FRONTDOOR, INC.

PRESCRIPTION DRUG PLAN

Effective as of January 1, 2022

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 Frontdoor, Inc. 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:

Express Scripts (ESI)
Ones Express Way
St. Louis, MO 63121
(855) 283-7451
www.express-scripts.com

Specialty Medication must be placed through:

Accredo Specialty Pharmacy
877-895-9697

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" 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 PMB'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. *See the* ***"Prescription Plan Coverage Summary" attached as an Appendix.***

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. *See the* ***"Prescription Plan Coverage Summary" attached as an Appendix.***

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 supply limit.

Non-Participating Retail: Medications filled at a non-network pharmacy will not be covered.

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. If a generic equivalent is available, the member will pay the difference between the generic and the brand name costs, in addition to the brand name share of the negotiated charge.

Health Care Reform Preventive Items and Services (ACA Preventive Medications)

Certain items identified by the Plan as preventive care are covered in full and not subject to the co-pay amounts indicated. Includes vaccines, contraceptives, bowel prep agents, folic acid, aspirin, fluoride, statins, smoking cessation, breast cancer and HIV Prep medications. Some medication may be restricted to certain ages and/or quantities

Gene Therapy

Gene Therapy" is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a particular disease by:

- replacing a disease-causing gene with a healthy copy of the gene;
- inactivating a disease-causing gene that may not be functioning properly; or
- introducing a new or modified gene into the body to help treat a disease.

Subject to medical necessity, the Plan covers Gene Therapy products and, as applicable medical, surgical, and facility services directly related to administration of the Gene Therapy product.

Gene therapy services generally require prior authorization (discussed below). Accordingly each member or authorized prescriber should contact the PBM to confirm coverage in advance.

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. This is limited to Specialty medications filled at Accredo and Mail Order.

SaveOnSP Program

Members covered by the PPO are eligible for the SaveOnSP Program which helps the Plan and its members lower the cost of specialty medications. Under the program, certain specialty pharmacy drugs are considered non-essential health benefits under the Plan and the cost of such drugs will not be applied toward satisfying the member's out-of-pocket maximum. Although the cost of the specialty drugs will not be applied towards satisfying a member's out-of-pocket maximum, the cost of the drugs will be reimbursed by the manufacturer at no cost to the participant. To achieve this result, copays for certain specialty medications may be set to the maximum of the current Plan design or any available manufacturer-funded copay assistance. A list of drugs covered by the SaveOnSP program is available at: www.saveonsp.com/frontdoor

Mail Order

Prescriptions filled through the PBM's mail order program will be subject to the co-payments and co-insurance amounts set forth in the ***"Prescription Plan Coverage Summary" attached as an Appendix***. The supply limit for the mail order program is 90 days.

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 exclusively through the PBM's specialty pharmacy provider, Accredo Pharmacy, and are subject to prior authorization***. Some exceptions may apply. Specialty medications are generally limited to a 30-day supply. Specialty medications largely fall into the formulary brand category, but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-payment and co-insurance as listed below.

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.
- 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.
- Zolgensma
- Abortifacients (Std) Mifepres
- Fertility Agents (Std, All)
- Cosmetic-related drugs and supplies.
- Medical Foods
- Nutritional therapy for specific medical conditions
- Allergy serums (oral/sublingual only) Std.
- 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.

All benefit-related claims and appeals (e.g., clinical coverage issues, requests for coverage of a particular medication) will be administered by the PBM as described in the attached Appendix.

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Appendix

Claims and Appeals

Initial coverage review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

- Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to 877.328.9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If the patient'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 application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient'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. If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800.753.2851.

How an initial coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision	
		APPROVAL	DENIAL
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient: Automated call and letter, if fax unsuccessful Prescriber: Electronic or fax (and letter, if fax unsuccessful)	Patient: Letter Prescriber: Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: Automated call and letter Prescriber: Electronic or fax (and letter, if fax unsuccessful)	Patient: Live call and letter Prescriber: Electronic or fax (and letter, if fax unsuccessful)

* If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

** Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 appeal or urgent appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied

When an initial coverage review has been denied, also 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 appropriate department for clinical or administrative review requests:

- 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

Clinical appeal requests and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588


877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587


877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal 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 application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient'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.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests


800.753.2851


877.852.4070

Urgent administrative appeal requests

800.946.3979

877.328.9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision	
		APPROVAL	DENIAL
Standard Pre-	15 days	Patient Automated call fax (and letter, if fax unsuccessful) Prescriber Electronic or fax (and letter, if call unsuccessful)	Patient Letter Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient Automated call fax and letter (and letter, if fax unsuccessful) Prescriber Electronic or fax	Patient Live call and letter Prescriber Electronic or fax (and letter, if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- 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 adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests and administrative appeal requests can be sent to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal 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 application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient'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.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests

 800.753.2851

 877.852.4070

Urgent administrative appeal requests

 800.946.3979

 877.328.9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, panel of clinicians or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision	
		APPROVAL	DENIAL
Standard Pre-Service	15 days	Patient Automated call and letter, if fax unsuccessful) Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Letter Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient Automated call and letter Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Live call and letter Prescriber Electronic or fax (and letter, if fax unsuccessful)

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

External review

Please note: information below for external review applies for non-grandfathered plans following HCR and using MCMC. If you fall outside those guidelines, please contact your account team for language appropriate to your situation.

When and how to request an external review

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 (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third party utilization management company, at:

MCMC LLC
Attn: Express Scripts
Appeal Program 300
Crown Colony Drive,
Suite 203
Quincy, MA 02169-0929

617.375.7700, ext. 28253

617.375.7683

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).

How an external review is processed

Standard external review

MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization 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.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient 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.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified 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. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Appendix

2022 Prescription Plan Coverage Summary