

EXHIBIT C

EMPLOYEE BENEFIT PLAN
(herein referred to as the "Plan")

RESTATED

MASTER BENEFIT PLAN DOCUMENT
describing the
PRESCRIPTION DRUG PROGRAM
for the
Managed Care Plan (In-Area Benefits)

and

Comprehensive Medical Care Plan (Out-of-Area Benefits)

for the

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Plan Effective Date: September 1, 2005

Account No. 38000-B

NOTICE OF ELECTION OF EXEMPTION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans as follows:

1. Limitations on preexisting conditions exclusion periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to mental health benefits; and
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain government group health plans the right of exemption from certain provisions of this federal law. For the plan year beginning September 1, 2005 through August 31, 2006, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect of Texas (HealthSelect) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

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Article I - Supplemental Definitions

As used herein:

- A. **Allowable Amount** means the lesser of: (1) Usual and Customary; (2) Maximum Allowable Cost plus a contractually determined dispensing fee; or (3) the Average Wholesale Price less a contractually determined discount amount plus dispensing fee.
- B. **Average Wholesale Price (AWP)** means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.
- C. **Claims Administrator** for the purposes of the Prescription Drug Program means Medco Health Solutions, Inc. (Medco) administrator of the participating retail pharmacy program and mail service pharmacy program.
- D. **Copayment** means the amount paid by the Participant for each Prescription Order dispensed or refilled at a Participating (Network) Pharmacy. If a Participant receives a preferred or non-preferred brand name drug when a Generic Substituted Drug is available, the amount paid by the Participant will include the generic copayment plus the difference in cost between the generic drug and the preferred or non-preferred brand name drug dispensed.
- E. **Cosmetic Drug** means a drug that is used primarily to enhance appearance including but not limited to correction of skin wrinkles, skin aging and hair loss, even if the drug may have other non-cosmetic uses.
- F. **Covered Drug** means any Legend Drug or injectable insulin, including disposable syringes and needles needed for self-administration:
1. That is Medically Necessary and is ordered by a Physician or Other Provider naming a Participant as the recipient;
 2. For which a written or verbal Prescription Order is prepared by a Physician or Other Provider;
 3. For which a separate charge is customarily made;
 4. That is used for the purpose for which U.S. Food and Drug Administration (FDA) approval has been given; and
 5. That is dispensed by a Pharmacy and is received by the Participant while covered under this Supplementary Document, except when received in a Physician's or Other Provider's office, or during confinement while a patient in a Hospital or other acute care institution or Facility.
- G. **DESI Drugs (Drug Efficacy Study Implementation)** means drugs or medication that have been determined by the U.S. government to be "less than effective."
- H. **Experimental/Investigational** means drugs or medicines that cannot be purchased or that are not approved by the FDA for public use for any purpose and have not been proven to be safe, effective, and appropriate for the diagnosis or treatment of the injury or illness for which it is prescribed.
- I. **FDA** means the United States Food and Drug Administration, the federal agency responsible for drug oversight, (i.e. approval and dispensing protocols).
- J. **Generic Substituted Drug** means a drug manufactured and distributed after the patent of the innovator brand name drug has expired. The generic drug must have the same active ingredient, strength and dosage form as its brand name counterpart.
- K. **Identification Card** means the ID card issued to the Employee or Retiree indicating pertinent information applicable to his coverage, including certain retail Copayment amounts.

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- L. **Legend Drugs** means drugs, biologicals, or compounded prescriptions that are required by law to have a label stating “Caution Federal Law Prohibits Dispensing Without a Prescription,” and that are approved by the FDA for a particular use or purpose.
- M. **Master Benefit Plan Document** means the document describing the HealthSelect of Texas Plan.
- N. **Maximum Allowable Cost (MAC)** means a list of drugs subject to maximum allowable cost payment schedules developed by Medco. The payment schedules specify the maximum unit ingredient cost payable by the Plan for drugs on the MAC list. The MAC list and payment schedules are updated frequently.
- O. **Medically Necessary or Medical Necessity** means those [Covered Drugs](#) that are:
1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction;
 2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States;
 3. Not primarily for the convenience, personal preference, or appearance of the Participant or his [Physician or Other Provider](#);
 4. The most economical Covered Drugs that are appropriate for the safe and effective treatment of the Participant, and
 5. Not experimental/investigative in nature at the time the drugs are provided. A drug is experimental/investigative in nature if it is not generally accepted as standard medical treatment of the condition being treated or if any such drug requiring Federal or other governmental agency approval is not granted at the time the drug is provided.
- The [Claims Administrator](#) for the Plan shall determine whether or not a Covered Drug is Medically Necessary under the Plan and shall consider the views of the state and national medical communities and the views and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although a Physician or Other Provider may have prescribed Covered Drugs, such drugs may not be Medically Necessary within this definition.
- P. **Network** means a group of independent [Pharmacies](#) or chain of Pharmacies having a particular agreement for providing prescription drug services in a Network serving this Plan.
- Q. **Non-Preferred Brand Name Drug** means designated prescription brand name drugs available at a higher copayment than most Preferred brand name drugs. All new drugs will be designated as Non-preferred until reviewed by the [Pharmacy and Therapeutics Committee](#).
- R. **Nonparticipating (Non-Network) Pharmacy** means a Pharmacy which has not entered into an agreement with the Claims Administrator to provide prescription drug benefits to Participants covered under this Supplementary Document.
- S. **Off Label Use** means the use of FDA approved drugs for unapproved indications.
- T. **Over the Counter (OTC) Drugs** means drugs that may be purchased without a prescription. A drug that may be otherwise purchased without a prescription but is prescribed at a strength requiring a prescription is not considered to be OTC.
- U. **Participating (Network) Pharmacy** means an independent Pharmacy or chain of Pharmacies that have contracted with the [Claims Administrator](#) to provide Pharmacy services to Participants covered under this Supplementary Document.
- V. **Pharmacy** means a state and federally licensed establishment where the practice of pharmacy occurs that is physically separate and apart from any [Physician’s or Other Provider’s](#) office and where [Legend Drugs](#) and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

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- W. **Pharmacy and Therapeutics (P&T) Committee** means a committee of 7 independent members consisting of nationally recognized physicians and clinical pharmacists. The Committee's purpose is to develop the formulary, prescribing guidelines, coverage criteria (e.g., prior authorization) and drug utilization review interventions. The P&T Committee meets quarterly to review information on safety and efficacy of each drug considered for inclusion or exclusion from the Preferred and Non-preferred Brand Name Drug lists.
- X. **Physician or Other Provider** means a person who is licensed and authorized to prescribe [Legend Drugs](#) to humans under state and federal law.
- Y. **Preferred Brand Name List** means a list of prescription drugs, biologicals and devices approved by the Medco [Pharmacy and Therapeutics Committee](#) for inclusion in the pharmacy benefit program. The preferred brand name list is subject to change.
- Z. **Prescription Order** means a written or verbal order from a [Physician or Other Provider](#) to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or Other Providers located outside the United States to be dispensed in the United States are not covered under this Supplementary Document.
- AA. **Prior Authorization** means a process applied to certain drugs or classes of drugs to define the conditions under which these drugs will be covered by the pharmacy benefit program. The drugs and conditions for coverage are determined by the [P&T Committee](#) and are subject to periodic review and modification. If a prescription drug is not prior authorized or exceeds the quantity limitation, the Participant will be responsible for the entire cost of the prescription drug once the limits have been exceeded. The Participant's prescribing [Physician or Other Provider](#) may request reconsideration from the [Claims Administrator](#); however, Plan grievance and appeal rights are not available to the Participant.
- AB. **Quantity Limitation** means a process applied to selected classes of drugs to limit the amount of medication dispensed to an amount set forth in nationally recognized guidelines. Quantity limitations are recommended by the [P&T Committee](#) and are subject to periodic review and modification. If a prescription drug exceeds the quantity limitation, the Participant will be responsible for the entire cost of the prescription drugs exceeding the quantity limitation. The Participant's prescribing [Physician or Other Provider](#) may request reconsideration from the [Claims Administrator](#); however, Plan grievance and appeal rights are not available to the Participant.
- AC. **Tier** means a copayment level for [Covered Drugs](#).
- AD. **Trustee** means the Board of Trustees of the Employees Retirement System of Texas.
- AE. **Usual and Customary** means the price a cash patient would have paid the day the prescription was dispensed, inclusive of all applicable discounts.

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Article II – Terms and Provisions

All definitions, terms, and provisions recited in Exhibit A and Exhibit B of the HealthSelect of Texas Master Benefit Plan Document, except those contained in Articles IV, V, and VI, are hereby adopted and shall be construed to apply in like manner and with equal force to this Supplementary Document; provided, that if any such provisions are in conflict with provisions herein contained, the provisions of this Supplementary Document shall govern in any interpretations of rights or obligations accruing under the Plan.

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Article III – Benefits Provided

A. Benefits

1. *Participating (Network) Pharmacies*

- a. When any Participant, while covered under this Supplementary Document, shall obtain [Covered Drugs](#) at a [Participating \(Network\) Pharmacy](#), upon: (1) presentation of a current valid ID Card; (2) payment to the Pharmacy of the appropriate [Copayment](#) amount for the drugs received; and (3) providing a valid Prescription Order and the necessary recipient information and signatures required by the Pharmacy, the Plan will reimburse to the Participating (Network) Pharmacy an amount equal to the contractually agreed to [Allowable Amount](#) remaining for the Covered Drugs dispensed.
- b. If Covered Drugs are obtained from a Participating (Network) Pharmacy by a Participant while covered under this Supplementary Document, prior to the Employee's receipt of a ID Card, the Plan will reimburse the Employee for the contract amount paid, less the appropriate Copayment amount.
- c. If Covered Drugs are obtained from a Participating (Network) Pharmacy by a Participant while covered under this Supplementary Document, after the Employee's receipt of a ID Card, and the Participant does not comply with the requirements of Section A, Subsection 1, Paragraph a, above, at the time the Covered Drug is dispensed, the Plan will reimburse the Employee in an amount equal to the billed Pharmacy charge, less the appropriate Copayment amount, up to the amount the Plan would have paid the Participating (Network) Pharmacy under the contractual arrangement with the Pharmacy.

The Claims Administrator will provide documentation of its determination of the benefit amount upon request of the Employee.

2. *Nonparticipating (Non-Network) Pharmacies*

When any Participant, while covered under this Supplementary Document, shall obtain Covered Drugs at a [Nonparticipating \(Non-Network\) Pharmacy](#), the Plan will pay benefits equal to 60% of the lesser amount of the billed charge minus the appropriate [Copayment](#) amount or the [Average Wholesale Price](#) plus a dispensing fee minus the appropriate Copayment amount. If the Plan Year deductible has not been satisfied, it will be subtracted.

The [Claims Administrator](#) will provide documentation of its determination of the benefit amount upon request of the Employee or Retiree.

B. Limitations on Quantities Dispensed

1. [Covered Drugs](#), except as provided in Subsections 3 and 4, below, of this Section B, shall be limited to no more than a 30-day supply for a retail prescription and up to a 90-day supply for a mail order prescription on any occasion when a [Prescription Order](#) is dispensed. Replacement of lost, stolen or damaged medication is generally not provided under this Plan. The quantity limitation includes drugs necessary for the treatment of phenylketonuria or other heritable diseases when the drugs are dispensed under a Prescription Order. When approved by the Physician issuing the Prescription Order, generic substituted drugs will be substituted for brand name drugs.
2. Benefits for injectable insulin shall be limited to up to a 30-day supply per copayment at a [Participating \(Network\) Pharmacy](#) or up to a 90-day supply per mail order copayment through the mail order facility when the insulin is dispensed under a Prescription Order.
3. The quantity of disposable syringes and needles covered for self-administered injections shall be limited to amounts appropriate to the dosage amounts of covered drugs actually prescribed and dispensed, but cannot exceed the quantity required for up to a 30-day supply at a Participating

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(Network) Pharmacy or up to a 90-day supply through the mail order facility. When disposable syringes and needles are purchased with insulin, only one copayment for insulin, syringes and needles applies (30-day supply or 90-day supply as applicable). When disposable syringes and needles are purchased without insulin, a separate copayment for the syringes and needles applies (30-day supply or 90-day supply as applicable).

4. Payment for benefits covered under this Supplementary Document may be denied when drugs are dispensed or delivered in a manner intended to circumvent, or having the effect of circumventing, the quantity limitations described above, such as obtaining multiple refills for the same Prescription Order prior to the original supply being consumed.

C. Prior Authorization

Certain prescription drugs are covered under the Plan only if they are prescribed for treatment of a covered benefit and approved by the FDA for that treatment. These drugs require prior authorization that must be obtained from the [Claims Administrator](#) by the prescribing provider or the pharmacist. The list of prescription drugs and the coverage criteria requiring prior authorization are subject to periodic review and modification by the Claims Administrator. If prior authorization is not approved, the participant will be responsible for the entire cost of the prescription drug. Appeals are available through Medco for most drugs under prior authorization; however, appeals are not available through ERS.

D. Compound Medications

Claims for compound medications may be submitted in two ways:

1. The participating retail pharmacy may submit the claim electronically to the [Claims Administrator](#). The participant will pay a copayment at the time of service. The Claims Administrator will reimburse the pharmacy.
2. If the participant utilizes a non-network pharmacy or utilizes a network pharmacy that will not file the electronic claim, the participant must file a direct claim to the Claims Administrator. The participant will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

In order for a direct claim to be processed, the participant must send the Claims Administrator an itemized list of ingredients with a receipt and fully completed claim form. The claim and/or receipt must include:

1. The amount charged by the pharmacy;
2. The total volume or quantity of the compound (such as the number of capsules or the number of milligrams); and
3. The valid National Drug Code (NDC) for each ingredient.

E. Copayments

The benefits of this Supplementary Document shall be available for [Covered Drugs](#) up to a 30-day supply dispensed by a Participating (Network) Pharmacy after the Plan Year prescription drug deductible has been met and with application of one of the following [Copayment](#) amounts:

1. *Tier 1 Drugs (Primarily Generic Drugs):*

A Copayment amount of \$10.00 shall apply to each covered Tier 1 Drug dispensed.
A Copayment amount of \$15.00 shall apply to each covered maintenance Tier 1 Drug dispensed.

2. *Tier 2 Drugs (Mostly Preferred Brand Name Drugs):*

A Copayment amount of \$25.00 shall apply to each covered Tier 2 Drug dispensed.
A Copayment amount of \$35.00 shall apply to each covered maintenance Tier 2 Drug dispensed.

3. *Tier 3 Drugs (Non-Preferred Brand Name Drugs and Other Preferred Brand Name Drugs):*

A Copayment amount of \$40.00 shall apply to each covered Tier 3 Drug dispensed.

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A Copayment amount of \$55.00 shall apply to each covered maintenance Tier 3 Drug dispensed.

Non-sedating antihistamines are in Tier 3.

The benefits of this Supplementary Document shall be available for Covered Drugs up to a 90-day supply dispensed by the mail order pharmacy after the Plan Year prescription drug deductible has been met and with application of one of the following Copayment amounts:

1. *Tier 1 Drugs (Primarily Generic Drugs):*

A Copayment amount of \$30.00 shall apply to each covered Tier 1 Drug dispensed.

2. *Tier 2 Drugs (Mostly Preferred Brand Name Drugs):*

A Copayment amount of \$75.00 shall apply to each covered Tier 2 Drug dispensed.

3. *Tier 3 Drugs (Non-Preferred Brand Name Drugs and Other Preferred Brand Name Drugs):*

A Copayment amount of \$120.00 shall apply to each covered Tier 3 Drug dispensed.

Non-sedating antihistamines are in Tier 3.

The Copayment amounts for non-maintenance drugs at a participating pharmacy described above will be shown on the ID Card. The Participant is obligated to pay the appropriate [Copayment](#) amount to the Pharmacy before benefits under this Supplementary Document will apply.

F. **Plan Year Deductible**

Each Participant must satisfy a \$50 deductible per Plan Year (September 1 through August 31). The prescription drug copayments apply after the deductible has been satisfied for drugs dispensed through a participating retail pharmacy or mail order. For drugs dispensed through a non-participating pharmacy, the deductible and copayments are applied as required by the reimbursement formula.

G. **Identification Card**

1. ID Cards for each covered Employee or Retiree will be mailed to the Employee or Retiree. Where coverage applied for is other than for an individual Employee or Retiree, two cards will be provided.
2. The ID Card is required to be presented to [Participating \(Network\) Pharmacies](#) in order for a Participant to receive full program benefits. The card will contain information needed by the Participating (Network) Pharmacy to identify the Participant, the group, and the coverage. Participating (Network) Pharmacies are not permitted to process claims for reimbursement under this Supplementary Document unless the card is presented at the time [Covered Drugs](#) are received from the Pharmacy.
3. When coverage for any Employee or Retiree is terminated, or this Supplementary Document is terminated or cancelled by the Plan Administrator, for any reason, the Plan Administrator will immediately notify the Claims Administrator in writing and will recover from the Employee or Retiree any ID Cards issued to Participants which have not expired as of the Employee's or Retiree's termination date or the Supplementary Document termination date to prevent their further use.
4. In the event any Participant fails to surrender the card upon termination or cancellation of coverage and continues to make use of the ID Card, the Plan Administrator will assist the Claims Administrator in recovering any benefits paid out in "good-faith" payments to Participating (Network) Pharmacies honoring an ID Card. Such assistance shall include providing a current address or location to which cease and desist letters and collection notices could be sent and otherwise using the Plan Administrator's offices to locate the Employee, former Employee, or

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Retiree.

H. **Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards**

1. The unauthorized, fraudulent, improper, or abusive use of ID Cards issued to an Employee or Retiree and his covered family members shall include, but not be limited to:
 - a. Use of the ID Card prior to the Employee's or Retiree's effective date;
 - b. Use of the ID Card after the Employee's or Retiree's coverage terminates under the Plan;
 - c. Obtaining prescription drugs or other benefits for persons not covered under this Supplementary Document;
 - d. Obtaining prescription drugs or other benefits which are not covered under this Supplementary Document;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under this Supplementary Document;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary standards of use or in circumvention of the quantity limitations of this Supplementary Document;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Physicians or Other Providers; and
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The unauthorized, fraudulent, improper, or abusive use of ID Cards by any Participant can result in but is not limited to, the following sanctions being applied to all Participants covered under the Employee's or Retiree's coverage:
 - a. Denial of benefits;
 - b. Limitation on the use of the ID Card to one designated Participating (Network) Pharmacy of the Participant's choice;
 - c. Recoupment from the Participant of any benefit payments made;
 - d. Preapproval of drug purchases for all Participants covered under the Employee's or Retiree's coverage;
 - e. Notice to proper authorities of potential violations of law or professional ethics; and
 - f. Removal from the Texas Employees Group Benefits Program.

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Article IV – Limitations and Exclusions

The benefits of this Supplementary Document are not available for:

- A. Drugs which do not by law require a [Prescription Order](#) from a [Physician or Other Provider](#) (except injectable insulin). Drugs prescribed at a strength requiring a Prescription Order are not excluded, even if available without a prescription at a lesser strength.
- B. Drugs, insulin, or covered devices for which no valid [Prescription Order](#) is obtained, either in writing or given verbally to a pharmacist by a [Physician or Other Provider](#).
- C. Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
- D. Administration or injection of any drugs.
- E. Vitamins (except those vitamins which by law require a [Prescription Order](#) and for which there is no non-prescription alternative).
- F. Drugs dispensed in a [Physician's or Other Provider's](#) office or during confinement while a patient in a Hospital, or other acute care institution or Facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or Facility. Drugs dispensed in a Physician's or Other Provider's office, during confinement while a patient in a Hospital or Substance Abuse Facility, or while a patient in a Facility may be covered under the HealthSelect of Texas Plan.
- G. [Covered Drugs](#), devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this Section G shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- H. Any services provided or items furnished for which the [Pharmacy](#) normally does not charge.
- I. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the amount of Copayment provided under this Supplementary Document.
- J. Contraceptive devices and contraceptive materials (oral contraceptives are covered).
- K. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- L. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
- M. [Covered Drugs](#) dispensed in quantities in excess of the amounts stipulated in Article III of this Supplementary Document, or refills of any prescriptions in excess of the number of refills specified by the [Physician or Other Provider](#) or by law, or dispensed in quantities in excess of the amounts stipulated in Article III of this Supplementary Document, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- N. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (internal) infusion or by intravenous injection in the home setting. These fluids, solutions, nutrients, or medications may be covered under the HealthSelect of Texas Plan.

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- O. Drugs used primarily for cosmetic purposes such as, but not limited to: Retin-A, Renova, Solage, Rogaine.
- P. Drugs prescribed and dispensed for the treatment of obesity, with an FDA indication for weight loss or for use in any program of weight reduction, weight loss, or dietary control, even if the Participant has medical conditions which might be helped by a reduction of obesity or weight and even though prescribed by a physician.
- Q. Any smoking cessation prescription drug products, including, but not limited to, nicotine gum and nicotine patches.
- R. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the ID Card.
- S. Drugs used or drugs intended to be used illegally or unethically.
- T. Legend Drugs which are being used for purposes other than those approved by the FDA.
- U. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Master Benefit Plan Document for HealthSelect of Texas or for which benefits have been exhausted.
- V. Coordination of benefit claims by other group plans, except when required for other governmental programs in which case ERS will coordinate benefits.
- W. Homeopathic products and herbal remedies.

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Article V – Termination of the Prescription Drug Program Supplementary Document

- A. This Supplementary Document and coverage of all Participants under the Plan shall automatically terminate:
 - 1. When the applicable Master Benefit Plan Document is terminated for any reason; and
 - 2. By cancellation at the request in writing of the Plan Administrator, not less than 30 days in advance.
- B. The coverage of any Participant under this Supplementary Document shall automatically terminate when his coverage under the applicable Master Benefit Plan Document is terminated.
- C. Under no circumstances shall the Plan Administrator be obligated to notify any Participant of the termination of this Supplementary Document or of his coverage under the Plan.
- D. No conversion privilege afforded a Participant under the applicable Master Benefit Plan Document shall be deemed to apply to this Supplementary Document.
- E. The Plan shall be liable for any claims incurred by Participants after termination of coverage which are paid by the [Claims Administrator](#) due to failure of the Employer to submit notice.
- F. The Plan Administrator reserves the right to cancel or deny coverage for any Participant for unauthorized, fraudulent, abusive, or improper use of the ID Card, including limitations on quantities of [Covered Drugs](#) dispensed.

The Plan Effective Date is September 1, 2005. The Plan and the coverage provided therein shall become effective on the Plan Effective Date stipulated above.

Employees Retirement System of Texas

By: _____
Executive Director