

**Amendment No. Two  
to the  
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  
(hereinafter referred to as “ERS”)**

**Account No. 38000-B**

**Implementing Amendment effective:  
September 1, 2009**

**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, 2009 through August 31, 2010, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect<sup>SM</sup> of Texas (HealthSelect<sup>SM</sup>) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect<sup>SM</sup> during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

**I. Exhibit C of the 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) is amended as follows:**

**A. Article I (Definitions) mislabeled as Sections M (Network) through CC (Usual and Customary) is modified to correct unintentional drafting errors by deleting the mislabeled section letters and re-labeling them as Sections P (Network) through FF (Usual and Customary) as follows:**

- 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 PBM to provide prescription drug benefits to Participants covered under this Prescription Drug Program.
- 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 PBM to provide Pharmacy services to Participants covered under this Prescription Drug Program.
- 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.
- W. **Pharmacy and Therapeutics (P&T) Committee** means a committee of independent members consisting of 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 periodically 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. **Pharmacy Benefits Manager (PBM)** for the purposes of the Prescription Drug Program means Caremark Rx, L.L.C. (Caremark), administrator of the participating retail pharmacy program and mail service pharmacy program.
- Y. **Physician or Other Provider** means a person who is licensed and authorized to prescribe Legend Drugs to humans under state and federal law.

- Z. **Preferred Drug List** means a list of prescription drugs, biologicals and devices approved by the P&T Committee for inclusion in the pharmacy benefit program. The Preferred Drug List is subject to change.
- AA. **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 Prescription Drug Program.
- BB. **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 recommended 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 PBM; however, Plan grievance and appeal rights are not available to the Participant.
- CC. **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 PBM; however, Plan grievance and appeal rights are not available to the Participant.
- DD. **Tier** means a copayment level for Covered Drugs.
- EE. **Trustee** means the Board of Trustees of the Employees Retirement System of Texas.
- FF. **Usual and Customary** means the price a cash patient would have paid the day the prescription was dispensed, inclusive of all applicable discounts.
- B. Article III (Benefits Provided), Section A (Benefits) is modified by deleting subsection (2) in its entirety and substituting the following:**

2. Nonparticipating (Non-Network) Pharmacies.

When any Participant, while covered under this Prescription Drug Program, shall obtain Covered Drugs at a Nonparticipating (Non-Network) Pharmacy, the Plan will pay benefits equal to 60% of the remaining balance of the lesser of the Usual and Customary price minus the Plan Year deductible (if not met) and appropriate Copayment amount or the ERS contract price of the drug minus the Plan Year deductible (if not met) and the appropriate Copayment amount.

Please note that if a brand name medication that has an available generic equivalent is dispensed, in addition to paying the generic Copayment, the Participant shall be

responsible for the difference in the cost between the generic and preferred or Non-Preferred Brand Name Drug.

Written Proof of Loss must be furnished to the PBM at its designated office, or to its duly authorized agent. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time due to absence of legal capacity of the Employee or Retiree. The PBM will provide documentation of its determination of the benefit amount upon request of the Employee or Retiree.

**For: Employees Retirement System of Texas**

By: Signature on File  
Ann S. Fuelberg, Executive Director

Date: Date on File

**For: Caremark Rx, L.L.C.**

By: Signature on File

Title: On File

Date: On File