventions to guide patients toward a healthier lifestyle. For more information, you may contact Express-Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Pulmonary Care Value Program

Qualified members will receive access to Pulmonary Remote Monitoring – high-touch tools designed to improve adherence and optimize healthy behaviors. You are required to receive your inhaled products commonly used to treat asthma and/or COPD through a preferred quality network of pharmacies, for 90-day supplies. You may also receive personal assistance and access to pulmonary specialist pharmacists through the Pulmonary Therapeutic Resource Center to help you stay on your course of treatment. For more information, you may contact Express-Scripts at 1-800- 766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Certain oral oncology medications you will be required to fill through ESI's specialty pharmacy – Accredo. Other oral oncology medications not available at Accredo may be filled at any participating pharmacy. However, if you are receiving your medication through your physician's office, your physician will redirect you to fill your prescription through a specialty pharmacy. For more information, you may contact Express-Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Rare Conditions Care Value℠ Program

Part of Express Scripts SafeGuardRx® program, through Accredo® specialty pharmacy, patients taking rare-condition medications will receive enhanced care. Express Scripts' Therapeutic Resource Centers offer support from specialist pharmacists, nurses and other pharmacy experts who have extensive training in rare conditions and medications. They provide, One-on-one patient counseling and education; In-home nursing services for products requiring extensive training, administration or infusion assistance; Proprietary drug-specific protocols and patient management programs to ensure safe and appropriate use of medications; and Personalized support in managing other health- related challenges, including resources to support the patient's financial, emotional and social well-being.

Expenses Not Covered

The following costs are "Excluded Costs" under the Plan:

(1) Costs for any Prescription Drugs which are not medically necessary, or which are above reasonable and customary charges;

(2) Charges incurred by or for an individual before he or she became a participant in the Plan; and

(3) Costs of any of the following:
- Non-Federal Legend Drugs
- Federal Legend Non-Drugs
- Non-Federal Legend Non-Drugs
- Investigational Drugs
- Std Rx/OTC Equivalents
- Abortifacients (Std) Mifeprex
- Implants By Route and Dosage form, Non-specialty
- Plan B, all other situations
- HD: Emergency Contraceptives (Std)
- HD: Relenza/Tamiflu (Std)
- Yohimbine (Std)
- Drugs to Treat Impotency Except Yohimbine (Std), all other situations
- Ostomy Supplies (Std)
- Dental Fluoride Products (Std, Legend)
- STD Cosmetic Drugs - ALL Hypopigmentation, Renova, Vaniqa
- Biologicals, Immunizations/Vaccines, Allergy Sera, Blood Prd
- [OTC and Legend] HCR FOLIC ACID OTC GENERIC (child 154809), all other situations
- [OTC and Legend] HSA00111: IRON SUPPLEMENTS GENERIC & OTC, all other situations
- [OTC and Legend] HSA00234 & DC O: OTC HCR SMOKING CESSATION EXC CHAN, all other situations
- [OTC and Legend] ACA Merged Offering Vitamin D and Calcium/Vitamin D, all other situations
- Prescription Drugs specifically excluded from the Express Scripts formulary

The above list is intended to represent the types of prescriptions not covered under the Express Scripts plan. To find out if a particular medication is covered, or for information about limits on specific prescriptions, you may contact Express Scripts at 1-800-766-4695 or register and log onto the Express Scripts website at www.express-scripts.com and select **Price a medication** from the menu. Then search for a specific medication and then click on **View coverage notes** from the results page.

Preferred Drug Step Therapy – Enrollment

Certain therapeutic classes of drugs will require patients to follow clinical guidelines and choose the selected drug first before “stepping up” to alternative medications. The Plan targets categories where drugs are clinically interchangeable and requires a member to try a generic or preferred brand medication before higher cost non- preferred drugs unless special circumstances exist. This program works to lower drug costs and increase member savings. For more information, you may contact Express Scripts at 1-800-766-4695 or log onto the Express Scripts website at www.express-scripts.com.

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

(3) Control drugs are only valid for a maximum of six months or less as defined by state regulations.

Quantity Limits

The Plan will not pay or reimburse the cost of:

(1) Any prescription that is for more than a 30-day supply at a participating retail pharmacy;

(2) Any prescription that is for more than a 90-day supply through the Home Delivery Option; or

(3) Refills that exceed the number prescribed by the participant’s physician, or any prescription that is filled more than one (1) year after the date the prescription is written.

The plan may impose quantity limits on certain medications at the time of fulfillment. Your pharmacist will let you know if quantity limits apply. If you receive, a rejection or reduced days’ supply of a specific drug this may be the reason. You may contact Express Scripts at 1-800-766-4695 in order to confirm drug coverage.