



EXPRESS SCRIPTS®



Get the most from
your prescription plan

The University of New Mexico



Welcome to Express Scripts

»» What's Inside

| | |
|---|----|
| Your plan at a glance | 2 |
| Your preferred medicines..... | 3 |
| Medicines requiring prior authorization | 4 |
| The benefit of step therapy | 7 |
| Filling your prescriptions | 7 |
| Using home delivery from Express Scripts Pharmacy.. | 8 |
| Using a participating retail pharmacy..... | 10 |
| Using an out-of-network pharmacy..... | 10 |
| Accredo, your specialty pharmacy | 11 |
| Vaccines and preventive care | 12 |
| Healthcare reform coverage..... | 13 |
| Appeals | 14 |
| At-a-glance guide..... | 19 |
| Helpful contact information you may need..... | 20 |

At Express Scripts, the company chosen by the University of New Mexico to manage your prescription plan, your health is important to us. We know there's a person behind every prescription we fill, and we're ready to serve you.



Your plan at a glance

You have choices when it comes to having your prescriptions filled. Express Scripts ensures that you have access to high-quality, cost-effective medicines through a network of retail pharmacies and by offering convenient home delivery of your maintenance medicines – those medicines you take on an ongoing basis – through Express Scripts Pharmacy®. Your costs out of pocket are based on the type of prescription you have filled and where you have it filled:

THE UNIVERSITY OF NEW MEXICO PLAN

Retail network pharmacy cost (up to a 30-day supply)

\$10 copay for each generic drug

25% coinsurance (\$35 minimum/\$70 maximum) for each preferred (formulary) brand-name drug

25% coinsurance (\$55 minimum/\$110 maximum) for each nonpreferred (nonformulary) brand-name drug

Retail network pharmacy cost (between a 31- and 90-day supply)

\$20 copay for each generic drug

25% coinsurance (\$87.50 minimum/\$175 maximum) for each preferred (formulary) brand-name drug

25% coinsurance (\$137.50 minimum/\$275 maximum) for each nonpreferred (nonformulary) brand-name drug

Home delivery from Express Scripts Pharmacy cost (up to a 90-day supply)

\$20 copay for each generic drug

25% coinsurance (\$87.50 minimum/\$175 maximum) for each preferred (formulary) brand-name drug

25% coinsurance (\$137.50 minimum/\$275 maximum) for each nonpreferred (nonformulary) brand-name drug

Specialty drug cost:

20% coinsurance with a maximum of \$250.

Once a member has paid \$1,250 in out-of-pocket expenses on specialty medicines, all subsequent specialty medicines will change to a \$0 copay for the remainder of the plan year. *(Due to the SaveonSP program's offer of zero copay on a select group of medications, these drugs are excluded from this specialty out-of-pocket maximum.)*

Specialty SaveonSP Program:

The University of New Mexico has partnered with SaveonSP to provide a specialty pharmacy copay assistance program. A select group of specialty medications in 13 therapy classes are part of the SaveonSP program. See more information in the specialty benefit section of this handbook.

Out-of-Pocket (OOP) Maximum (shared with in-network Medical only)*:

Individual OOP Maximum - \$3,000

Individual and/or Family OOP Maximum - \$6,000

* See pages 9 and 10 SaveonSP exclusions to out-of-pocket maximum, when choosing not to participate.

Your preferred medicines

The University of New Mexico and Express Scripts have worked together to develop a list of drugs covered under your plan and referred to in this booklet as a formulary. Your formulary offers a wide selection of generic and brand-name prescription drugs chosen to help keep prescription drug costs down.

Medicines requiring prior authorization

Drugs excluded on your formulary will require prior authorization for coverage.

Frequently asked questions about prior authorization

1. What is prior authorization?

Prior authorization is a program that helps you get prescription drugs you need **with safety, savings and – most importantly – your good health in mind**. It helps you get the most from your healthcare dollars with **prescription drugs that work well for you and that are covered by your prescription plan**. It also helps control the rising cost of prescription drugs for everyone in your plan. The program monitors certain prescription drugs and their costs so you can get the right medicine at the right cost. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need. If you're prescribed certain medicine, it may need a prior authorization. **A prior authorization makes sure you're getting a cost-effective prescription drug that works for you**. For instance, prior authorization ensures that covered medicines are used for treating medical problems rather than for other purposes.

Example: A medicine may be in the program because it treats a serious skin condition, but it could also be used for cosmetic purposes, such as reducing wrinkles. To make sure your medicine is used to treat a medical condition and promote your health and wellness, your plan may cover it only when a doctor prescribes it for a medical problem.

In this program, **your own medical professionals are consulted**. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan can cover the medicine. Only your doctor (or sometimes a pharmacist) can provide this information and request a prior authorization.

Important facts about generic drugs

Today, 9 in 10 prescriptions filled in the U.S. are for generic drugs. FDA-approved generic drugs are equivalent to the brand-name drug.¹

- *The FDA-approved generic drugs must have the same active ingredient, strength, dosage form and route of administration as the brand-name drug.*
- *The generic manufacturer must prove its drug is the same (bioequivalent) as the brand-name drug to be an FDA-approved generic drug.*
- *All manufacturing, packaging and testing sites must pass the same quality standards as those of brand-name drugs.*

2. Who decides what prescription drugs to include in my prior authorization program?

Your plan has chosen a prior authorization program **developed under the guidance and direction of independent licensed doctors, pharmacists and other medical experts.**

Together with Express Scripts—who manages your prescription plan—these experts review the most current research on thousands of prescription drugs tested and approved by the FDA as safe and effective. They recommend prescription drugs that are appropriate for a prior authorization program, **and your pharmacy benefit plan chooses the prescription drugs that will be covered.**

3. What kinds of prescription drugs need a prior authorization in my program?

Your prior authorization program applies to prescription drugs that:

a. Your plan wants to make sure you need for a medical condition

AND

b. Could be used for non-medical purposes.

To find out if a medicine requires a prior authorization, log in at express-scripts.com and select “Price a Medication” from the drop-down menu under “Prescriptions.” After you look up a medicine’s name, you’ll see cost and coverage information. Or call Member Services at **800.232.6549**.

4. Why couldn’t I get my original prescription filled at the pharmacy?

Here’s what occurs when a prescription needs a prior authorization:

- a. Your pharmacist sees a note on the computer system indicating “prior authorization required.” Your pharmacist lets you know that your prescription needs a prior authorization – which simply means that **more information is needed to determine if your plan can cover the medicine.**
- b. You can ask your doctor to submit a coverage review request to Express Scripts’ online portal, esrx.com/PA. The prior authorization phone lines are open 24 hours a day, 7 days a week, so a determination can be made right away.

OR

You can ask your doctor if you could use another medicine that’s covered by your plan.

OR

You can simply pay full price for the prescription at your pharmacy.

- c. If your doctor (or pharmacist) requests a prior authorization, an Express Scripts licensed pharmacist will:
 - Check your plan’s guidelines to see if your prescription can be covered

AND

- Note whether your plan will cover the medicine only when it’s used for treating specific medical conditions, rather than for other purposes.

Your doctor or pharmacist will be asked questions about your specific condition. If the information provided meets your plan's requirements, you pay the plan's copayment at the pharmacy.

5. I need a prescription filled immediately. What can I do?

At the pharmacy, your pharmacist may tell you that your prescription requires prior authorization.

If this occurs and you need your medicine quickly, you can:

- a. **Talk with your pharmacist about filling a partial supply** of your prescription right away. You may have to pay full price for this prescription.
- b. Then, **ask your pharmacist to contact your doctor**. Your doctor needs to call the Express Scripts prior authorization department to find out if this drug can be covered by your plan. Only your doctor (or in some cases, your pharmacist) can provide the information needed to make this determination.

6. Does this program deny me the medicine I need?

No, the program can help you get an effective medicine to treat your condition. Through prior authorization, you can **receive the right prescription for you that is covered by your plan**. If it's determined that your plan doesn't cover the medicine you were prescribed, you can ask your doctor about getting another medicine that is covered. You'll receive it for your plan's copayment. Or, you can get the original prescription filled at your pharmacy by paying the full price.

7. What happens if my doctor's request for prior authorization is denied?

Your prescription plan doesn't cover certain medicines. If you want to file an appeal to have your prescription covered, contact Express Scripts at the number on your member ID card.

8. I filed an appeal and it was denied. What can I do?

There are two things you can do:

- a. You can talk with your doctor again about prescribing one of the prescriptions that are covered by your plan. Your copayment for one of these medicines will usually be affordable.

OR

- b. You can pay the full price for a medicine that isn't covered by your plan.

9. I sent a prescription to Express Scripts Pharmacy, but I was contacted and told it needs a prior authorization. What happens now?

Express Scripts Pharmacy will try to contact your doctor. You may want to let your doctor know that this call will be coming. If your doctor thinks you need this prescription for your condition, he/she can talk with an Express Scripts Pharmacy home delivery representative about a prior authorization.

The benefit of step therapy

Step therapy is all about health and value – about getting the most effective medicine for your health and money. That means using a tried-and-true medicine that’s proven safe and effective for your condition at the lowest possible cost to you and your plan sponsor.

How does step therapy work?

Prescription medicines are grouped into two categories:

Step 1 medicines are generic and lower-cost brand drugs that have been rigorously tested and approved by the FDA. Generics should be prescribed because they can provide the same health benefit as higher-cost medicine. (See page 3 for more information.)

Step 2 medicines are brand-name drugs such as those you see advertised on TV. They’re recommended only if a Step 1 medicine doesn’t work for you. Step 2 medicines almost always cost you and your plan sponsor more than Step 1 medicines.

What if my doctor prescribes a Step 2 medicine?

Ask if a generic (Step 1) medicine may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medicine to a Step 1 medicine. If a Step 1 medicine is not a good choice for you, then your doctor can request prior authorization (described in more detail on page 2) to determine if a Step 2 medicine will be covered by your plan.

Who decides which prescription drugs are included in step therapy?

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicine for inclusion in the step therapy program. Together, they review the most current research on thousands of prescription drugs tested and approved by the FDA for safety and effectiveness, recommending appropriate prescription drugs for the program. The University of New Mexico then selects the medicine that will be covered by your prescription plan.

For more information on step therapy in your plan, visit express-scripts.com or call **800.232.6549**.

Filling your prescriptions

You have two ways to fill your prescriptions, depending on your medicine needs. For long-term medicine needs – for example, drugs used to treat high blood pressure or diabetes – home delivery from Express Scripts Pharmacy is the convenient, safe way to get your prescription. For short-term medicine needs, such as antibiotics for strep throat or pain relievers for an injury, filling at a participating retail pharmacy is optimal. Both options are detailed on the next page.

When you use home delivery from Express Scripts Pharmacy, you can count on:

- Up to a 90-day supply of your medicines
- Free standard shipping in a plain weather-resistant tampered evident pouch
- Flexible payment options and auto refills
- A registered pharmacist available at any time, day or night, year round
- Refill orders placed at your convenience, by telephone or online

Using home delivery from Express Scripts Pharmacy

For long-term medicine needs, home delivery offers the best value for the prescriptions you take regularly to treat ongoing conditions. Your medicines are delivered safely and conveniently to you. Please note that drugs used to treat migraines must be filled through Express Scripts Pharmacy to receive coverage under the plan. By doing so, patients will receive personalized care from pharmacists and nurses in the Express Scripts Neuroscience Therapeutic Resource Center^o.

Four ways to get started with home delivery

A home delivery order form was included in your Welcome Kit with your member ID card. You can print additional forms if needed or start home delivery by using one of these methods:

1 Electronically

- Ask your doctor to send your prescription to Express Scripts Pharmacy by e-prescribing or by faxing to 800.613.5628. Only doctors' offices can fax prescriptions. Faxes from other locations such as your home or workplace can't be accepted.

2 Online

- Ask your doctor to write a prescription for up to a 30-day supply and fill it immediately at your local pharmacy.
- After you've filled your 30-day prescription, go to **express-scripts.com**. If you're a first-time visitor, please take a moment to register. (Be sure you have your member ID number handy.)
- For refills remaining on long-term prescriptions filled at retail, your medicine will be listed under the section "Prescriptions You Can Order Today" on the home page. Simply select "Prescription in cart" and "Checkout" by accessing the items in your cart on the top right of the screen. We'll do the rest.

Free standard delivery to your home from Express Scripts Pharmacy

Your medicine will be mailed to your home via standard U.S. Postal Service delivery at no charge,² usually within eight business days from the day we receive the prescription. Your medicine will arrive in a plain, weather-resistant and tamper-evident pouch, with packaging accommodations made for temperature control if needed.

²Overnight delivery is available, at an additional cost. The cost varies depending on the destination city and state.

3 By mail

- Ask your doctor to write two prescriptions: one for up to a 30-day supply that you can fill immediately at your local pharmacy; one for up to a 90-day supply of your medicine, plus refills for up to one year.
- Complete a home delivery order form. You can print a form from **express-scripts.com**.
- Return the completed order form, your written prescription for your 90-day supply and payment³ to the address on the form.

³To help avoid delays in filling your prescription, be sure to include payment with your order.

Fewer Refills Saves You Money

If your doctor writes a prescription for a 30-day supply of medicine with 11 refills (for a total of 12 “fills”), Express Scripts will fill your prescription for a 90-day supply of medicine in a single fill.

You'll then have three additional 90-day refills remaining.⁴ We refer to this as “consolidation of refills.” What’s important for you to know is this consolidation saves you money by requiring fewer copayments.

⁴Pending individual state law.

We prefer that your doctor write a prescription for a 90-day supply with three refills. Express Scripts will, if possible, consolidate your refills to save you money. Refills for some medicines – such as controlled substances, sleeping medicines, inhalers and certain other drugs – can’t be consolidated.

What does this mean for you?

Consolidating your prescription will enable you to receive a 90-day supply for a single home delivery copayment rather than pay three separate 30-day copayments. And, you won’t need to refill as often with a 90-day supply.

Remember, it’s best if you let your doctor know in advance that your prescription for home delivery should be written for a 90-day supply, with three refills.

⁵If you live in Oklahoma or Texas, Express Scripts is prohibited by state law from automatically consolidating your prescription. To save yourself some money, have your doctor write your prescription for a 90-day supply with three refills.

Using a participating retail pharmacy

For short-term medicine needs, a participating retail pharmacy is your most convenient option. When filling prescriptions that you need immediately, simply present your Express Scripts member ID card and written prescription to your pharmacist and pay your copayment as shown on page 2.

You can locate your nearest participating retail pharmacy at any time by logging in at express-scripts.com and choosing “Find a Pharmacy” from the menu under “Prescriptions.” You can also use the Express Scripts® mobile app or call **800.232.6549**.

Using an out-of-network pharmacy

If you use a pharmacy that’s not covered in your network, you must pay the entire cost of the prescription and then submit a claim for reimbursement. You will be reimbursed for the amount the covered medicine would have cost at a participating retail pharmacy minus the appropriate copayment. Claim forms are located online at express-scripts.com and can be requested by calling University of New Mexico Member Services at **800.232.6549**.

Claims must be submitted within 365 days of the prescription purchase date.

We're here to help

Through programs specific to your condition, you can receive a complete range of services and specialty medicines – many of which can be very costly and are often unavailable through retail pharmacies. The conditions include, but are not limited to:

- Cancer
- Hemophilia
- Hepatitis
- Multiple sclerosis
- Psoriasis

Accredo, your specialty pharmacy

Accredo, the full-service Express Scripts specialty pharmacy, provides personalized care to patients with chronic, complex health conditions. Accredo offers several comprehensive disease-specific patient-care management programs:

Patient counseling – disease-specific pharmacy and nursing clinical care teams provide the support you need to help manage your condition

- Pharmacists and nurses with specialty training emphasize patient adherence to the treatment, implementing evidence-based practice guidelines and patient empowerment strategies
- Follows an initial clinical assessment, performed to gauge your baseline understanding of your therapy, including medicine administration and side-effect management
- Evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving your overall health
- Maintains an open line of communication with you

Patient education – convenient access to highly trained clinical care teams, including specialty trained pharmacists and nurses and patient care advocates

- Schedules follow-ups to detect new or worsening symptoms, medication side effects and issues that could affect health, proper drug utilization and adherence to the treatment plan
- Clinical interventions customized to meet your needs, including management of non-adherence, side effects, supplies, and site pain and infection
- Disease-specific nurses and pharmacists on call 24/7

Convenient medicine delivery – coordinated delivery to your home or any other approved location

Refill reminders – ongoing refill reminders from a patient care advocate

Language assistance – translation services are available for non-English speaking patients. Specialty medications must be filled through Accredo. Exceptions may apply for medications requiring an immediate fill.

The University of New Mexico has partnered with SaveonSP to provide a specialty pharmacy copay assistance program. A select group of approximately 80 specialty medications in 13 therapy classes are part of the SaveonSP program. Employees and their family members who are identified as taking one of these specialty drugs prior to July 1, 2020, will be contacted by SaveonSP to explain the program and assist with enrollment into the program. If a member has not spoken to SaveonSP and attempts to fill one of the select specialty medications, an Accredo representative will make outreach to the patient prior to processing the prescription and assist with enrollment into the program by transferring the member to SaveonSP.

For the University of New Mexico members who qualify for and enroll in the SaveonSP program, the cost of this select group of specialty drugs will be reimbursed by the manufacturer and result in **no cost to the member**. During enrollment, SaveonSP will discuss the claim payment process.

Please Note: A higher copay will result as part of the primary claim process through Accredo. That amount will be invoiced to copay assistance for further payment. Questions surrounding the payment process should be directed to SaveonSP. Members who qualify for, but decline to sign up for, the SaveonSP program, will pay the prescription drug copayment amount stated on the SaveonSP program drug list, which will represent a **significant** cost to you. You are encouraged to enroll if you or a family member qualifies for the SaveonSP program.

Specialty medications apply to the benefit out-of-pocket (OOP) maximum, with the exception of the specialty drugs that are part of the SaveonSP copay assistance program.

For additional information about the services available to you through Accredo, please call **800.803.2523**.

Vaccines and preventive care

The University of New Mexico has implemented a vaccine program that covers influenza, tetanus and zoster vaccines, as well as other ACA preventive care vaccines, for \$0 copayment. On the next page are some examples of vaccines that are covered.

| Vaccine | ACIP Abbreviation | Age Limitation MIN | Age Limitation MAX |
|---|----------------------------|------------------------|--------------------|
| Diphtheria and tetanus and/or pertussis | DT | ≥ 1 year | none |
| | DTaP and Combos | ≥ 1 month | 7 years |
| | Td/Tdap | ≥ 7 years | none |
| Haemophilus influenzae type b | Hib | ≥ 1 month ≥ 50years | none |
| Hepatitis | HepA | ≥ 1 year | none |
| | HepB | none | none |
| Herpes zoster | HZV | ≥ 60 years | none |
| Shingrix | RZV | ≥ 50 years | none |
| Human papillomavirus | HPV4 HPV2 (female only) | 9 years | 26 years |
| Influenza | | ≥ 6 months | none |
| Measles, mumps and rubella | MMR | ≥ 6 months | none |
| | MMR+VAR | ≥ 1 years | none |
| Meningococcal | MenACWY MCV4 | 2 months | none |
| | MPSV4 | ≥ 2 years | none |
| Pneumococcal | PCV13 | ≥ 1 month | none |
| | PPSV23 | ≥ 2 years | none |
| Poliovirus | IPV | ≥ 1 month | none |
| Rotavirus | RV1/RV5 | ≥ 1 month | 9 months |
| Varicella | VAR | ≥ 1 years | none |

Due to healthcare reform, the following medicines are covered for a \$0 copayment with a prescription. They are covered for both over-the-counter (OTC) medicines and those requiring a prescription. Some are available OTC; however, you still must present a prescription from your doctor at the pharmacy to be eligible to pay \$0.

| | | |
|---|---|---|
| Aspirin to prevent cardiovascular disease | ➤ | Men age 45 to 79 years |
| Aspirin to prevent preeclampsia | ➤ | Women under the age of 55 |
| Oral fluoride supplementation | ➤ | Children from 6 months through 17 years |
| Folic acid supplementation | ➤ | Women of childbearing age (18 to 45) |
| Bowel preparation agents | ➤ | Adults age 50 to 75 years |
| Contraception—Diaphragm, generic oral contraception, generic emergency contraception, Mirena® | ➤ | Women age 50 or younger |
| Breast cancer – tamoxifen (generic), raloxifene (generic) and Soltamox® (brand) | ➤ | Women 35 years of age and older |
| Statins - Generic single entity, low/moderate doses | ➤ | Adults age 40 to 75 years |

Appeals

Appeals Administration

When a member or physician requests an appeal and additional information is provided, it is reviewed and evaluated by the Express Scripts Appeals unit to determine if the drug use meets coverage conditions specified or intended by the University of New Mexico according to the procedures set forth below. Appeal decisions are made by a pharmacist, prescription plan specialist or panel of clinicians. The Express Scripts appeal unit may also decide to forward a first level or second level appeal to a third-party Utilization Management company (Independent Review Organization) for review and decision. Appeal procedures apply to appeals of adverse benefit determinations based on medical necessity, appropriateness or effectiveness of a covered benefit. The external review coordination procedures apply to appeals of adverse benefit determinations based on medical necessity, appropriateness or claims involving medical decision making once all internal levels of appeal process have been exhausted. Appeals related to eligibility to participate in the plan and related to plan design are coordinated by the University of New Mexico.

Rescission of Coverage is subject to the “Rescission of Coverage in the Event of Fraud or Intentional Misrepresentations of Material Fact” appeals procedure in the Medical Plan Participation Benefit Booklet, which reads “If you knowingly make a false statement on your enrollment Application or file a false claim, such Application or claim may be rescinded retroactively back to the date of the Application or claim. Any premiums collected from the Participant for coverage that is later revoked due to a fraudulent application may be refunded to the Participant by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent Application or claim, the Participant may be responsible for full reimbursement of the claim amount to the University of New Mexico.”

Appeals Process

To initiate a level 1 appeal, a Plan Participant (all references to Participant in the Appeals section of the Benefit Booklet include the Employee and/or covered Dependent(s)) must submit a written request for an appeal to Express Scripts within one hundred eighty (180) days of receipt of a notice of denial of medicine(s) under the Plan. The Participant must tell, or present evidence (e.g., documents) and testimony to, Express Scripts the reason why the denial should be overturned and include any information supporting the appeal. Express Scripts will evaluate or forward the appeal request and all accompanying documentation to a third-party Utilization Management company. For standard cases, the Participant will receive in writing within one (1) working day an acknowledgement of receipt of the appeal request which includes allowance of five (5) business days for the Participant to submit any additional information. The acknowledgement letter will also contain the contact information for who is handling the appeal.

To initiate a level 2 appeal, a Plan Participant must submit a written request for an appeal to Express Scripts within ninety (90) days of receipt of an adverse determination of a Level One appeal under the Plan. The Participant must tell, or present evidence (e.g., documents) and testimony to, Express Scripts the reason why the denial should be overturned and include any documentation supporting the appeal. Express Scripts will evaluate or forward the appeal request and all accompanying information to a third-party Utilization Management

company. For standard cases, the Participant will receive in writing within one (1) working day an acknowledgement of receipt of the appeal request which includes allowance of five (5) business days for the Participant to submit any additional information. The acknowledgement letter will also contain the contact information for who is handling the appeal.

Time Frames for Processing Appeals of Pharmaceutical Adverse Determinations

Standard, non-expedited Level 1 appeals involving the review of a denial of coverage for medicines requests will be completed within 15 calendar days for pre-service appeals and 30 calendar days for post-service appeals. The appeal review period may be extended for a maximum of ten (10) calendar days if: 1) there is reasonable cause beyond the reviewer's control for the delay; 2) can show that the delay will not result in increased medical risk to the Participant; and 3) provide a written progress report to the Participant and the related provider within the forty (40) day review period. Participants must agree, in writing, to a request to extend a deadline.

Some appeals of denials relating to claims involving urgent pharmaceutical care are processed on an expedited basis. Expedited decisions are made when a Participant's life or health or ability to regain maximum function would be jeopardized by following the standard appeal process and time frames; or, in the opinion of an attending provider with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In cases that require an expedited decision of a Medicine request, based at the request of an attending provider or Participant, a decision will be made within seventy-two (72) hours of the receipt of the request or more rapidly depending on medical exigencies. If a Participant requests an expedited decision, the request will be reviewed. If it is determined that the request for an expedited appeal is medically necessary, a decision will be made within seventy-two (72) hours of the request or more rapidly depending on medical exigencies. All required information will be transmitted between the reviewer, the applicable provider, and the Participant by the quickest means possible. If it is determined that a request for an expedited appeal is not medically necessary, the Participant will be notified and the appeal processed within fifteen (15) calendar days.

Internal Review of Appeal of Adverse Determination by a Third Party

Clinical appeals (claims involving medical judgment) will be reviewed by a third-party vendor physician consultant (same or similar specialty of the prescribing physician and/or with training and experience in the relevant field) not involved in the initial determination, nor by a subordinate of the person resolving the claim initially or who has any conflict of interest. Administrative appeals (no medical decision making) will be reviewed by a third-party pharmacist consultant not involved in the initial determination, nor by a subordinate of the person resolving the claim initially or who has any conflict of interest. The third-party consultant will re-review the request to make a determination regarding whether the requested health care services are medically necessary and/or covered under the Plan.

Notice of Decision on Appeal of Adverse Determination by Medical Director

If the third-party consultant decides to reverse an initial adverse determination, the third-party consultant will approve coverage of the medicine. The applicable Participant and the applicable provider will be notified by mail or electronic means (fax) within seventy-two (72) hours of such decision. If the third-party consultant decides to uphold an initial adverse determination, the applicable Participant and the applicable provider will be notified that the adverse determination has been upheld by written or electronic means within seventy-two (72) hours of such decision. Written notification must be provided in a linguistically appropriate manner. The Participant will be given appeal rights to pursue an External Review. Where there is an ongoing course of treatment that is the subject of the denied claim and an internal appeal, the plan will not reduce or terminate coverage of the treatment pending the outcome of the appeal.

External review

If the Participant is dissatisfied with any internal appeals decision for clinical claims (claims involving medical decision making), the Participant may request an external review by an Independent Review Organization (IRO) as defined by Applicable Law. An IRO is an independent review organization, external to the University of New Mexico and Express Scripts, that utilizes independent physicians with appropriate expertise to perform external reviews of appeals. The IRO will, with respect to claims involving investigational or experimental treatments, ensure adequate clinical and scientific experience and protocols are taken into account as part of the External Review process. In rendering a decision, the IRO will consider any appropriate additional information submitted by the Participant and will follow the plan documents governing the Participant's benefits.

For claims involving urgent care, a Participant may request an expedited external review if the adverse benefit determination involves a medical condition of the Participant for which the regular time frame would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, and the Participant filed a request for an expedited internal appeal; or, if the final internal adverse benefit determination involved a situation where the Participant had a medical condition where that time frame would pose such jeopardy, and if the final internal adverse benefit determination concerned an admission, availability of care, continued stay or health care service for which the Participant received emergency services and was not discharged from a facility.

Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an IRO at the same time as the internal review process occurs.

There are no fees or costs imposed on a Participant for the external review of an appeal. The Participant's decision as to whether or not to submit a denied appeal for external review will have no effect on the Participant's rights to any other benefits under the Plan.

When an appeal is denied by Express Scripts or a third-party vendor, the Participant will receive a letter that describes the process to follow if the Participant wishes to pursue an external review of an appeal through an IRO.

If a Participant files a request for an external review of an appeal with an IRO:

- The external review may only be requested after exhaustion of the required Internal Appeal procedures under the Plan, unless an expedited external review of a claim involving urgent care or an ongoing course of treatment is requested. Accordingly, the Participant must first submit an appeal with Express Scripts and receive a denial of appeal before requesting an external review of an appeal with an IRO.
- After a Participant receives a denial of an appeal, the Participant must submit the request for external review of appeal with the third-party vendor in writing within 4 months from the date of receipt of the adverse benefit determination, extended to the next working day if the date falls on a weekend or federal holiday.
- The third-party vendor will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to the IRO. The Participant may also submit additional information to be considered. For standard non-expedited appeals, the Participant will have ten (10) business days to submit additional information to the IRO.
- Within five days after receipt of the request for external review, the Plan will complete a preliminary review to determine if the Participant was covered under the Plan at the time the service was requested or provided; whether the adverse benefit determination relates to the Participant's failure to meet the eligibility requirements of the Plan; whether the Participant has exhausted the Plan's internal appeal process; and whether the Participant has provided all of the information and forms required to process an external review. Within one business day after completion of this preliminary review, the Plan will provide the Participant written notification giving any reasons for the ineligibility of the request for external review and describing the information or materials required, and the Plan will allow the Participant to perfect a request for external review within the four month filing period or within the 48-hour period following receipt of the notification, whichever is later.
- The Participant will be notified of the decision of the IRO within 45 days of the receipt of the request for the external review of an appeal for standard, non-urgent claims. The IRO's decision will include:
 - a) A general description of the reason for the request for external review;
 - b) The dates the IRO received the assignment to conduct the external review and the date of their decision;
 - c) Reference to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching their decision, taking into account adequate clinical and scientific experience and protocols with respect to claims involving experimental or investigative treatments;
 - d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision;
 - e) A statement that judicial review may be available; and

- f) Current contact information, including the phone number for any ombudsman under the PHS Act.
 - g) In the event of an expedited external appeal for claims involving urgent care, the IRO will make the decision as expeditiously as the Participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review and, if the notice is not in writing, within 48 hours after the date of providing the verbal notice, the IRO will provide written confirmation of the decision to the Participant and the Plan. Written notice must be provided in a linguistically appropriate manner. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings.
 - h) The decision of the IRO will be binding on the Participant as well as the Plan, except to the extent there may be other remedies available under state law.
- The statute of limitations or other defense based on timeliness is suspended during the time that an external review of your appeal is pending.

If a Participant does not submit a request for external review of an appeal:

- The University of New Mexico and Express Scripts waive any right to assert that the Participant failed to exhaust administrative remedies.

Experimental or Investigational Services/Treatment Exclusions

Experimental or Investigational services/treatment are not covered benefits. Experimental/ Investigational means any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings.

Compound Exclusion

Compound medicines containing certain ingredients that have an alternative that has been FDA-approved and is commercially available are not covered. Compounded medicines are made when a licensed pharmacist combines, mixes or alters a medicine's ingredients to meet a doctor's request. The FDA does not verify the quality, safety and/or effectiveness of compounded medicines. While they may be used if an FDA-approved, commercially available drug doesn't work, compounded medicines have ingredients that can often cost more - but are not necessarily more effective - than similar FDA-approved medicines.

At-a-glance guide

Online

If you have Internet access, you can use the Express Scripts website to quickly find information. Register today at **express-scripts.com** to:

- Order home delivery refills of your prescriptions
- Track the status of your home delivery prescriptions
- Check prescription pricing and coverage
- Print or request home delivery order forms
- Locate a participating retail pharmacy
- Submit claims or download claim forms
- Obtain health information and much more

By mobile app

Search Express Scripts in your device's app store and download for free.

- Order home delivery refills of your prescriptions
- Track the status of your home delivery prescriptions
- Check prescription pricing and coverage
- Display virtual ID card
- Set dose reminders

By phone

Call **800.232.6549** to speak with a prescription plan specialist and:

- Ask questions about your prescription plan
- Request home delivery order forms or envelopes
- Find the nearest participating retail pharmacy
- Request claim forms for prescriptions filled at out-of-network pharmacies
- Speak with a registered pharmacist
- Order refills

All services listed are available 24 hours a day, 7 days a week.

To access TTY service for hearing-impaired members, call **800.899.2114**.

By e-prescribing or fax from your doctor

Your doctor may send your prescriptions to Express Scripts for home delivery by using e-prescribing or by faxing to **800.613.5628**.

Helpful contact information you may need

| | |
|---|---|
| Express Scripts website..... | express-scripts.com |
| Express Scripts mobile app (download) | express-scripts.com/mobileapp |
| Prescription plan specialists | 800.232.6549 |
| TDD | 800.759.1089 |
| Accredo..... | 800.803.2523 |
| Prior Authorization (doctors only) | esrx.com/PA |

Your privacy is important

Express Scripts is committed to meeting the University of New Mexico guidelines related to protecting your privacy as well as those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA includes provisions to ensure privacy of your personal health information.

In order to provide you with pharmacy services and to administer your prescription plan, we may require personal health and prescription information from you, your doctor or your retail pharmacy. We use this information only to verify your identity and pricing under program; to check for adverse drug interactions; to accurately process your prescription order; and to keep you informed about the proper use of your medicines, available treatment and benefit options.

Under the terms of our contract with the University of New Mexico, Express Scripts is required to provide individual pharmacy claims data for payment processing and record keeping without identifying individual members. As part of the contract, we are also obligated to report any unusual activity that may constitute fraud or abuse of benefits.

