Cedars-Sinai MedImpact Prescription Drug Benefit

July 1, 2021

ATTACHMENT 4—MedImpact Prescription Drug Benefit

This prescription drug benefit booklet is part of the Cedars-Sinai Medical Center Health and Welfare Plan Summary Plan Description (SPD). This booklet describes prescription drug benefits and claim payment procedures for employees enrolled in the Blue Cross HMO or Blue Cross PPO medical benefit plans. Additional provisions are described in the Wrap-Around Summary Plan Description for the Cedars-Sinai Medical Center Health and Welfare Plan ("Wrap SPD"). This booklet and the Wrap SPD together constitute the SPD for the prescription drug benefits under the Blue Cross PPO and Blue Cross HMO medical benefit plans.

BENEFIT RESOURCES

For Information About...	Contact...
• Prescription drug benefits and claims • Questions about medications and the formulary • Finding an in-network retail pharmacy	**MedImpact** Phone: 800-788-2949 (English) Fax: Appeals Coordinator 858-790-6060 Web: medimpact.com Pharmacy Locator: medimpact.com
• Mail order prescriptions	**MedImpact Direct Mail-Order Pharmacy** Phone: 855-873-8739 (TTY dial 711) Email customerservice@medimpactdirect.com Web: medimpactdirect.com App: Search "MedImpact Direct Pharmacy"
• Specialty medications	**MedImpact Direct Specialty Program** Phone: 877-391-1103 (TTY dial 711) Email: specialtyservicecenter@medimpactdirect.com
• Eligibility and enrollment for healthcare (including medical and prescription drug benefits) • General benefit questions	**MBC HR Employee Benefits Help Desk** PO Box 601719 Dallas TX 75360-1719 Phone: 888-302-3941 Fax: 206-299-3158 Email: mbc.cshs@milliman.com Web: Cedars-Sinai.MyBenefitChoice.com Hours: Monday–Friday 5 a.m.–5 p.m. PT (Closed major holidays)

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ELIGIBILITY AND ENROLLMENT

If you're eligible and enrolled in the Cedars-Sinai-sponsored Blue Cross PPO or Blue Cross HMO medical benefit plan, you're automatically covered under this prescription drug benefit. (There's no separate enrollment for prescription drug benefits.) If you have questions about eligibility and enrollment in medical benefits or your legal and ERISA rights, see the Healthcare, Insurance, HealthFund and Flexible Spending Account Benefits Summary Plan Description, or contact the MBC HR Employee Benefits Help Desk.

Note: If you are enrolled in the Anthem Vivity HMO medical plan, the information in this booklet does not apply to you; see your Vivity HMO booklet for details about your plan's prescription drug benefits.

Questions about your benefits?

Contact the MBC HR Employee Benefits Help Desk

Phone:	888-302-3941 Monday–Friday 5 a.m.–5 p.m. PT (Closed major holidays)
Fax:	206-299-3158
Email:	mbc.cshs@milliman.com
Web:	Cedars-Sinai.MyBenefitChoice.com

MEDICARE DRUG PLAN CREDITABLE COVERAGE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, you may have the right to get coverage through a Medicare drug plan when your Cedars-Sinai or employer-sponsored coverage ends. You receive a notice about these rights when enrolling in benefits the first time and each year in your Open Enrollment packet.

If your Cedars-Sinai medical (including prescription drug) coverage ends and you are eligible to enroll for Medicare, please contact the MBC HR Employee Benefits Help Desk to obtain a personalized Medicare drug plan creditable coverage notice right away. When you enroll in a Medicare drug plan, you may be required to provide a creditable coverage notice to show that you maintained creditable coverage and are not required to pay a higher premium.

The Prescription Drug Benefit is administered by MedImpact Healthcare Systems, Inc.

USING THE PRESCRIPTION DRUG BENEFIT

GETTING PRESCRIPTIONS FILLED

Prescription medications are covered only at MedImpact network pharmacies or through the MedImpact Direct mail-order pharmacy. The MedImpact retail pharmacy network is large and includes Rite Aid, Ralphs, Walgreens, Target, CVS, Vons and more. Specialty medications are covered only through the MedImpact Direct specialty program.

Prescriptions filled elsewhere ARE NOT COVERED.

Benefits are the same in or out of California, as long as you find a MedImpact participating pharmacy. For assistance in finding a participating pharmacy, call MedImpact at 800-788-2949 or visit MedImpact's pharmacy locator portal.

MedImpact Network Pharmacies

When you purchase prescriptions from any participating MedImpact network pharmacy, you'll show your MedImpact ID card and pay only the required copay or coinsurance for covered medications. You won't need to file a claim. (If you participate in the HealthFund or healthcare flexible spending account, keep your receipt for reimbursement and/or substantiation of your copay/coinsurance.)

To find out if a pharmacy is in the MedImpact network, contact MedImpact:

Phone: 800-788-2949

Web: medimpact.com

90-Day Supply for Ongoing Medications

If you (or your covered family member) take ongoing maintenance drugs, you can get a 90-day supply through a MedImpact network pharmacy or the mail service program through MedImpact Direct. Remember to ask your doctor to write the prescription for a 90-day supply. For new prescriptions, three 30-day fills will be required to ensure effectiveness before 90-day maintenance fills can begin.

MedImpact Direct Mail-Order Pharmacy

You will need a 90-day supply prescription for your first custom delivery order. If you have your order shipped via standard delivery, you should receive your prescription within 10 days.

You have three options to start a mail-order prescription:

- **Option 1** — Ask your doctor to email your prescription to customerservice@medimpactdirect.com or fax it to 888-783-1773. Pharmacy staff will call you to get your approval before shipping your prescription.
- **Option 2** — Mail in your paper prescription, a completed order form (which you can download from medimpactdirect.com/GettingStarted and your payment to MedImpact Direct.
- **Option 3** — Call MedImpact Direct at 855-873-8739.

Once your first order is received and processed, you can register online at medimpactdirect.com to order refills and customize delivery options for future orders.

COPAY/COINSURANCE AMOUNTS

You pay the following amounts if your prescription complies with program coverage rules (including use of generics and prior authorizations, where required); the program pays for the rest.

	Blue Cross PPO		Blue Cross HMO	
MedImpact Rx Benefit	**MedImpact Retail Network Pharmacies and MedImpact Direct Mail Order**			
	30-Day Supply (retail only)	90-Day Supply (retail and mail order)	30-Day Supply (retail only)	90-Day Supply (retail and mail order)
Maintenance medications (Specified)	$0	$0	$0	$0
Generic*	$5	$10	$5	$10
Brand formulary*	25% maximum $30	25% maximum $60	$20	$40
Brand nonformulary*	30% maximum $60	30% maximum $120	$35	$70
Specialty	$50	Not covered	$50	Not covered
Out-of-pocket maximum**	$3,600/person $4,450/family (Rx only)		$6,100/person $11,700/family (Rx only)	

*These two rules apply:

- If the cost of the drug is less than the copay, you pay the cost instead.
- If you request a brand drug when a generic is available, you pay the brand formulary or brand nonformulary copay (whichever the case may be), plus the difference between the brand drug cost and generic drug cost. (In this situation, the cost could be more than the maximum listed above.)

** If you use a coupon on a medication, only the amount you actually pay out-of-pocket will be applied toward the out-of-pocket maximum.

In addition, the following two programs have a $0 copay:

- MedNetwork® Vaccine Program
- Pre-Exposure Prophylaxis (PrEP) for eligible individuals at high risk of HIV (Affordable Care Act mandate).

MEDIMPACT DIRECT CUSTOMER SERVICE

MedImpact Direct Mail-Order Pharmacy

Phone: 855-873-8739 (TTY dial 771)

Email: customerservice@medimpactdirect.com

Web: medimpactdirect.com

App: Search "MedImpact"

You can get a mail-order form by calling customer service or online at medimpactdirect.com/gettingstarted.

MedImpact Direct Specialty Program

Phone: 877-391-1103 (TTY dial 771)

Email: specialtyservicecenter@medimpactdirect.com

MAINTENANCE MEDICATIONS

Maintenance medications for the following conditions are covered at no cost to you ($0 copay). To find out if a specific drug is covered, call MedImpact at 800-788-2949.

Types of Maintenance Medications

Generic Only		Generic or Brand
Angina	High cholesterol	Aspirin
Anticoagulants	Hypertension	Bowel preparations
Anticonvulsants	Immunosuppressives	Breast cancer prevention
Antidepressants	Influenza	Fluoride
Antipsychotics	Malaria	Folic acid
Arrhythmias	Obesity	Immunizations
Asthma	Osteoporosis	Prenatal vitamins
Chemical dependency	Stroke prevention	Smoking deterrents
Diabetes		Women's contraceptives

FORMULARY DRUGS

The prescription drug benefit provides access to a wide array of prescription drugs. These drugs vary in effectiveness and cost, so MedImpact establishes and maintains a formulary (sometimes referred to as preferred drugs). Drugs on the formulary have been designated as preferred by MedImpact through a process that involves their independent Pharmacy and Therapeutics Committee, composed of physicians and pharmacists. The committee ensures that drugs important to covered conditions are included, based on criteria such as

effectiveness, cost, side effects and interaction with other medicines. You'll always pay less for formulary drugs than nonformulary drugs.

To view the formulary, visit medimpact.com.

SPECIALTY DRUGS

To be covered, specialty drugs (such as injectable drugs for rheumatoid arthritis and multiple sclerosis) must be purchased through the MedImpact specialty pharmacy. You can pick up your specialty medication at a MedImpact retail specialty pharmacy or receive your medications via delivery to your home, workplace, physician's office or any other designated location. Contact the MedImpact Direct specialty pharmacy at 877-391-1103 or via email at specialtyservicecenter@medimpactdirect.com to find a network pharmacy location or make delivery arrangements.

See the table on page 3 for your copay or coinsurance amounts.

Drugs that must be injected by a physician in the physician's office are not covered by this prescription drug benefit (see the Blue Cross benefit booklet for coverage information on these drugs).

Manufacturer Coupons Do Not Apply Toward Out-of-Pocket Maximum

In some cases, manufacturers of specialty drugs offer discounts, coupons or similar financial assistance to help cover the cost of a specialty medication. To better manage this assistance, the plan may vary the manufacturer-funded coupons and set them to approximate the maximum of any available assistance programs. In any case, your out-of-pocket cost for a specialty medication will never exceed the copay you would normally pay under the plan.

If you use a coupon on a medication, only the amount you actually pay out-of-pocket will be applied toward the out-of-pocket maximum.

COORDINATION OF PHARMACY CARE—QUANTITY, AGE OR GENDER RESTRICTIONS

Under pharmacy best practices, some types of medications have:

- **Quantity/dosage limits**. To comply with FDA product label indications; prescriptions for these drugs may be limited to a specific number of doses per month or per fill, as well as the number of days' supply you can receive at one time
- **Age restrictions.** Some drugs are approved for adults only
- **Gender restrictions**. Some drugs are approved for males only/females only.

If your prescription not consistent with FDA quantity, age or gender guidelines, MedImpact will not approve the expense without their prior authorization.

STEP THERAPY

Another best practice used is step therapy, a pharmacy program that requires you to try a generic or preferred medication first (Step 1). If that medication is found to be ineffective or your Rx history shows that the generic drug was previously dispensed, then the brand or higher-cost medication can be dispensed (Step 2). Not all nonpreferred or brand medications require step therapy. If your medication is covered under the step therapy program and there is no record of a generic drug previously being dispensed, then you must try the generic first or get prior authorization from MedImpact. (See the next section for instructions.)

To find the recommended prescribing guidelines for medications covered by the prescription drug benefit, visit medimpact.com. (You'll need to sign in or register if this is your first visit to the MedImpact site.)

PRIOR AUTHORIZATION

Prior authorization is necessary for certain drugs when more information is needed to determine if they are covered by the plan, or if a brand drug is prescribed and the generic equivalent has not been demonstrated to be ineffective. The list of covered drugs and medications requiring prior authorization is modified from time to time when new drugs are approved, new clinical indications are discovered or drugs are pulled from the market.

To find out if a medication your physician prescribed requires prior authorization, see the prescribing guidelines for medications covered by the prescription drug benefit posted on medimpact.com. (You'll need to sign in or register if this is your first visit to the MedImpact site.)

To get prior authorization, ask your physician to submit a medication request form describing how your prescription complies with clinical guidelines or why you must have the brand name drug without trying the generic first. Your physician's office may call MedImpact at 800-788-2949 for a medication request form.

If neither you nor your doctor request prior authorization for a drug that requires it, most likely you'll find out at the pharmacy. If the pharmacy contacts MedImpact for prior authorization, MedImpact will fax a medication request form to your physician, and then evaluate the information your physician provides to determine whether the prescription can be covered under the prescription drug benefit.

Additionally, if best practices require that you try certain therapies or medications before taking a particular medication, a MedImpact clinician will contact your doctor to find out if you've tried the preferred treatment first.

If you (or a covered family member) believe MedImpact's decision about whether a medication is covered or the amount the program pays for a medication is incorrect, in whole or in part, it is considered a denied benefit (also referred to as an adverse benefit determination) and you may ask to have the decision re-examined, using the Benefit Claims and Appeals procedures starting on page 12.

AUTOMATIC GENERIC DRUG SUBSTITUTION

To help contain the high cost of prescription drugs, the pharmacy automatically substitutes a generic drug for the prescribed brand drug if a generic is available and can be safely and effectively substituted. If there is no generic equivalent, you'll receive the brand drug and pay the brand formulary or brand nonformulary copay.

If you tell the pharmacist you want the brand drug rather than the generic, you'll pay the brand formulary or brand nonformulary copay PLUS the difference between the brand drug cost and the generic drug cost. When a generic is available, the brand copay will be honored IF your doctor specifically orders a brand medication (and indicates "Do Not Substitute" on the Rx) and is able to provide supporting clinical evidence specifying the reasons why you should not be provided the generic drug.

TIPS FOR GETTING THE MOST OUT OF YOUR PRESCRIPTION DRUG BENEFITS

Ask your doctor about:	Ask your pharmacist about:
• Alternatives to prescription drugs • Lower-cost options in prescription drugs (including generic alternatives) • Side effects of the drug • Interactions the drug might have with your other medicines or supplements • Whether a formulary drug will work for you (if the proposed drug isn't on the formulary) • Whether a formulary drug is available (if the prescription isn't on the formulary)	• What effect this drug will have on other drugs you are taking • Side effects of the drug • How the drug should be stored to maintain its potency • The drug's expiration date (have the date put on the label) • Whether an old medicine is still safe to use, considering its age, method of storage and your current health and other medications

Be sure to take all medications as instructed by your physician and pharmacist.

OPIOID OVERUTILIZATION AND SAFETY CONTROLS PROGRAM

This program is designed to help control the overutilization of prescribed medications, with a primary focus on drugs prone to misuse, addiction and/or overdose.

Through drug utilization controls, the opioid cumulative dosing program seeks to increase patient safety, improve clinical management and reduce fraud, waste and abuse.

OTHER PRESCRIPTION DRUG RESOURCES

For more information about the drugs your doctor prescribes, try these resources:

- medimpact.com
- **Pharmacist at a local MedImpact network pharmacy** — for details on any prescription drug you're taking, including possible side effects or hazardous drug combinations.
- **National Health Information Center at 800-336-4797** — for free health information and referrals.

WHAT'S COVERED

In general, the prescription drug benefit covers most outpatient prescription medications approved by the US Food and Drug Administration (FDA) as well as certain medical supplies. Prescriptions must be:

- Written by an authorized prescriber
- Considered medically necessary
- Not experimental or prescribed in an experimental manner
- For covered participants.

Some medications are covered under the prescription drug benefit only if they are prescribed for a certain use. As a result, some medications must receive prior authorization before they will be covered. Your pharmacist will inform you if a particular medication must receive prior authorization. In some cases, your pharmacist will initiate the prior authorization process for you, but normally your physician must submit a request to MedImpact. You and your doctor will be notified of the determination.

In addition, some medications are subject to dosage and quantity limits.

Unless otherwise excluded, covered prescription drugs and supplies include the following when ordered by an authorized prescriber (subject to any prior authorization, medical necessity and/or other limits):

- Any drug that, under applicable state law, may be dispensed only with the written prescription of a physician or other lawful prescriber
- Birth control prescription products and over-the-counter products for women only are covered with $0 copay when prescribed by a physician
- Bowel preps for men and women between ages 50 and 75 when required for preparation of a colonoscopy
- Blood and urine glucose monitoring strips
- Chemotherapy prescribed for outpatient use
- Compounded medications with at least one legend drug ingredient (only the cost of covered ingredients)
- Erectile dysfunction medications (limited to males and not to exceed 18 pills within a rolling 90-day period)
- Fluoride vitamins, to age 18
- Folic acid for women of child-bearing age (age 18 through 45 years)
- Growth hormones
- Hemophilia drugs, if self-administered
- Insulin
- Insulin syringes when you have an active insulin prescription
- Methadone
- Over-the-counter aspirin for male patients aged 45 to 79 years and female patients age 55 to 79 years, at $0 copay when prescribed by a physician
- Over-the-counter fluoride, at $0 copay, for covered children older than 6 months of age through 18 years of age
- Over-the-counter iron, at $0 copay, if prescribed by a physician for a period of 6 months to 1 year, for those at increased risk for iron-deficiency anemia

- Over-the-counter vitamin D for patients age 65 or over who are not in an assisted living facility, at $0 copay, when prescribed by a physician
- Prescription vitamins, when prescribed for medical conditions of pregnancy and osteoporosis; prenatal vitamins are covered only up to age 50
- Relenza/Tamiflu, up to two treatments per calendar year; Tamiflu is limited to 10 caps in 180 days and Relenza is limited to 10 inhalations over five days
- Smoking cessation methods when prescribed by a physician at $0 copay; all over-the-counter and prescription methods are limited to two 12-week periods (168 doses) per year
- Vaccines recommended by the Centers for Disease Control at $0 copay (visit http://www.cdc.gov/vaccines/acip/index.html for a complete list).

WHAT'S NOT COVERED

Medications that are not filled through a MedImpact network pharmacy or MedImpact Direct mail order ARE NOT COVERED. Specialty medications not filled through the MedImpact Direct specialty program ARE NOT COVERED.

Additional charges that are not covered under the program include but are not limited to:

- Anti-obesity drugs (anorexiants)
- Any drug dispensed for a duration in excess of that allowed by the program
- Any medication that can be obtained without a prescription (except those described under What's Covered)
- Any prescription in excess of a 90-day supply
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
- A prescription drug that is not appropriately provided; a prescription drug is considered appropriately provided if it meets each of the following requirements:
  - An authorized prescriber orders it for the diagnosis or treatment of a sickness or injury.
  - The prevailing opinion within the appropriate specialty of the United States medical profession is that it's safe and effective for its intended use and commonly accepted by medical authorities for the diagnosis.
  - An authorized prescriber with the appropriate training and experience to prescribe the drug furnishes the drug.
- Charges for the administration or injection of any drug
- Charges for which no legal liability would exist without coverage under this program
- Charges incurred before the effective date or after the termination date of participation in this program
- Charges prohibited by any law of the jurisdiction where the participant resides when the expense is incurred
- Cosmetic or dietary supplements; health and beauty aids
- DHEA
- Drugs labeled "Caution — limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual; if one of the following is true, the drug is considered experimental or investigational:
  - The prescription drug is under study or in clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications (clinical trials include but are not limited to Phases I, II and III clinical trials).
  - The prevailing opinion within the appropriate specialty of the United States medical profession is that the drug needs further evaluation for the particular diagnosis or set of indications before it is used outside the context of clinical trials or other research settings.
  - The drug does not have FDA approval or approval is given only under the FDA's Treatment of Investigational New Drug regulation or a similar regulation.

- The drug has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use (an accepted off-label use is based on published reports in authoritative medical literature and entries in the following drug compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information).
- An institutional review board acknowledges that the use of the drug is experimental or investigational.
- Research protocols indicate that the use of the drug is experimental or investigational.

- Drugs obtained outside the United States
- Fertility drugs
- Hair growth drugs used primarily to slow hair loss or promote hair growth
- Homeopathic medications
- Idiopathic short stature drugs
- Injectable drugs that are commonly supplied and injected in a physician's office (as determined by the Prescription Drug Benefit)
- Medication to be taken by or administered to an individual, in whole or in part, who's confined as an inpatient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals
- Non-legend drugs other than insulin, unless listed as covered
- Nonprescription vitamin, mineral or food supplements, except for vitamin D when prescribed for someone 65 or over who is not in an assisted living facility
- Over-the-counter Claritin (even if prescribed by a physician)
- Over-the-counter diabetic supplies (except blood glucose monitoring strips, lancets and syringes are covered)
- Prescriptions that an eligible person is entitled to receive without charge from a workers' compensation program or any municipal, state or federal program
- Therapeutic devices or appliances, including support garments and other non-medicated substances, regardless of intended use, insulin/syringes/needles when prescribed alone, and syringes/needles for other than diabetic use
- Treatment, procedure or drugs for withdrawal from caffeine
- Tretinoin for cosmetic purposes — all dosage forms for individuals 25 or older.

The following sources can be used in determining whether these requirements have been met:

- Published reports in authoritative medical literature
- Regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration
- Listings in the following drug compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information
- Other authoritative medical sources as necessary.

BENEFIT CLAIMS AND APPEALS

The procedures for getting prescriptions filled or seeking reimbursement from MedImpact are explained in Using the Prescription Drug Benefit starting on page 2. Cedars-Sinai (as plan administrator) has delegated responsibility for approving or denying prescription drug claims to MedImpact, which is referred to as the claims administrator below.

Changes During the Coronavirus Pandemic

During the COVID-19 national emergency, some claims and appeals deadlines are extended. For more information, contact MedImpact at 800-788-2949.

If you or your eligible family member has a prescription drug claim denied because of eligibility or enrollment (for example, your new spouse goes to the pharmacy and is told he or she is not covered) contact the MBC HR Employee Benefits Help Desk (phone: 888-302-3941 or email: mbc.cshs@milliman.com) instead of MedImpact. Procedures for eligibility and enrollment denials and appeals are described in the Healthcare, Insurance, HealthFund and Flexible Spending Account Benefits Summary Plan Description.

If you (or a covered family member) have a disagreement about whether a medication is covered or the amount the program pays for a medication, contact MedImpact. If you believe MedImpact's decision is incorrect, in whole or in part, it is considered a denied benefit (or an adverse benefit determination) and you may ask to have the decision re-examined, using the appeal procedures in this section.

Plan	Claims Administrator	Contact information	
Prescription Drug Benefit*	MedImpact Healthcare Systems, Inc. Attn: Appeals Department 10181 Scripps Gateway Ct. San Diego, CA 92131	Phone: Fax: Web:	800-788-2949 Appeal Coordinator: 858-790-6060 medimpact.com

* Although this benefit is self-insured, as claims administrator, MedImpact has ultimate and final discretionary authority to determine benefit claims. See the Wrap-Around Summary Plan Description for the Cedars-Sinai Medical Center Health and Welfare Plan for details about eligibility.

As claims administrator, MedImpact processes benefit claims and appeal requests according to its policies and procedures and applicable state and/or federal statutes and regulations. The claims administrator reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Terms Used in Benefit Claims and Appeals Section

A **claim** is a request for payment. When you give a prescription to a pharmacy to be filled, the pharmacy then sends the prescription to the claims administrator for approval and payment. This is a claim.

If the claims administrator does not approve the filling and payment of the prescription, it's a **denied claim**. The terms "benefit denial" and "adverse benefit determination" are denied claims.

An **appeal** is a request to the claims administrator to have the decision not to approve and pay for your prescription reconsidered.

TYPES OF CLAIMS AND TIMING

The claims administrator decides if a medication is approved and paid by the prescription drug benefit (or not). If your claim is denied and you file an appeal, the claims administrator has two processes for reviewing the claim:

- **Clinical.** Where medical judgment was used or coverage was retroactively rescinded. Denied clinical reviews have two levels of appeals:
  - Level 1 Internal review
  - Level 2 External review
- **Administrative.** Where no medical judgment is needed, such as the drug is or is not covered. Administrative claims are eligible for only Level 1 Internal review.

The prescription drug benefit claims and appeal procedures (and deadlines) are based on when you are notified that the prescription drug benefit will not pay for the prescription—before, during or after you've received the medication—and the urgency of the situation.

Before: Standard Preservice Claims

Most prescriptions are preservice claims because the claims administrator notifies the pharmacy if the prescription will be approved and the claim is paid (or not) before you receive the drug.

In addition, prior authorization is required before the prescription drug benefit pays for some medications or for exceptions to quantity, age or gender limits. If you are required to get prior authorization from the claims administrator, it's considered a preservice claim.

Non-urgent preservice claims will be reviewed using the standard review time frames (as outlined starting on page 16).

Before: Urgent Preservice Claims

The preservice claims will be reviewed using the urgent review time frames if the claim has to be decided more quickly because a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that, in the opinion of the attending healthcare provider, could cause severe pain that cannot be managed without the requested treatment.

All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you or your attending professional by telephone, facsimile or other similar method.

Usually the claims administrator determines if urgent review is required. However, the claims administrator will defer to the attending provider's determination of whether a claim is urgent care.

During: Concurrent Review

If a previously-approved treatment or prescription is reduced or terminated, the claims administrator will notify you sufficiently in advance to give you an opportunity to appeal and obtain a decision on appeal before the reduction or termination takes effect. (There is no legally defined time frame for these situations.)

If you request to extend ongoing treatment in a non-urgent care situation, your request will be considered a new claim and decided according to the preservice (standard review) or postservice time frames, whichever applies; if it's an urgent situation, the preservice (urgent review) time frames will be used.

After: Postservice Claims

When you request payment of the benefits after the prescription drug has been received. In theory this should never happen, since you are required to use network pharmacies and network pharmacies submit claims for you. However, in some cases you might have a prescription filled when the pharmacy does not submit your prescription to the claims administrator (requiring you to pay the entire cost out-of-pocket) on your behalf, and you would then have to submit a claim form for reimbursement to the claims administrator.

Claims Type Change

The claim type is determined initially when the claims administrator first receives the prescription. However, if the urgency claim changes as it proceeds through the review and/or appeal process, it may be re-characterized. For example, a claim may initially be urgent. If the urgency lessens, it may be re-defined as a standard preservice claim.

AUTHORIZED REPRESENTATIVES

A representative may act on your behalf under these claims procedures.

If you receive a benefit denial (administrative) or adverse benefit determination (clinical) on your claim, either you or your representative may ask for an appeal (ask the claims administrator to reconsider its decision).

Who is your representative?

- For urgent appeals, a healthcare professional with knowledge of your situation is always deemed to be acting as your representative.
- For standard preservice and post-service appeals, the treating healthcare professional will be deemed to be acting as your representative.

If you do not authorize the healthcare professional to appeal the decision on your behalf, you may reject the representation and withdraw the appeal.

If you do not object to the representation, or if you authorize another person or healthcare professional to represent you to the conclusion of the appeal process, you will have exhausted your appeal rights. (You and your representative are using your appeal rights; your representative does not have his/her own appeal rights.)

Your representative must be identified and their authority to act on your behalf must be verified. If your representative is asking for an appeal on your behalf, contact the claims administrator at the number on page 12 for the authorization procedures.

In these appeal procedures, "you" means both you and any representative acting on your behalf.

DENIAL OF INITIAL PRESCRIPTION DRUG BENEFIT

The following situations are common examples of claims denials. The claims administrator uses the term "benefit denial" for administrative review/appeals and "adverse benefit determination" for clinical review/appeals.

- **At the in-network pharmacy.** If the pharmacist or pharmacy staff tells you a medication is not covered or in some way does qualify to be paid by the pharmacy benefit.
- **At an out-of-network pharmacy.** If you try to have your prescription filled at an out-of-network pharmacy, it will not be covered. Only prescriptions filled at network pharmacies are covered.
- If your **Prior Authorization request is denied**.

- **If the pharmacist or pharmacy staff tells you they must have Prior Authorization** from the claims administrator to fill your prescription, or if other information is needed to fill your prescription, it's considered an "incorrectly filed claim." You will be notified in person or by telephone (unless you request written notice) of what you must do to have the prescription drug benefit pay for the prescription (such as, get prior authorization or provide specific information). You must be notified you have an "incorrectly filed claim" within:

Preservice (Urgent)	Preservice (Standard)	Post Service
24 hours	5 business days	N/A

Your deadline for submitting the additional information to the claims administrator will be no less than:

Preservice (Urgent)	Preservice (Standard)	Post Service
48 hours	45 calendar days	N/A

If you don't submit the specified information by the deadline, your claim will be denied.

Initial Claims Denial Time Frames

If the prescription drug benefit will not pay for the prescription, the claims administrator will notify you about the benefit denial/adverse benefit determination as soon as possible, but in no more than...

Preservice (Urgent)	Preservice (Standard)	Post Service
72 hours	15 calendar days	30 calendar days

... from when the claims administrator received the claim (for example, when the pharmacy submitted the prescription to the claims administrator for approval).

The non-urgent deadlines (above) may be extended up to 15 days if matters beyond the claims administrator's control require extension and you are notified within the original 15-day or 30-day period.

Preservice (Urgent)	Preservice (Standard)	Post Service
No extension permitted	15 calendar days (30 days total)	15 calendar days (45 days total)

Notification of Claims Denial

For all types of denied claims, the claims administrator will send you a written notice of the benefit denial/adverse benefit determination, which includes:

- Decision and specific reason for the denial
- Information sufficient to identify the claim involved
- Reference to the language in the plan, summary plan description, certificate of coverage or other plan benefit document on which the decision is based, as appropriate
- Information about any internal rule, guideline, protocol, standard (such as medically necessary) or other similar criterion relied upon in making the determination, or a statement about your right to request a copy of this information free of charge

- If used in the decision, an explanation of any scientific or clinical judgment and how it applies to the plan and your benefit claim, or a statement about your right to request a copy of this information free of charge
- A description of the review procedures and the time limits that apply to them, external review rights and how to request external review, the right to obtain information about claims procedures and the right to sue in federal court after exhausting the Rx benefit claims procedures
- Upon request, the availability of translated notices (in Spanish, Tagalog or Navajo).

If additional information was requested:

- A description of any additional material or information needed to process your claim
- An explanation of why the additional material or information is needed.

Urgent preservice claims also include:

- A description of the urgent review process. Note that claims involving urgent care can also be provided orally, so long as you are provided with written notification not later than three days after the oral notification.

LEVEL 1 APPEALS

If you receive a benefit denial (administrative) or adverse benefit determination (clinical) on your claim, you may ask the claims administrator reconsider its decision by filing a Level 1 appeal. You can submit an appeal in writing or orally by contacting the claims administrator at the phone number listed on page 12:

- **Writing.** The claims administrator will send their Appeal Form to you or your representative to complete and return.
- **Orally**. The claims administrator's appeal coordinator will have an Appeal Form faxed to your physician to begin the appeal process.

You will need to provide the following information:

- The PA reference number (from the denial letter)
- Claimant (who the drug was prescribed to) name and contact information
- Group Name: Cedars-Sinai
- Attending provider's name and contact information
- Date(s) the drug was denied
- The prescription information (drug name, strength, quantity, duration)
- If an authorized representative filing the claim, name and contact information
- If requesting an urgent review, any reasons why the appeal should be processed on an urgent basis.
- If the time frame qualifies as an Expedited Preservice Claim (described on page 13) you may request an urgent review using urgent time frames. Usually the claims administrator determines if urgent review is required. However, the claims administrator will defer to the attending provider's determination of whether a claim is urgent care.

Appeal Filing Deadlines

If you are notified that previously-approved medications will be reduced or terminated, you must file your appeal within 30 calendar days after notification.

In all other situations, you must file your appeal within **180 calendar days** after you are notified of the denial. If you miss these deadlines, you forfeit your right to further review of an adverse decision under these procedures or in a court of law.

Submitting Additional Information

You may submit written comments, documents, records and other information supporting your claim. The claims administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination. If the claims administrator receives additional information after the appeal is decided and the notice is sent, the information will be considered in the next appeal level, if applicable.

If new information indicates the medication should be covered, the claims administrator may reverse a benefit denial/adverse benefit determination at any point in the appeal process. If this happens, the claims administrator will not complete all of the steps or follow the time frames stated in the appeal process.

You have the right to review the claim file. The claims administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with your claim. In addition,

before you receive an adverse benefit determination on review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale.

In a case involving urgent care, you may request an urgent review orally or in writing, and all information may be transmitted by telephone, fax, email or other expeditious method.

Level 1 Appeal Review

When considering your appeal, the reviewer(s) will not rely upon the initial benefit determination. The appeal will not be conducted by a reviewer who was involved in the initial determination or who works for the person who made the initial determination.

Clinical Appeals

Level 1 clinical appeals are reviewed by a clinical pharmacist reviewer using appropriate medical criteria and clinical guidelines. If the reviewer consults a clinical peer, he or she will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. All clinical appeals are decided by a clinical pharmacist reviewer/clinical peer (with the approval of the claims administrator). Any medical or vocational experts whose advice was obtained on behalf of the plan will also be identified.

Administrative Appeals

Administrative appeals are reviewed by the Administrative Review Committee, which is made up of prior authorization and utilization management staff; one member must be a pharmacist or physician. They review the relevant documentation to determine if the medication is covered by the prescription drug benefit.

Notification of the Level 1 Appeal Outcome

The claims administrator will notify you of the outcome of the appeal as soon as possible, but not later than:

Preservice (Urgent)	Preservice (Standard)	Post Service
72 hours	15 calendar days	30 calendar days

... from when the claims administrator received the level 1 appeal.

Appeal Denial

If upon review the claims administrator decides that the original decision was correct, that is considered a denied benefit (administrative appeals) or adverse benefit determination (clinical appeals). The notification from the claims administrator includes all of the information described in Notification of Claims Denial on page 16.

If you believe the claims administrator's decision on your clinical appeal was wrong, you may request an external review. This level of review is not available for administrative appeals.

LEVEL 2 CLINICAL APPEALS: EXTERNAL REVIEW

If your level 1 clinical appeal agrees with the initial adverse benefit determination, you may request an independent external review. The level 2 appeal will be conducted by an external reviewer from a contracted Independent Review Organization (IRO). The claims administrator contracts with at least 3 IROs. The reviewer will be selected on a rotating basis from one of the three IROs.

You can make an appeal in writing or orally by contacting the claims administrator at the phone number listed on page 12. Your request must be filed within 4 months after the date of receipt of the benefits denial notice:

- **Writing:** The claims administrator will send their Appeal/Grievance Form to you or your representative to complete and return.
- **Orally**: The claims administrator's appeal coordinator will have an Appeal Form faxed to your physician to begin the appeal process.

If it's an expedited preservice claim (described on page 13), you may request an expedited review that will follow the urgent time frames.

The claims administrator has the following time frame from the date you file the appeal to determine if the claim is eligible for external review and urgent review (if requested).

Preservice (Urgent)	Preservice (Standard)	Post Service
Immediately	5 business days	5 business days

Level 2 Appeal Filing Deadlines

You have **120 days** from the date the claims administrator issued the adverse benefit determination on your level 1 clinical appeal.

Submitting Additional Information

Upon assignment, the claims administrator will send the IRO the documents and any other information considered in making the level 1 clinical appeal decision as soon as possible, but no longer than:

Preservice (Urgent)	Preservice (Standard)	Post Service
24 hours	5 business days	5 business days

You do not have to resend the information that you submitted for level 1 clinical appeal. However, you are encouraged to submit any additional information that you think is important for review within the following times after you receive a notice of the IRO review:

Preservice (Urgent)	Preservice (Standard)	Post Service
48 hours	10 business days	10 business days

If you send any additional information to the IRO, the IRO will copy and forward it to the claims administrator. If based on the new information the claims administrator reverses its decision, you will be notified within one business day, and the IRO will terminate the external review.

Level 2 Appeals Review

The review will be conducted by a licensed physician or other appropriate healthcare provider who is knowledgeable about the recommended treatments through recent or current clinical experience treating patients with the same or similar condition.

The IRO will review all of the information and documents received. In making its decision, the IRO is not bound by the claims administrator's prior determination.

Notification of the Level 2 Appeal Outcome

The IRO will provide written notice of the final external review decision as soon as possible, no longer than the following time frames after the IRO receives the request for external review:

Preservice (Urgent)	Preservice (Standard)	Post Service
72 hours	45 calendar days	45 calendar days

If an urgent review, the claims administrator will notify you orally as soon as possible, followed by a written notice within 72 hours.

In addition to the information listed under Notification of Claims Denial on page 16, the notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

If the final external review decision reverses the claims administrator's level 1 claims appeal decision, the claims administrator will follow the final external review decision of the IRO.

LEGAL ACTIONS AGAINST THE PLAN

You have the right to file a legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). However, before doing so you are required to exhaust:

- Level 1 of the administrative appeal process
- Level 1 (internal) and level 2 (external independent review, if applicable) of the clinical appeal process.

You may not take legal action more than two years from accrual of the cause of action.

The claims administrator has full discretionary power and authority to interpret the plan and its rules, and to determine questions of eligibility and claims for benefits. To the extent permitted by law, the decision of the claims administrator will be final and binding on all parties.

DEFINITIONS

Allowed amount. Maximum amount on which payment is based for covered healthcare services. This amount is based on the minimum guaranteed contracted rate agreed upon by Cedars-Sinai and MedImpact. If an out-of-network pharmacy charges more than the allowed amount, you may have to pay the difference.

Appeal. A request to the claims administrator to have the decision not to approve and pay for your prescription reconsidered.

Brand-name drug. A drug that possesses a trademark, usually descriptive of its chemical makeup. A particular pharmaceutical company markets and sells the brand-name product. There may be a patent or other form of market exclusivity for the drug and while this condition exists, the product cannot be copied or duplicated without authorization.

Claim. A request for payment. When you give a prescription to a pharmacy to be filled, the pharmacy then sends the prescription to the claims administrator for approval and payment. This is a claim.

Denied claim. If the claims administrator does not approve the filling and payment of the prescription, it's a denied claim. The terms "benefit denial" and "adverse benefit determination" are denied claims.

Coinsurance. The percentage of the allowed amount you pay for covered drugs or supplies.

Copay. The dollar amount you pay for covered drugs or supplies.

Generic drug. The pharmaceutical equivalent of a brand-name drug, usually sold under its pharmaceutical name. A-rated generic drugs can be expected to provide the same results as their corresponding brand-name equivalents. Generic manufacturers sell products at a lower price because of the competition created by more than one supplier of the drug.

Legend drug. Any drug federal law requires to be labeled: "Caution: Federal law prohibits dispensing without a prescription."

Maintenance drug. Prescription drug used for treatment of chronic medical conditions, such as diabetes, hypertension and heart disease.

MedImpact ID card. An ID card that allows you to use a MedImpact network pharmacy to purchase prescription drugs and pay only the copay or coinsurance for covered drugs.

MedImpact network pharmacy. A pharmacy that agrees to participate in MedImpact's retail pharmacy network, where you receive lower prices and have no claim forms to fill out.

Formulary drug. A drug selected by MedImpact based on criteria such as clinical effectiveness and cost and listed on the MedImpact formulary.

Prior authorization (or prior approval). The process for obtaining certain drugs only after prior approval (which is administered by MedImpact).

Specialty drug. Covered drug that must be purchased from a MedImpact specialty pharmacy and used at home; examples include injectable drugs for rheumatoid arthritis and multiple sclerosis. Drugs that must be injected by a physician in his/her office are not covered by this prescription drug benefit (see the Blue Cross medical benefit booklet for coverage information on these drugs).

LEGAL AND ERISA INFORMATION

Under the Employee Retirement Income Security Act of 1974 as amended (ERISA), you are entitled to certain information about your benefits. Including:

- A summary of your rights under ERISA
- Other information required by ERISA
- Additional legal information that affects your benefits and your rights to benefits.

This booklet describes only prescription drug benefits and claim payment and appeal procedures. Legal and ERISA information is described in the Healthcare, Insurance, HealthFund and Flexible Spending Account Benefit Summary Plan Description. Please see that document for information about:

- Eligibility and enrollment. You don't enroll in the Prescription Drug Benefit; if you are eligible and enroll in the Cedars-Sinai-sponsored Blue Cross HMO or Blue Cross PPO medical benefits plan, you're automatically covered under this program.
- When you leave Cedars-Sinai, or your eligible family members' medical coverage ends, you may be able to continue coverage under the Silver Passport program, COBRA, Cal-COBRA or purchase coverage through a state or the federal healthcare marketplace.
- If currently Medicare-eligible or you will be eligible for Medicare in the next 12 months, you may be eligible for Medicare drug coverage. See the Medicare Drug Plan Notice of Creditable Coverage in the beginning of this document and included in your Open Enrollment packet or contact the MBC HR Employee Benefits Help Desk (888-302-3941) for more information.
- Coordination of payments if you are covered under another health plan that covers prescription drug benefits (such as your spouse's employer's plan or Medicare).
- Third party liability. If you are injured, become ill, need medical care or prescription drugs or die because of an accident and someone else is legally liable for the bills, your Cedars-Sinai benefits will cover the expenses (as described in this booklet), but this benefit plan (or party paying the benefits) will have all the rights of recovery you have against the responsible party.
- HIPAA privacy rights.
- ERISA rights legal information.