

PHARMACY PLAN ADDENDUM

PRESCRIPTION DRUG BENEFITS

Attention: The prescription drug benefits outlined below are administered as of 1/1/2016 by OptumRx, a pharmacy benefits manager with acquired subsidiary, OptumRxRx. You will receive a separate identification card directly from OptumRx to use for prescription drug benefits.

Pharmacy Plan Deductible and Out-of-Pocket Maximum

The deductible information in the chart below applies only to prescription drug benefits. There is a \$100 prescription drug deductible (for Tier 2 and Tier 3 drugs only) per person per calendar year. The calendar year out-of-pocket maximum includes all in-network covered services for medical and pharmacy benefits. For example, pharmacy deductible, medical copays, prescription copays, etc., all apply to the calendar year out-of-pocket maximum.

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Pharmacy Deductible Pharmacy deductible is <u>separate</u> from medical deductible.	\$100 individual	\$100 individual
Calendar Year Out-of-Pocket Maximum Applies to medical and pharmacy.	\$2,250 individual (\$6,750 per family)	There is no out-of-pocket maximum for out-of-network services.

Pharmacy Plan Benefits

The plan will routinely review the drugs in the tier levels and adjust the status of new or existing drugs on the formulary. OptumRx reserves the right to determine if prior authorization criteria has been met (see Prior Authorization under Prescription Drug Definitions). To verify any such change in a drug's tier level, contact OptumRx at the number on the back of your OptumRx ID card or visit the OptumRx website at www.optumrx.com.

RETAIL PHARMACY

	IN-NETWORK <i>Participating Pharmacy: Prescription drugs will be covered at 100% of the allowed charge after the prescription drug deductible is met & subject to the following copays.</i>			OUT-OF-NETWORK <i>Non-Participating Pharmacy: Prescription drugs will be covered at 75% of the allowed charge after the prescription drug deductible is met & subject to the following copays.</i>	
Type	1-31 day supply (available for maintenance & non-maintenance drugs)	32-60 day supply (available for maintenance drugs only)	61-90 day supply (available for maintenance drugs only)	1-31 day supply	32-60 day supply (available for maintenance drugs only; 60-day maximum)
Tier 1 (Generic)	\$15	\$30	\$30	\$15	\$30
Tier 2 (Preferred Brand)	\$35	\$70	\$70	\$35	\$70
Tier 3 (Non-Preferred Brand with no generic equivalent :)	\$55	\$110	\$110	\$55	\$110
Tier 4 (Specialty)	\$100	n/a	n/a	n/a	n/a
Tier 2 or 3 Drugs with a with Generic Alternative	\$55 copayment for a 1-31 day supply plus the member will be responsible for the difference in drug cost between the Tier 2 or Tier 3 drug and the generic drug.				

MAIL ORDER / HOME DELIVERY PROGRAM

	IN-NETWORK <i>Participating Pharmacy: Prescription drugs will be covered at 100% of the allowed charge after the prescription drug deductible is met & subject to the following copays</i>		
Type	1-31 day supply (available for maintenance & non-maintenance drugs)	32-60 day supply (available for maintenance drugs only)	61-90 day supply (available for maintenance drugs only)
Tier 1 (Generic)	\$10	\$20	\$20
Tier 2 (Preferred Brand)	\$30	\$60	\$60
Tier 3 (Non-Preferred Brand)	\$50	\$100	\$100
Tier 4 (Specialty)	\$100	n/a	n/a
Tier 2 or 3 Drugs with a with Generic Alternative	\$50 copayment for a 1-31 day supply plus the member will be responsible for the difference in drug cost between the Tier 2 or Tier 3 drug and the generic drug.		

Maintenance drugs (including certain diabetic supplies) can be dispensed up to a maximum of 90-day supply for two 31-day supply copays.

Preventive Medications

The plan covers some preventive medications as required by Health Care Reform 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. Some of these medications include:

Aspirin products	Cover at \$0 copay oral over-the-counter (OTC) aspirin products (with prescription) only for age limit greater than 44 years. Exclude prescription aspirin products, non-oral aspirin products, or aspirin strengths > 325 mg
Fluoride Products	Cover at \$0 copay prescription (generic single ingredient only) oral fluoride supplementation products for ages 6 months to 6 years. Exclude branded oral fluoride supplementation products
Folic Acid & Prenatal Vitamins	Cover at \$0 copay OTC folic acid supplementation products (with prescription), including prenatal vitamins containing folic acid for women < 55 years of age. Exclude prescription folic acid supplementation products and any product containing > 0.8mg or < 0.4mg of folic acid
Iron Supplements	Cover at \$0 copay prescription and OTC (with prescription) iron supplementation products for children ages 6 months to 12 months. Exclude intravenous iron products and bulk iron products
Vitamin D	Cover at \$0 copay OTC only Vitamin D (single ingredient only with prescription) products for adults 65 years or older
Smoking Cessation Products	Cover at \$0 copay prescription and OTC (with prescription) smoking cessation products (e.g., nicotine products, bupropion [generic only], Chantix) for adults. Currently no exclusions. To ensure appropriate utilization, a quantity limit of 2 cycles per year applies to each active ingredient.
Immunizations	Cover at \$0 copay single-entity and combination vaccinations for diphtheria, haemophilus influenzae type b*, hepatitis A, hepatitis B, herpes zoster*, human papillomavirus*, polio, influenza, measles, mumps, rubella, meningococcal infections, pertussis, pneumococcal infections, rotavirus*, tetanus, varicella. Exclude vaccines not listed in the ACIP Immunization Schedules. *Age and/or gender limits apply in accordance with the recommendations of the ACIP to the following vaccines: <ul style="list-style-type: none"> • Haemophilus influenzae type b – applies only to children < 6 years of age • Herpes zoster – applies only to adults > 50 years of age • Human papillomavirus – applies to only children and adults 9 years to 26 years of age • Rotavirus – applies only to children < 8 months
OTC Contraceptives	Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay OTC female contraceptive products (with prescription) with the following quantity limits: <ul style="list-style-type: none"> • Female condoms – Quantity limit of 12 units per month • Spermicides (e.g., vaginal gel/foam/film/suppositories) – Quantity limit of 12 units (or days' supply for gel/foam) per month • Sponges - Quantity limit of 12 units per month <p>OTC female contraceptive products and prescription emergency contraceptive products are not considered maintenance medications; therefore these products are not eligible for 90-day supplies.</p>

<p align="center">Prescription Contraceptives</p>	<p>Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay prescription contraceptive drugs as follows:</p> <ul style="list-style-type: none"> • Prescription & OTC Emergency contraceptives (with prescription) - generics only; exclude branded products; not eligible for 90-day supply • Oral Contraceptives – Quantity limit of 1 tab per day applies to all products <ul style="list-style-type: none"> - Monophasic, Biphasic, Triphasic, Extended Cycle – generics only; exclude branded products; - Four-phasic – only brand product available within drug class (Natazia) • Contraceptive Patch – generic only; quantity limit of 3 patches per month • Contraceptive Ring – only brand product available within drug class (Nuvaring); quantity limit of 1 ring per month • Injectable Contraceptives – generics only; exclude branded products#; quantity limit of 1 injection per 90 days
<p>Contraceptive Devices - Diaphragms</p>	<p>Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay prescription contraceptive devices as follows:</p> <ul style="list-style-type: none"> • Diaphragms – Quantity limit of 1 unit per year
<p>Contraceptive Devices - Cervical Caps</p>	<p>Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay prescription contraceptive devices as follows:</p> <ul style="list-style-type: none"> • Cervical caps – Quantity limit of 1 unit per year
<p>Contraceptive Devices - IUD's</p>	<p>Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay prescription contraceptive devices as follows: IUD</p>
<p>Contraceptive Devices - Implants</p>	<p>Identified Eligible Products: Applies only to women < 55 years of age Cover at \$0 copay prescription contraceptive devices as follows:</p> <ul style="list-style-type: none"> • Contraceptive Implants
<p>Bowel Prep Agents for Colorectal Cancer Screening</p>	<p>Identified Eligible Products: Applies only to adults 50 years of age or older. Cover at \$0 copay generic prescription bowel preparation agents. Quantity limit of 1 bowel prep product per year. Exclude branded bowel preparation products.</p>
<p>Breast Cancer Prevention and Treatment</p>	<p>Identified Eligible Products: Applies only to women. Cover at \$0 copay oral generic tamoxifen for prevention or treatment. Exclude brand tamoxifen and both brand and generic raloxifene.</p>

Member Services

Visit OptumRx's website, www.optumrx.com, to view your plan design and co-payment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Member Services directly at 1-844-265-1771. For future reference, this number is listed on the back of your OptumRx ID card.

Pharmacy Plan Covered Expenses

Prescription drug benefits are subject to the following terms and conditions:

- To be eligible for benefits, drugs must be FDA-approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."
- Even if your physician has written a prescription for a drug, the drug may not be covered if there is an equivalent non-legend (over-the-counter) drug available. Your network pharmacist should tell you when this is the case.
- Drugs are classified in Tiers generally by their cost to the plan with Tier 1 drugs having the lowest cost to the plan and Tier 3 having the highest cost to the plan. To determine the Tier in which a drug is classified, log into the OptumRx website at www.optumrx.com. Once there, you can search for your drug by clicking the "Price and Save" button located at the top of the Dashboard. Type the name of your drug into the "Enter a Medication Name" box and search. The Tier drug classifications are updated periodically. Select continue to compare pricing at local retail pharmacies.
- Prescription drug coverage is modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan, or clinical edit(s) may apply (i.e., prior authorization, step therapy, quantity limitation) in accordance with the guidelines. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the 1-844-265-1771 OptumRx Customer Service Department number on the back of your OptumRx ID card for more information.
- In-network pharmacies are pharmacies that have a contract with OptumRx to dispense prescription drugs under the plan.
- Compounded drugs contain two or more drugs mixed together. To be eligible for coverage compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Drug compounding for the purpose of convenience is not considered medically necessary. Compound drugs are always classified as Tier 3 drugs.

Attention: Just because a drug is classified by the plan as Tier 1 or any other classification on our website this does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

- Specialty drugs are prescription drugs often referred to as biotech drugs or biologics, which include high cost oral, injectable, and infusion drugs that are administered for specific chronic conditions, such as (including but not limited to) hemophilia, fertility, multiple sclerosis, and rheumatoid arthritis. Specialty drugs are limited to a maximum day supply of 31 days. Visit the most current Formulary Reference Guide with specialty drugs listed at <http://hr.ua.edu/optumrx-pharmacy-benefits>.

- The calendar year prescription drug deductible must be satisfied on a per person per calendar year basis. This deductible can be satisfied through allowed drug charges from a retail pharmacy, the mail order pharmacy, or a combination of the two.
- Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days in a 30-day supply).
- The maximum day supply for a new maintenance drug or maintenance drug dosage change is 31 days. After 31 days, subsequent refills can be for up to 60 or 90 days at a retail pharmacy or through mail order for maintenance drugs.
- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.
- If your drug is not covered and you think it should be, you may ask OptumRx to make an exception to the drug coverage rules. Your doctor or other prescriber must fill out the proper prior authorization paperwork and give OptumRx a statement that explains the medical reasons for requesting an exception.

Prescription Drug Medications

Generic Medications (Tier 1)

Generic medications contain the same active ingredients as brand-name medications and meet the same U.S. Food and Drug Administration standards for quality, strength and purity. However, generic drugs normally cost substantially less than their brand name counterparts. Therefore, generic drugs offer an alternative to help reduce your medication costs. Ask your doctor to see if a generic drug could treat your condition.

Formulary and Non-Formulary Medications

The Formulary is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. OptumRx provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs lower.

A current formulary drug list is available online or upon request by calling OptumRx Member Services. To avoid paying higher co-payments associated with non-preferred (Tier 3) drugs; please take a copy of the formulary drug list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your eligible family participants.

Coverage Limits

Your plan may have certain coverage limits. For instance, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. Examples include: anti-migraine drugs, rheumatoid arthritis and osteoarthritis drugs, impotence drugs, sleep aids, and pain management drugs. This is known as Quantity Management.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use OptumRx's Mail Program, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets the plan's coverage conditions. The coverage review process for prior authorization will allow OptumRx to obtain more information about your treatment (information that is not available on your original prescription, such as age, sex, and condition) in determining whether a given medication qualifies for coverage under the plan based on whether these criteria have been met.

We will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal. Or, if the prescribed drug is not the preferred initial therapy as determined by OptumRx, an alternative drug therapy will be recommended.

Below is a sample of some medications that require prior approval – please note this is not an exhaustive list:

- ADHD (Attention Deficit Hyperactivity Disorder) – CNS Stimulant Type Agents > 20 years of age.
- ADHD Agents (Amphetamines) > 20 years of age
- Androgens and Anabolics Steroids
- Appetite suppressants and weight loss agents
- Dermatologicals (Tretinoins/Tazorac – All Dosage Forms) > 35 year of age
- Erythroid Stimulants
- Growth Hormones
- Interferons
- Non-sedating Antihistamines
- Pain Management – Narcotic Analgesics

Pharmacy Plan ID Cards

OptumRx will provide an initial benefit ID card upon enrollment in the plan. Present your ID card when filling a prescription at the pharmacy. Should you need additional or replacement ID cards, please contact OptumRx Member Services or visit www.optumrx.com to either request a new card or print a temporary card.

Retail Pharmacies

Network Retail Pharmacies

The OptumRx Pharmacy Network is a national network comprised of nearly 65,000 retail pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. Use one of these pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local pharmacy, visit www.optumrx.com and click "Locate a pharmacy" or contact Member Services.

Non-Network Retail Pharmacies

You may be reimbursed by OptumRx should you visit a non-network pharmacy. However, it is to your advantage to visit an OptumRx network pharmacy. The non-network pharmacies will require you to pay for the full cost of the drug at the time of purchase, not just your co-payment amount. You must then complete a direct reimbursement claim form and forward it to OptumRx. Direct reimbursement claim forms are available on the website or by calling Member Services.

OptumRx Home Delivery - Mail Order Pharmacy Program

OptumRx Home Delivery pharmacy program is designed for plan participants taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The program provides medication, delivered directly to your home or other requested location, postage paid.

In order to participate in the OptumRx Home Delivery pharmacy program, you must first enroll online or via paper form. To enroll online, visit www.optumrx.com and select the button labeled "Sign up for Home Deliver" then follow the enrollment instructions. The paper enrollment form is also available for download. To fill your prescription, you must mail your prescription, order form and payment as directed on the OptumRx website. You may also ask your doctor to complete an electronically filed prescription or ask your doctor to fax your prescription by calling the number on the back of your card for further instruction. Your medication will usually be delivered within 14 days of OptumRx receiving your order. For additional information or questions about the enrollment process, call Member Services at 1-844-265-1771.

To order refills, call the number located on the back of your ID card, or visit www.optumrx.com.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Member Services.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions; one prescription should be written and filled at your local pharmacy and the second should be written and mailed to the OptumRx Home Delivery program.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, OptumRx's pharmacists will contact either you or your doctor prior to dispensing the medication.

Specialty Medications

BriovaRx is a pharmacy that is focused on providing you with the best possible care while you undergo specialty medication treatment. BriovaRx will work as part of your care team with your health care provider, support you with counseling and information about your medications, assist you with medication self-administration training, and communicate with your healthcare provider regarding follow up, as needed, plus help you enroll in a Copay Assistance Program, when needed. BriovaRx will also call you each month to coordinate the refill shipment of your medication and will provide 24-hour emergency pharmacy services over the phone. A clinician is always available, 24 hours a day, 7 days a week, for emergency on-call services at our toll-free number: **1-855-4BRIOVA (1-855-427-4682)**.

Pharmacy Plan Expenses Not Covered

If any expense not covered is contrary to any law to which the plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement. No payment will be made under any portion of the plan for the following list:

- A drug that can be purchased without a prescription order; these are commonly called over-the-counter (OTC) drugs;
- Therapeutic devices or appliances, support garments and other non-medical devices;
- Medication that is to be taken by or administered to a plan participant, in whole or in part, while the plan participant is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals;
- Investigational or experimental drugs; including compounded medications for non-FDA approved use;
- Prescriptions that a plan participant is entitled to receive without charge under any Worker's Compensation law or any municipal state or federal program;
- Hair growth stimulants;
- Drugs prescribed to remove or reduce wrinkles in the skin;
- Appetite suppressants or any drug used for weight loss; unless pre-authorized;
- Nutritional supplements unless covered as a "prescribed preventive drug as previously noted" ;
- Ostomy supplies;
- Topical fluoride products;
- Non-systemic prescription contraceptives;
- Growth hormones; unless pre-authorized;
- Implantable, time-released medications;
- Injectibles;
- Charges for the administration or injection of any drug;
- Biologicals/Vaccines/Immunization agents;
- Plasma/Blood Products (except hemophilia factors);
- Allergy serums;
- Any prescription filled in excess of the number specified by the doctor or any refill dispensed after one year from the doctor's original order; and
- Drugs with cosmetic implications.

The 2017 Premium Formulary Exclusions list can be found on the Human Resources website: <http://hr.ua.edu/optumrx-pharmacy-benefits>. This list is subject to change periodically.

Pharmacy Plan Definitions

Brand-name drug (brand drug): A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

Copayment/Coinsurance: A portion of the total cost of the claim that must be paid by the member.

Date of Service: Date on which a prescription is filled or dispensed.

Days Supply: The number of days payable by the plan for the dispensed drug.

Direct Claim: A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement.

Federal Legend Drugs: A drug that requires a prescription; these drugs can be identified by the presence of “Federal Legend” on the label.

Formulary: A list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics committee updates this list regularly based on continuous evaluation of medications. You can contact OptumRx at 1-844-265-1771 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.optumrx.com/myOptumRxRx. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and client name’s costs lower.

Generic Drug: A medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. Generic medications may differ in color, size, or shape, but the Food and Drug Administration (FDA) requires that they have the same strength, purity, and quality as their brand-name counterparts. A generic medication can be produced once the manufacturer of the brand-name medication is required to allow other manufacturers the opportunity to produce the medication.

In-Network Retail Claims: Claims processed by pharmacies that are included in the member’s pharmacy network.

Maintenance Medication: Medications prescribed for long-term use, (i.e., the medication taken daily by high-blood pressure sufferers or diabetics).

Multi Source (Brand) Drug: Medication that may have an FDA generic equivalent substitute available.

Network Pharmacy: A retail pharmacy that has an agreement currently in effect with OptumRx for this Plan to dispense Prescription Drugs to Participants.

Out-Of-Network Claims: Claims processed by pharmacies that do not participate in the member’s pharmacy network.

Over the Counter (OTC Medication): Medication that does not require a prescription.

Out-of-Network Pharmacy: A retail pharmacy that does not currently have an agreement with Medco for this Plan.

Prior Authorization: Review to determine the medical appropriateness of the prescribed medication for your medical condition. It is the process by which a medication or benefit may be covered by ensuring that it is in accordance with the FDA and not primarily prescribed for convenience, etc.

Quantity Management: Review to determine whether the prescribed drug meets product labeling or clinical guidelines for quantity restrictions in order to promote safe and effective drug therapy.

Specialty Drugs: Prescription drugs often referred to as biotech drugs or biologics, which include high cost oral, injectable, and infusion drugs that are administered for specific chronic conditions, such as (including but not limited to) hemophilia, fertility, multiple sclerosis, and rheumatoid arthritis. Visit the most current Formulary Reference Guide with specialty drugs listed at <http://hr.ua.edu/optumrx-pharmacy-benefits>.

Step Therapy: Review process to qualify that a prescribed drug is the preferred initial therapy choice as determined by OptumRx based on your medical history. It is the process by which a medication or benefit may be covered by ensuring that certain criteria have been met (age, sex, condition), and/or prescribed after an alternate therapy or course of treatment has failed or is inappropriate, etc.

Pharmacy Claims and Appeals

Determinations on prescription drug benefits under the plan will be made by OptumRx in accordance with the plan. The plan has the right to deny coverage if it does not meet medical necessity as determined by OptumRx's Prior Authorization criteria. You may request coverage beyond your plan's standard benefit offering, or if you are dissatisfied with a benefit determination made by OptumRx, you may appeal the determination in writing to OptumRx. OptumRx's appeals process for administrative and clinical denial is structured to follow the requirements as described below.

You have the right to appeal any decision that denies payment for an item or service (in whole or in part). You may also submit written comments, documents, or other information relevant to the appeal.

Who may file an appeal?

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney, or a friend) may file an appeal. OptumRx Prior Authorization Department reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your authorized representative. Call OptumRx Customer Service at 1-844-265-1771 to request a copy of the "Designated Representative Form".

How do I file an appeal?

You have the right to appeal this medication coverage decision within 180 days from the date of this denial notification. You or your prescriber may obtain appeals information, including independent appeal rights, by calling OptumRx Prior Authorization Department at 800-626-0072. You can also review your plan's prescription drug benefit information or contact your benefits office for more detailed information regarding the appeal process.

In order to file an appeal, and provide additional information about your request, please send any written comments, documents or other relevant documentation with your appeal to the address listed below:

OptumRx Prior Authorization Department
P.O. Box 5252
Lisle, IL 60532

Phone: 800-626-0072
Fax: 866-511-2202

How long does the appeals process take?

If you proceed with the appeals process, OptumRx Prior Authorization Department will review the denial decision and provide you with a written determination explaining why the initial denial decision was upheld within 15 calendar days from the receipt of the appeal request.

For second level internal appeals, OptumRx Prior Authorization Department will review the denial decision and provide you with a written determination explaining why the initial denial decision was upheld within 15 calendar days from the receipt of the appeal request.

Please note that if you receive a denial after requesting a second level internal appeal, you will have exhausted all levels of internal appeal.

If any of the following occurs, you may be able to request an external review of your claim by an independent third party, known as an Independent Review Organization (IRO), who will review the denial and issue a final decision, if

- You do not receive a timely decision, or
- If OptumRx continues to deny the payment, coverage, or service requested after the final level of internal appeal, or if
- OptumRx does not adhere to certain legal requirements regarding claims procedures.

What if my appeal request is urgent?

If your situation meets the definition of urgent under the law, your review will be expedited. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your prescriber; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If you believe your situation is urgent, you may request an expedited appeal by calling OptumRx Prior Authorization Department at 800-626-0072.

You will be notified of the result of your expedited appeal within 72 hours from the receipt of your appeal request. If you are in an urgent situation and receiving an ongoing course of treatment, you may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

External Review Process

What is an external review?

An external review is a complete reexamination of your case by an Independent Review Organization (IRO).

Who may file an external review?

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney, or a friend) may file an external review. OptumRx Prior Authorization Department reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your authorized representative.

How do I file an external review?

To file an external review, you must send OptumRx Prior Authorization Department a letter within four months of receiving the final denial decision letter (or if you meet the situation above under "What if my appeal request is urgent?") and explain the reason for your disagreement with this denial decision.

You are not required to bear any costs, including filing fees, when requesting a case be sent for an external review by an IRO.

OptumRx Prior Authorization Department will forward your letter and the entire case file to the IRO within five business days of receipt of information, or within two business days of receipt of information for an expedited external review.

Upon receipt of the necessary information, the IRO will timely notify you of your request's eligibility and acceptance for external review. You may submit (in writing) additional information that the IRO must consider when conducting the external review within 10 business days from the date of receipt of this notice.

The IRO will provide you a written notice of the final external review decision within 45 calendar days after the IRO receives the request for the external review, or within 72 hours for urgent requests. If the IRO overturns the denial, OptumRx Prior Authorization Department will authorize or pay for the services in question.

In order to file an external appeal, and provide additional information about your request, please send any written comments, documents or other relevant documentation with your appeal to the address below:

OptumRx Prior Authorization Department
P. O Box 5252
Lisle, IL 60532

Phone: 800-626-0072
Fax: 866-511-2202

What if my External Review request is urgent?

You may request an expedited external review by contacting OptumRx Prior Authorization Department within four months of the date of this notice by calling 800-626-0072 or by faxing 866-511-2202.

Other Resources to Help You

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a state consumer assistance program or ombudsmen may be able to help you. Please refer to the U.S. Department of Labor's Technical Release 2011-01 for a list of available consumer assistance programs and ombudsmen in your state, which is available at <http://www.dol.gov/ebsa/newsroom/tr11-01.html>.