Businessolver, Inc. Summary Plan Description (SPD) Summit 3500 Plan

This Summary Plan Description (SPD) outlines the basic features of the Plan and how it operates to help you receive the maximum advantage from your pharmacy benefit.

About OptumRx and Contact Info

The prescription drug program for Businessolver, Inc. Horizon 2500 participants is administered by OptumRx and its affiliates. This is only a summary of the key parts of the Plan. You may contact OptumRx toll free at: 1-855-524-0381 or visit the OptumRx website at: www.optumrx.com, or utilize the OptumRx mobile app for more details about the 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, Businessolver, Inc. Horizon 2500 plan will provide coverage for up to a 90 day maximum allowable retail day supply per dispensing (standard supply), subject to the cost share listed in the **Benefit Grid**.

Home Delivery Pharmacy Benefit

The Plan utilizes OptumRx as the mail order pharmacy. To set up mail-order services, visit www.optumrx.com, use the OptumRx App or call 1-888-543-1369 for assistance. Businessolver, Inc. Horizon 2500 plan will provide coverage for up to a 90 day supply per dispensing (standard mail order supply), subject to the cost share listed in the **Benefit Grid**.

Members can enroll in to receive automatic refills from OptumRx Home Delivery using their credit card on file. Members can opt-into this service at the medication level. Members can opt-out of the program at any time

Specialty Pharmacy Benefit

The Plan utilizes Briova as the specialty pharmacy. To set up specialty services visit www.optumrx.com or call 1-888-543-1369 or assistance. Businessolver, Inc. Horizon 2500 plan will provide coverage for up to a 30 day supply per dispensing (standard supply), subject to the cost share listed in the **Benefit Grid**.

What You Will Pay
Benefit Grid

Benefit Grid	What You Will Pay				Limitations, Exceptions, and Other Important Information
	In-Network Pharmacy	In-House Pharmacy	Mail Order Pharmacy	Out-of-Network Pharmacy	
Generic Drugs (Tier 1)	Deductible than 20%	N/A	Deductible than 20%	N/A	See Formulary document
Preferred Brand Drugs (Tier 2)	Deductible than 20%	N/A	Deductible than 20%	N/A	
Non-Preferred Brand Drugs (Tier 3)	Deductible than 20%	N/A	Deductible than 20%	N/A	
Specialty Drugs (Tier 4)	Deductible than 20%	N/A	Deductible than 20%	N/A	

Out of Pocket Expenses
There are three phases that your Plan will experience throughout the year as determined by reaching predetermined thresholds in your medical and pharmacy spending:

- **Deductible Phase:** You pay the full cost of medical and pharmacy services until you meet your deductible of $3,500 (single) or $7,000 (family). The deductible does apply to your out-of-pocket maximum

- **Coinsurance phase:** After you meet the deductible amount, you and your health plan share the cost of covered expenses, called coinsurance. You are responsible for paying your coinsurance amount listed on the **Benefit Grid** until you reach your maximum out-of-pocket of $4,500 (single) or $8,150 (family)

- **100% Coverage Phase:** Once you have reached your maximum out-of-pocket 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.optumrx.com, or utilizing the OptumRx mobile app.

- **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 settings. If you have specific questions regarding your coverage, please contact OptumRx at 1-855-524-0381

General Covered Drugs

- Federal Legend Drugs
- State Restricted Drugs
- Antihemophilia Agents
- Diabetic Supplies
- Needles and Syringes
- Specialty Pharmacy Drugs
- Compounded Medications of which all ingredients are covered by the Plan
- ACA Preventative Medication Drug List (covered at 100%)

General Excluded Drugs

- Over the Counter (OTC) medications or their equivalents, unless the individual's pharmacy benefit offers coverage of OTC medications
- Drugs specifically listed as not covered
- Any drug products used for cosmetic purposes
- 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
- Foreign sourced drugs or drugs not approved by the United States Food & Drug Administration (FDA), except in certain cases of drug shortage, when allowed under the individual's pharmacy benefit

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 OptumRx.

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

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.optumrx.com

Vigilant Drug Program – Me Too
Chemically similar drugs that share the same mechanism of action and incur more cost over other more cost effective options are excluded from the Plan.

Vigilant Drug Program – Non-Essential Drug Program
Products which are available on the market and offer little clinical value versus other well tested FDA-approved products are excluded from the Plan

Vigilant Drug Program – High Cost Generics
Higher-cost generic products when a lower-cost generic equivalent is available are excluded from the Plan.

Vigilant Drug Program – High Cost Brands with Generics
Higher-cost brand products when a clinically equivalent, lower-cost generic option is available are excluded from the Plan.

Vigilant Drug Program – New Drugs to Market (NDTM)
This program targets new unique chemical entities and new drug products that fall within the scope of the pharmacy benefit that has yet to undergo review by the OptumRx P&T Committee. At their market launch, these drugs are excluded from coverage while they are undergoing a clinical evaluation for either placement on our formulary or exclusion.

Free Meter Program
Provides a blood glucose monitoring system for personal diabetes management at no cost to members. Select meters are available for order directly from the manufacturers.

Bulk Chemical Exclusions for Compounds
Compounding is a practice in which a pharmacist or other health care professional combines mixes or alters ingredients to create a medication tailored to the needs of an individual patient. As a result, compounded medications may serve a role on rare occasions when a patient cannot be treated with an FDA-approved medication, such as when an elderly patient or a child cannot swallow a tablet and needs a medicine in a liquid form that is not commercially available. However, compounded medications are not approved by the FDA, so their safety, quality and effectiveness have not been verified. These drugs are excluded from the Plan.

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.

- **Obtaining Coverage:** Coverage, questions or information about the medication request may be obtained by:
    - Members or their physicians can initiate the prior authorization review process by contacting OptumRx's prior authorization department. Pharmacy technicians then work with physicians to obtain the information needed for the review. Once OptumRx receives a completed prior authorization request via telephone or fax, they will conduct a clinical review within two business days. OptumRx communicates the clinical decision in writing to the physician and send a copy to the member.

Appeals of Adverse Benefit Determinations

If an adverse benefit determination is rendered, in whole or in part, or a benefit denial is rendered on the member's claim, the member may file an appeal of that determination. The member's appeal of the adverse benefit determination can either be verbal or written and submitted to OptumRx within 180 days after the member receives notice of the adverse benefit determination. .

If the adverse benefit determination is rendered with respect to an urgent Prior Authorization (PA) request, a healthcare professional with knowledge of the member's condition is always deemed to act as the member's representative.

If the member does not object to representation by a healthcare professional or authorizes the healthcare professional or another party to represent him/her to the conclusion of the appeal process, the member will have exhausted his/her opportunity to appeal the adverse benefit determination or benefit denial in the future. However, if the member does not authorize the healthcare professional to request an appeal on his/her behalf, the member may reject the representation and withdraw the appeal request.

Any member representatives must be identified and their authority verified in accordance with OptumRX policy and procedures. There are no fees or costs charged to the member for any level of appeal conducted by OptumRX on behalf of Businessolver, Inc. Horizon 2500 Plan.
The member's appeal should include the following information:

- Name of the person filing the appeal

- Pharmacy benefit 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:

OptumRx
Attn: Appeals Coordinator
P.O. Box 25184
Santa Ana, CA

OR

PA (Clinical) Appeal Phone # 888-403-3398
PA (Clinical) Appeal Fax # 844-403-1029

OptumRx's Review

The review of a member's claim or appeal of an adverse benefit determination on behalf of Businessolver, Inc. Horizon 2500 Plan will be conducted in accordance with the guidelines under Businessolver, Inc. Horizon 2500's pharmacy benefit plan, the requirements of the Employee Retirement Income Security Act (ERISA) and any related laws. Members will be accorded all rights granted to them under ERISA, if applicable.

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

OptumRx 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 Businessolver, Inc. Horizon 2500'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

OptumRx provides a single level of appeal for administrative denials. Upon receipt of such an appeal, OptumRx 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

Pre-Service Clinical Prior Authorization – OptumRx will make a decision on a first-level appeal of an adverse benefit determination rendered on a pre-service clinical Prior Authorization claim within 15 days after it receives the member's appeal. If OptumRx renders an adverse benefit determination on the first-level appeal of the pre-service clinical Prior Authorization claim, the member may appeal that decision by providing the information described above. A decision on the member's second-level appeal of the adverse benefit determination will be made (by the IRO) 45 days after the new appeal is received. If the member appeals an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than 72 hours after the appeal request is received.

- *Administrative Denial Appeal* – OptumRx will make a decision on an appeal of an adverse benefit determination rendered on an administrative denial within 15 days after it receives such appeal
- *Post Service Claim Appeal* – OptumRx will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim within 30 days after it receives such appeal

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, OptumRx 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, and
- 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 OptumRx'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, OptumRx will notify the member of any adverse benefit determination in writing. (Decisions on urgent care claims will also be communicated by telephone.) 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

If a member pays the full cost of a prescription, regardless of the reason, and needs reimbursement, paper claim forms can be obtained by calling OptumRx at 1-855-524-0381 or log on to www.optumrx.com. Only eligible claims are considered for coverage and all standard plan benefits apply. The standard turnaround time is four to six weeks for reimbursement of submitted paper claims. Members are reimbursed based on the pharmacy-discounted price, less the applicable copay.

Foreign Claims

Medications filled through foreign providers must have a U.S. FDA-approved alternative to allow for processing as a brand or generic product. If an approved alternative is not available, the foreign claim will be rejected. OptumRx uses an online program that will convert foreign currency to U.S. dollars for member reimbursements.

OptumRx Essential Health Benefit (EHB) Zero Copay Medications

The Patient Protection and Affordable Care Act (PPACA), commonly known as healthcare reform, was signed into federal law in 2010. The PPACA established a package of items and services known as essential health benefits, which includes preventative services and medications. As of 2014, certain health plans are required to cover recommended preventive services and medications without charging a copayment, coinsurance or deductible. OptumRx has developed a list of medications and coverage criteria to support preventive medication requirements based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC) to be covered under the pharmacy benefit.

Recommendations from USPSTF and the CDC can occur at any time and health plans have specified timelines to implement these recommendations to be compliant with federal law. Plans that meet the definition of a “grandfathered” plan are not subject to PPACA’s Essential Health Benefit requirements. Under the Affordable Care Act (ACA), plans are required to cover USPSTF preventive recommendations that have an A or B rating.
In an on-going effort to remain compliant with healthcare reform requirements under the Affordable Care Act, OptumRx updates the list of medications and coverage criteria for preventative medications to be covered at zero-copay under the pharmacy benefit as needed. State specific requirements may vary.

Expanded Preventive Medication List (PML)

For members enrolled in High Deductible Health Plans (HDHP) there is a specific list of drugs that will by-pass the deductible. This list includes medications identified as those most likely to qualify as “preventive” based on the U.S. Department of Treasury Department/IRS guidance. This list may not include all medications considered preventive or every health condition for which a preventive drug may be prescribed.

Non-Embedded Deductible

The family as a whole must meet the “Family” deductible before they will go into the copay/coinsurance phase of their benefit.

Non-Embedded Maximum Out-of-Pocket

The family as a whole must meet the “Family” maximum out-of-pocket before they will go into the 100% coverage phase of their benefit.

Vaccines

OptumRx offers a vaccine program that allows for coverage under the pharmacy benefit with $0 copay. The OptumRx vaccine program covers all vaccinations recommended as routine, by the CDC's Advisory Committee on Immunization Practices (ACIP).