

**FORVIS MAZARS, LLP  
PRESCRIPTION DRUG PLAN**

**Effective as of January 1, 2025**

**INTRODUCTION:**

This document (referred to as the “Prescription Drug Plan” or simply the “Plan”) describes the prescription drug benefits offered to eligible employees and dependents (referred to as “members”) enrolled for coverage under Forvis Mazars, LLP group medical plan (the “Medical Plan”). The Prescription Drug Plan is a component sub-plan under the Medical Plan.

**PHARMACY BENEFIT MANAGER:**

The Employer has contracted with a pharmacy benefit manager (the “PBM”) to help administer the Plan. The name of and contact information for the PBM is:

Navitus  
361 Integrity Drive  
Madison, WI 53717  
877.571.7500

The contact information for mail order and specialty pharmacy medications is as follows:

Costco Mail Order  
Pharmacy.costco.com  
800.607.6861

Lumicera Specialty Pharmacy  
Lumicera.com  
855.847.3553

**PRESCRIPTION DRUG BENEFITS:**

***Covered Drugs***

Subject to the exclusions and limitations described below, the Prescription Drug Plan covers FDA-approved drugs that, by federal or state law, can only be dispensed upon written prescription from an authorized prescriber (for example, a licensed physician, dentist, osteopath, podiatrist, optometrist or advanced practitioner) and dispensed by a licensed pharmacist.

The Prescription Drug Plan has adopted the PBM’s formulary, including the PBM’s preferred drug list, as its covered formulary. Formulary drugs are included in the list of preferred medications that a committee of pharmacists and providers deems to be the safest, most effective and most economical.

“Non-formulary” medications, based on the PBM’s current formulary, are not covered by the Plan unless the member obtains approval from the PBM for substitution of a clinically comparable drug. Such approval generally will only be made if the non-formulary drug would result in a cost savings to the Plan, is based on objective medical criteria, and is drug is prescribed by the member’s treating prescriber.

A list of drugs included on the PBM's formulary may change from time to time and is available on the PBM's website.

In all events, only medically necessary prescription drugs will be covered by the Prescription Drug Plan.

***Annual Deductibles / Out-of-Pocket Maximums***

Pharmacy expenses are included for purposes of the applying the Medical Plan's annual deductible and out-of-pocket maximums.

<b>ANNUAL DEDUCTIBLE</b>		
	<b>Choice Plan In-Network</b>	<b>HDHP In-Network</b>
<b>Individual only</b>	N/A	\$1,800
<b>Family</b>	N/A	\$3,600

<b>OUT-OF-POCKET MAXIMUMS</b>		
	<b>Choice Plan In-Network</b>	<b>HDHP In-Network</b>
<b>Individual only</b>	\$3,500	\$4,000
<b>Family</b>	\$7,000	\$8,000
<b>Fertility</b>	\$5,000 (lifetime max)	\$5,000 (lifetime max)

***Co-Payments and Co-Insurance***

Co-payments and co-insurance must be paid at the time the prescription order is submitted. If the cost of the drug is less than the co-payment or co-insurance, the member will pay the lower amount. Co-payment and co-insurance amounts are based on the type of medication the member receives. Generic and brand-name medication types are established and updated periodically by a nationally recognized drug pricing and classification source.

To confirm a co-payment and co-insurance amount before you have a prescription filled, a member should contact the PBM or consult the PBM's website.

Prescription drugs obtained through a retail pharmacy are subject to a 30-day or 90-day supply limit as described below.

	<b>Member Cost Sharing Network Provider</b>	
<b>Retail</b>	<b>Choice Plan In-Network</b>	<b>HDHP In-Network</b>
Generic (Tier 1)	30 Day: \$10 co-payment 90 Day: \$30 co-payment	30 Day: \$10 co-payment 90 Day: \$30 co-payment
Preferred Name Brand (Tier 2)	30 Day: \$30 co-payment 90 Day: \$90 co-payment	30 Day: \$30 co-payment 90 Day: \$90 co-payment
Non-Preferred Name Brand (Tier 3)	30 Day: \$50 co-payment 90 Day: \$150 co-payment	30 Day: \$50 co-payment 90 Day: \$150 co-payment
Specialty (Tier 4)	\$200 co-payment	\$200 co-payment

**Generic Substitution Program:** If a member’s provider prescribes a brand name drug, the pharmacy automatically will substitute a generic equivalent, where available and clinically appropriate, unless the member’s provider issues the prescription with a “dispense as written” (“DAW”) notation; or the member instructs the pharmacy to dispense the brand name drug only. The member may also be requested to pay the difference between the generic and the brand name costs.

***Preventive Medications***

The Plan pays the full cost of all prescribed preventive medications classified as such by the PBM in accordance with the Patient Protection and Affordable Care Act. The PBM may offer an expanded list of preventive medications beyond what is legally required. A complete list of covered preventive medications may be found on the PBM’s website.

***Third Party Payment Assistance Programs***

If a third-party payment assistance program is utilized (including without limitation manufacturer coupons or rebates), any assistance received by the member to help offset the member’s co-payment or co-insurance obligation will not be applied to the Plan’s deductible or maximum out of pocket limits.

***Mail Order***

Prescriptions filled through the PBM’s mail order program will be subject to the following co-payments and co-insurance amounts. The supply limit for the mail order program is 90 days.

	<b>Member Cost Sharing Network Provider</b>	
<b>Mail Order</b>	<b>Choice Plan In-Network</b>	<b>HDHP In-Network</b>
Generic (Tier 1)	\$30 co-payment	\$30 co-payment
Preferred Name Brand (Tier 2)	\$90 co-payment	\$90 co-payment
Non-Preferred Name Brand (Tier 3)	\$150 co-payment	\$150 co-payment
Specialty (Tier 4)	\$200 co-payment	\$200 co-payment

***Specialty Medications***

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. ***These medications must be obtained through a PBM-approved specialty pharmacy and are subject to prior authorization.*** Some exceptions may apply. These medications are subject to the appropriate co-payment and co-insurance as listed above.

***Prior Authorization***

Certain prescription drugs are subject to prior authorization and must be preapproved by the PBM before they will be a covered drug. Drugs subject to prior authorization may cause potentially serious side effects and/or have a high potential for inappropriate use. The member or authorized prescriber should contact the PBM to confirm whether a prescribed medication is subject to prior authorization.

Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. A member or authorized prescriber should contact the PBM prior to commencing any step therapy alternative and discuss the need for prior authorization.

A member or authorized prescriber may initiate the prior authorization process by contacting the PBM. If approved, the member’s prescription will be filled within any stated coverage limits.

***Specific Exclusions/Limitations***

The following exclusions/limitations apply for purposes of the Prescription Drug Plan only.

- Prescriptions which are not medically necessary.

- Non-prescription / over-the-counter drugs.
- Prescriptions filled without required prior authorization.
- Prescriptions that are covered by workers' compensation laws or other county, state or federal programs.
- Drugs or supplies that are covered under the medical portion of your health care coverage.
- Experimental, investigational or unproven drugs, or drugs used for a treatment not approved by the FDA.
- Cosmetic-related drugs and supplies.
- Drugs taken while in a hospital, nursing home, or similar facility.
- General anesthetics.
- Drugs obtained outside the United States.
- Professional charges in connection with administering or injecting drugs.
- Drugs included on the list of excluded drugs maintained by the PBM and available on the PBM's website.

**REVIEW AND APPEALS PROCESS:**

All eligibility-related claims and appeals must be made in accordance with the claims procedures prescribed for the Medical Plan.

Coverage-related claims must be made in accordance with the procedures outlined below.

A member must use and exhaust the administrative claims and appeals procedure set forth below before bringing a suit in either state or federal court. Similarly, failure to follow the prescribed procedures in a timely manner will also cause the member to lose his or her right to sue regarding an adverse benefit determination.

***Initial coverage review***

The preferred method to request an initial coverage review is for the member or prescriber to submit a prior authorization request electronically or to call the PBM directly.

If the member's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the member's health may be in serious jeopardy or the member may experience pain that cannot be adequately controlled while the member waits for a decision on the review.

The PBM's initial determination and notification to the member and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe
Standard Pre-Service*	Decisions are completed as soon as possible from receipt of request, but no later than: 15 days
Standard Post-Service*	30 days
Urgent**	72 hours

\*If necessary, this period may be extended one-time for up to 15 days if the extension is necessary due to matters beyond the control of the PBM and the member is notified prior to the expiration of the initial review period. If an extension is necessary because the member failed to provide the necessary information needed to make a determination, the member will have 45 days from receipt of the notice within which to provide the needed information. The claim will be denied in full if the member fails to timely provide the information within 45 days.

\*\*If additional information is necessary to make a determination, the member will be notified within 24 hours of receipt of the initial claim and will be provided a 48-hour extension to provide the information.

### ***Appeal of adverse benefit determinations***

When an initial coverage review has been denied (referred to as an “adverse benefit determination”), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the PBM’s appeals department and include the following information:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements, letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

### ***How an appeal is processed***

The PBM will review and respond to any appeal of an adverse benefit determination in accordance with the PBM’s customary appeal policies which will conform with federal regulations. Depending on the type of appeal, appeal decisions will be made by a PBM pharmacist, physician, panel of clinicians, trained prior authorization staff member, or independent utilization management company. If the initial adverse benefit determination is upheld on appeal, the PBM will explain the reason for the denial and identify pertinent Plan provision upon which the denial is based.

Appeal decisions and notifications will be made within the following timeframes:

Type of Claim	Decision Timeframe
	<b>Decisions are completed as soon as possible from receipt of request, but no later than:</b>
Standard Pre-Service	15 days
Standard Post-Service	30 days
Urgent*	72 hours

\*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the member and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

### ***Additional appeals to Plan Sponsor***

After exhausting the appeals procedures with the PBM, a member or prescriber may appeal an adverse benefit determination to the Plan Sponsor or designated committee. Such appeal must be made in writing no later than 90 days after exhausting the PBM’s appeal procedures.

### ***Right to External Review***

A member has the right to request an independent external review for an adverse benefit determination involving medical judgment, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be first exhausted prior to requesting an external review. An external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

### ***How an External Review is processed***

If a member’s claim is eligible for external review and the member (or prescriber) timely makes such a request, the claim will be forwarded to an independent review organization (IRO). The request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim (generally within 45 calendar days from receipt) of the request and will send the claimant, the Plan and the PBM written notice of the IRO’s decision. Urgent claims will be processed in expedited manner within the time frames prescribed by federal law.

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**PLAN SPONSOR ADOPTION PAGE**

The undersigned, on behalf of the Plan Sponsor, hereby adopts the prescription drug carveout plan, in the form attached hereto, effective as of the date set forth therein.

FORVIS MAZARS, LLP

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_