Reference Document
Summary Plan Description

About MedImpact and Contact Info

The prescription drug program for State of Colorado Plan participants is administered by MedImpact Healthcare Systems, Inc. ("MedImpact") This is only a summary of the key parts of the Plan. You may contact MedImpact toll free at: 888-783-1774, or you may visit the MedImpact website at: www.medimpact.com for more details about the applicable copays and drug coverages under your plan benefits.

How to Fill Prescriptions

You have multiple ways to fill your prescriptions depending on your medication needs.

Retail Pharmacy Benefit

For covered prescription drugs obtained at an in-network retail pharmacy, State of Colorado will provide coverage for up to a 90-day supply per dispensing (standard supply), subject to the cost share listed in the **Copay Grid**.

Reference the Medical SPD for:

Eligibility & Termination specifics
Coordination of Benefits
COBRA Continuation Rights

When you use a participating MedImpact network Pharmacy your copay will depend on the type of drug; there are three tiers of drugs as well as Specialty Drugs, each with different copays. To receive your benefit, you may use Birdi, MedImpact's mail-order program, or go to a drug store that accepts your Medical ID card. To find a participating drug store near you, contact MedImpact by phone or visit the website. Prescriptions purchased at out-of-network pharmacies are not covered.

Members may use pharmacy discount programs such as GoodRx, however, any medications purchased using those programs will not count towards your deductible or out-of-pocket maximum.

- Tier 1 – Generic Drugs you will generally pay the lowest copay.
- Tier 2 – Preferred Brand-Name Drugs are Brand-Name Drugs that are on the Premium Formulary. You will pay a mid-level copay for cost-effective, preferred brand-name drugs.
- Tier 3 – Non-Preferred-Brand-Name Drugs – you will pay a higher copay for non-preferred brand-name drugs.
- Tier 10 – Preventive Drugs – Drugs that are available to members at no cost.
- Specialty Drugs – Drugs that are not covered at a retail pharmacy and must be purchased through MedImpact's Specialty Pharmacy.

What are Preventive Drugs? (Tier 10)

Preventive drugs are considered to be used for preventive purposes if they are being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered.

Please note, in order to get coverage at no cost for preventive care medications and products you will need a prescription from your doctor. Some products may be subject to clinical review and require a Prior Authorization before the $0 cost share applies.

See the Premium Preventive Drug List by going to https://dhr.colorado.gov/state-employees/state-employee-benefits/medical/cigna-medical and looking at the "No-Cost Preventative Care Medications" link. You can check specific medications at MedImpact.com using the "Drug Pricing" search bar at the top of the home page.

What are Generic Drugs? (Tier 1)

Generic Drugs are approved to be as safe and effective as their brand name counterparts, and on average cost 50% less than brand name drugs. Generic Drugs contain the same active ingredients and are available in the same strength and dosage form as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) regulates the manufacture of all Generic Drugs, which helps ensure their strength, quality and purity. The FDA also requires Generic Drugs to be absorbed into the body at the same rate and to the same extent as the branded product, which ensures that generic and branded products provide the same effectiveness in children, adults, and the elderly. See "definitions" appendix for detailed explanation of Generic Drugs.

What are Preferred Brand-Name Drugs? (Tier 2)

Preferred brand-name drugs are a selected list of medicines on the MedImpact Preferred Drug List that are clinically appropriate and cost-effective to meet individual needs. This list is commonly referred to as the "formulary" drug list. You can view MedImpact Preferred Drug List by logging onto www.medimpact.com. You may want to download the MedImpact mobile app, available on App Store and Google Play, or print a copy of the drug list and take it to your physician the next time you need a prescription. If a generic isn't available for your prescription, ask your physician to prescribe a preferred brand-name drug from the list, if appropriate for your needs. See "definitions" appendix for detailed explanation of brand drugs and Formulary.

What are Non-Preferred Brand-Name Drugs? (Tier 3)

These are brand-name drugs that aren't part of the MedImpact Preferred Drug List and will require you to pay a higher co-payment than a preferred or Generic Drug. Other limitations for coverage of certain conditions are shown in the Medical plan document as "Exclusions."

What are Specialty Drugs/ Limited Distribution Drugs (LDD) (Tier 4)

Specialty drugs are a selected list of medicines on the MedImpact Specialty Drug List that are approved for rare and/or complex medical conditions. They require special handling, administration, and monitoring. They typically require prior approval before your plan will help pay for them. These drugs must be filled through MedImpact's Specialty Pharmacy. For information on Specialty medications you can email SpecialtyServiceCenter@medimpactdirect.com. For security and privacy reasons, please do not include any personal health information. For other questions, call MedImpact at 1-877-391-1103 (TTY dial 711), 8 am to 8 pm Eastern Time, Monday-Friday.

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How Does "Dispense as Written" (DAW) Work?

If you are on a Copay Plan, your physician may prescribe your medication with a note to Dispense as Written. This means no generic substitutions are allowable and you will pay the Tier 1 copay plus the cost difference between Brand Drug and Generic Drug. The amount you pay to make up the difference between the Brand Drug and Generic Drug does not count towards your deductible or Out-of-Pocket Maximum. You will continue to pay the difference even after you meet your Out-of-Pocket Maximum.

If you are on the HDHP, your physician may prescribe your medication with a note to Dispense as Written. This means no generic substitutions are allowable and, you will pay the full cost of the Brand Drug but only the cost of the generic drug will count toward your Out-of-Pocket Maximum and Deductible. After you reach your deductible, you will pay your copay and the difference between the Brand Drug and Generic Drug. The amount you pay to make up the difference between the Brand Drug and Generic Drug does not count towards your Deductible or Out-of-Pocket Maximum. You will continue to pay the difference even after you meet your Out-of-Pocket Maximum.

Note: There is a clinical exceptions process available through MedImpact, if you had an adverse reaction, allergy, or sensitivity to generic equivalent, if you had a failed trial with generic equivalent, or if transitioning to a generic equivalent could result in destabilization or unnecessary risk to you. A clinical exception begins with a Prior Authorization. To start the Prior Authorization process, you or your provider can contact MedImpact at 888-783-1774. If the Prior Authorization is denied then you or your physician may request an appeal using the Appeals Form found at https://www.medimpact.com/members/ContactUs.

What are Non-Formulary/Excluded Drugs?

These are drugs that the plan does not cover. You may request that the plan cover a Non-Formulary/Excluded Drug using the appeals process discussed below.

Mail Order Pharmacy Benefit

The Plan utilizes Birdi as the mail order pharmacy. To set up mail order services, visit www.medimpact.com or call 855-873-8739 for assistance. State of Colorado will provide coverage for up to a 90-day supply per dispensing (standard mail order supply), subject to the cost share listed in the **Copay Grid**.

Specialty Pharmacy Benefit

The Plan utilizes MedImpact Direct Specialty® as the specialty pharmacy. To set up specialty services visit www.medimpact.com or call 877-391-1103 for assistance. State of Colorado will provide coverage for up to a 30-day supply per dispensing (standard supply), subject to the cost share listed in the **Copay Grid**.

MedImpact Assist® Copay Assistance Program

Accumulator Management

Discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your specialty medications (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not count against your annual deductible or maximum out-of-pocket requirement. Only the amount that you pay separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to your annual deductible and maximum out-of-pocket requirement.

Example:
If your specialty medication costs $100, and you use an $80 coupon and then pay the remaining $20 out of pocket, then only the $20 will apply to your annual deductible or maximum out-of-pocket limits.

Variable Copay

In order for the plan to better manage available manufacturer-funded copay assistance, copays for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to the participant be greater than the maximum copayment published in the Plan Document and Summary Plan Description. Manufacturer-funded copay assistance received will not be credited to your annual deductible or maximum out-of-pocket requirement.

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What You Will Pay

Copay Basic Plan		Fulfillment Channels			
		Retail	Mail	Retail-90	Specialty/LDD
Tier	**Description**	**Copays / Coinsurance**			
1	Generic	$7	$14	$14	$7
2	Preferred Brand	$30	$60	$60	$30
3	Non-Preferred Brand	$60	$120	$120	$60
4	Specialty / Limited Distribution Drugs (LDD)[1]	20% with $120 max	N/A	N/A	20% with $120 max
10	Preventive	$0	$0	$0	$0
Medical/Rx Plan Out-of-Pocket Max		$4,500 individual / $9,000 family (embedded)			

Copay Plus Plan		Fulfillment Channels			
		Retail	Mail	Retail-90	Specialty/LDD
Tier	**Description**	**Copays / Coinsurance**			
1	Generic	$10	$20	$20	$10
2	Preferred Brand	$30	$60	$60	$30
3	Non-Preferred Brand	$60	$120	$120	$60
4	Specialty / LDD[2]	20% with $120 max	N/A	N/A	20% with $120 max
10	Preventive	$0	$0	$0	$0
Medical/Rx Plan Out-of-Pocket Max		$3,500 individual / $7,000 family (embedded)			

[1] If the specialty drug (infusion therapy drugs) is covered under the Cigna medical plan, then if administered in an outpatient facility or at home, then the medical deductible and coinsurance apply. If services are administered in the physician's office (in network) the specialty drug is covered at 100% no deductible, though the medical provider may charge for their services.

[2] If the specialty drug (infusion therapy drugs) is covered under the Cigna medical plan, then if administered in an outpatient facility or at home, then the medical deductible and coinsurance apply. If services are administered in the physician's office (in network) the specialty drug is covered at 100% no deductible, though the medical provider may charge for their services.

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HDHP		Fulfillment Channels			
		Retail	Mail	Retail-90	Specialty/LDD
Tier	**Description**	**Copays / Coinsurance**			
1	Generic	$10	$20	$20	$10
2	Preferred Brand	$40	$80	$80	$40
3	Non-Preferred Brand	$60	$120	$120	$60
4	Specialty / LDD[3]	25% with $120 max	N/A	N/A	25% with $120 max
10	Preventive	$0	$0	$0	$0
Medical/Rx Deductible		$1,750 individual / $3,500 family (embedded)			
Medical/Rx Plan Out-of-Pocket Max		$5,000 individual / $10,000 family (embedded) / $8,000 individual within a family			

Out of Pocket Expenses

There are three phases that your Plan will experience throughout the year as determined by reaching the following thresholds in your medical and pharmacy spending:

- **Deductible Phase:** You pay the full cost of medical and pharmacy services until you meet your deductible (individual) or (family). The deductible does apply to your out-of-pocket maximum.
- **Copayment phase:** You pay the copayment amounts listed in the **Copay Grid** until you reach your out-of-pocket maximum of (individual) or (family).
- **100% Coverage Phase:** Once you have reached your out-of-pocket maximum your Plan pays 100% of eligible medical and prescription drug expenses for the rest of the benefit year.

Website Information

Access to additional Plan information and tools such as those listed below are accessible by visiting www.medimpact.com.

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[3] If the specialty drug (infusion therapy drugs) is covered under the Cigna medical plan, then if administered in an outpatient facility or at home, then the medical deductible and coinsurance apply. If services are administered in the physician's office (in network) the specialty drug is covered at 100% no deductible, though the medical provider may charge for their services.

- **Pharmacy Location Services**: Find a participating pharmacy using the online pharmacy locator
- **Drug Price Check**: Identify which drugs are covered by your Plan, get an estimated cost before filling a prescription and compare estimated costs between generic and brand-name drugs
- **Tracking Out-Of-Pocket Expenses**: See current remaining Plan balances, up-to-date out-of-pocket expenses, and maximum out-of-pocket expense limits

Benefit Coverage and Limitations

The Formulary is a list of medications that are covered by your Plan; however, specific coverage and/or utilization limitations may apply. Members may have specific benefit exclusions, copayments or coverage considerations that are not reflected specifically in the Formulary. The Formulary applies only to outpatient drugs prescribed to members and does not apply to medications used in an in-patient setting. If you have specific questions regarding your coverage, please contact MedImpact at 888-783-1774.

General Covered Drugs

For a listing of covered drugs, please refer to the resources listed under the "Pharmacy: MedImpact" section of the https://dhr.colorado.gov/state-employees/state-employee-benefits/medical/cigna-medical website.

General Excluded Drugs, including but not limited to:

- Over the Counter Products
- Cosmetic Indications
- Diagnostic Supplies (non-Diabetes)
- Surgical Supplies
- Medical Devices
- Ostomy
- Urine Test Strips
- Alcohol Swabs
- Insulin Pump & Supplies
- Digital Therapy
- Abortifacients
- Compound Medications
- Bulk Chemicals
- Experimental drug products or any drug product used in an experimental manner
- Non-self-administered injectable drug products unless otherwise specified in the Formulary listing
- Glucometers (free meter can be obtained through manufacturer), with the exception of continuous glucose monitors which are covered under your pharmacy benefit

Custom Items:

• Up to 12-month supply of HCR Contraceptives
• Insulin copay maxes at $100 for 30-day supply and $300 for 90-day supply bypassing any deductible for non-ACA/Preventative
• UM Edits on many drug classes requiring PA, Quantity Limit and Step Therapy

Quantity Limitations: There may be Quantity Limits on certain medicines. Quantity Limits are based on the FDA's recommended dosing guidelines for each medication and are reviewed regularly by the Plan to ensure

clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions. Requests for drug quantities above Plan limits require review and authorization by MedImpact.

Prior Authorization (PA): A program used to validate diagnosis or other treatment information to assure the prescription is being prescribed appropriately. Often this requires additional information from the prescriber for approval.

Step Therapy: A program in which the member must try one or more prerequisite drugs before the Step Therapy drug will be covered by the Plan. This is designed for people who regularly take prescription drugs to manage ongoing medical conditions.

Example:

- **Step 1 medications: Generic drugs that have the same health benefits as higher-cost medications.**
- **Step 2 medications: Brand-name drugs recommended if a Step 1 medication does not work for you. Step 2 medications may cost you and your Plan more than Step 1 medications.**

Brand Name Drugs and Generic Drugs
A generic drug is a prescription drug that is marketed by one or more pharmaceutical companies under its non-proprietary name after its patent has expired. A brand name drug refers to a prescription drug that is marketed by one company under its proprietary name before or after its patent has expired.

If you elect to receive a brand-name drug, or if your prescriber requires that a brand-name drug be dispensed when a generic equivalent medication is available, you will pay the applicable brand co-payment plus the difference in cost between the brand and the generic medications.

Generic medications remain your lowest-cost choice — offering you the least expensive alternative without sacrificing safety and effectiveness. Generic drugs are safe and as effective as their brand-name counterparts, and they cost you less.

If you are taking a medication that's not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug. To find out which drugs are preferred log on to www.medimpact.com and select "Formulary Search" from the menu on the left side of the webpage.

Medication Request (Prior Authorization) Process

Depending upon Plan benefit design a medication request process may apply as follows:

- **Coverage Exceptions:** Drugs that are listed in the Formulary with associated Prior Authorization (PA) require evaluation prior to dispensing at a pharmacy. Each request will be reviewed on an individual member need basis. If the request does not meet the guidelines, the request for coverage of the prescription will not be approved and alternative therapy may be recommended.

- **To obtain a Prior Authorization, you can do so by:**
  - Having your prescriber fax a completed **Medication Request Form** to MedImpact at (858) 790-7100. The Medication Request Form can be found at https://www.medimpact.com/clients/Prior-Authorization-Forms.
  - Contacting MedImpact at 888-783-1774 and providing all of the necessary information requested. MedImpact will provide an authorization number, specific for the prescription drug, for all approved requests. Non-approved requests may be appealed. The prescriber must provide information to support the appeal. Prior Authorization is generally not available for prescription drugs that are specifically excluded by the benefit design.

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Appeals of Adverse Benefit Determinations

If your Prior Authorization request is denied, you can appeal this decision. Instructions on how to appeal will be listed in the Prior Authorization denial letter mailed to you. The Appeals form can be found at https://www.medimpact.com/members/ContactUs. The member's appeal should include the following information:

- Name of the person filing the appeal
- Pharmacy benefit member identification number
- Date of birth
- Written statement of the issue(s) being appealed
- Drug name(s) being requested, and
- Written comments, documents, records or other information relating to the claim.

The member's appeal and supporting documentation may be mailed or faxed to:

MedImpact HealthCare Systems, Inc.
Attn: Appeals Coordinator
10181 Scripps Gateway Ct.
San Diego, CA 92131

OR

Fax**: 858-790-6060**

MedImpact's Review

The review of a member's claim or appeal of an adverse benefit determination on behalf of State of Colorado will be conducted in accordance with the State of Colorado's pharmacy benefit plan and any related laws.

Review of Adverse Benefit Determinations of Pre-Service Clinical Prior Authorizations

MedImpact will provide the first-level review of appeals of adverse benefit determination for pre-service clinical Prior Authorizations (PA). Such claims will be reviewed against pre-determined clinical criteria relevant to the drug or benefit being requested under State of Colorado's pharmacy benefit plan. If the member's first-level appeal is denied, the member may appeal the decision and request an additional second-level review. The second-level review will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

MedImpact provides a single level of appeal for administrative denials. Upon receipt of such an appeal, MedImpact will review the member's request for a particular drug or benefit against the terms of the Plan, including preferred drug lists or formularies selected by the Plan.

Timing of Review

- **Urgent:** 24 calendar hours. (Does NOT Skip Weekends and MedImpact Holidays)
- **Non-urgent:** 5 business days. (Skips Weekends and MedImpact Holidays)
- **Note:** When your prescriber completes the Medication Request Form to request Prior Authorization, there is a check box indicating whether the request is Urgent or Non-Urgent. This determines the turnaround times listed below.

Request Type (PA/FE/ST)	Request Type (Urgent/	Initial Request Turnaround Time	Initial Request Pended for	Decision Turnaround Time

	Standard)		Information	
Prior Authorization	Urgent	24 calendar hours	5 calendar days	24 calendar hours
Prior Authorization	Standard	5 business days	45 calendar days	5 business days
Formulary Exception	Urgent	24 calendar hours	5 calendar days	24 calendar hours
Prior Authorization	Standard	5 business days	45 calendar days	5 business days
Step Therapy	Urgent	24 calendar hours	5 calendar days	24 calendar hours
Step Therapy	Standard	5 business days	45 calendar days	5 business days

Scope of Review
During its pre-authorization review, first-level review of the appeal of a pre-service clinical Prior Authorization claim, or review of a post-service claim or administrative denial, MedImpact shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim
- Follow reasonable procedures to verify the benefits determination is made in accordance with applicable Plan documents
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members,
- Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If a member appeals MedImpact's denial of a pre-service clinical claim and requests an additional second-level review by an IRO, the IRO shall:

- Consult with an appropriate healthcare professional who was not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual)
- Identify the healthcare professional, if any, whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, and
- Provide for an expedited review process for urgent care claims.

Notice of Adverse Benefit Determination
Following the review of a member's claim, MedImpact will notify the member of any adverse benefit determination in writing.
This notice will include:

- The specific reason(s) for the adverse benefit determination
- References to pertinent Plan provisions on which the adverse benefit determination was based
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion will be provided free of charge upon written request, and
- If the adverse benefit determination is upheld by the IRO, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Direct Member Reimbursement

In the event the covered member does not present his or her identification card to the network pharmacy at the time of purchase, the covered member will be responsible for full payment for the medication(s). The member must then submit a Direct Member Reimbursement (DMR) form as directed by their Plan to request payment reimbursement.

Please contact MedImpact at 888-783-1774 or log on to www.medimpact.com to obtain the DMR form for submission.