MEDICARE PART D
Preferred Cost Share Participating Pharmacy Program Requirements & Manual

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### Audit Program
- Overview
- Signature Logs
- Return-To-Stock Items
- Multi-Ingredient Compound Prescription Claims
- Long Term Care Claims
- Audit Appeals Process

### General Pharmacy (non-audit related) Appeals Process
- Appeals Process
- Dispute Resolution
- Arbitration

### Attachments
#### Exhibit A
- Sample Cigna HealthSpring Medicare Rx Cards

#### Exhibit B
- Notice of “Medicare Prescription Drug Coverage and Your Rights”

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WELCOME and GENERAL INFORMATION

Welcome to the Cigna HealthSpring Medicare Part D Preferred Cost Share Participating Pharmacy Network (Network). This Network is comprised of a select group of pharmacies who have agreed to partner with Cigna HealthSpring to improve Medicare Part D Enrollees (Participants) health outcomes by promoting and adhering to clinical and quality guidelines and measurements. More information about this Network is throughout this Medicare Part D Preferred Cost Share Participating Pharmacy Program Requirements and Pharmacy Manual (Manual).

This Manual provides the Medicare Part D Preferred Pharmacy (Pharmacy) with detailed program requirements and related operational policies and procedures related to the Medicare Part D Prescription Drug Program (Program) that are not defined and described in the Medicare Part D Preferred Cost Share Participating Pharmacy Agreement (Agreement). If there is a conflict between the Agreement and the Manual, this Manual shall govern. By signing the Agreement, Pharmacy has agreed to comply with the Manual. Please be certain to orient all Pharmacy staff to these requirements.

Cigna HealthSpring reserves the right to update this document from time to time. The latest copy of this Manual can be found at www.Cigna.com/pharmacists. Material changes to this Manual will be communicated 30 days prior to the effective date of such changes and shall be posted on the web at www.Cigna.com/pharmacists in the “Notices” section.

All capitalized terms used in this document shall have the meaning ascribed to them in the Agreement unless otherwise noted.

Cigna HealthSpring Medicare Part D Preferred Cost Share Participating Pharmacy Agreement (Agreement): The Agreement is a direct agreement between Cigna HealthSpring and Pharmacy. Pharmacy is expected to adhere to all Agreement terms. Cigna HealthSpring and Pharmacy shall comply with all applicable state and federal statutory, regulatory and CMS requirements relating to Medicare Part D Participants including, but not limited to, the requirements set forth in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”), as codified in sections 1860D-1 through 1860D-41 of the Social Security Act (the Act) and the rules and regulations promulgated there under, as amended from time to time. Non-compliance to the Agreement and CMS requirements is subject to the termination provisions described in the Agreement.

Pharmacy should have a copy of the executed Agreement in its files. If you need a copy of have any questions about the Agreement, please email Cigna HealthSpring’s Pharmacy Network Operations at PharmacyNetworkOperations@Cigna.com.

Agreement Termination: Cigna HealthSpring and Pharmacy may terminate its participation in the Program only in accordance with the Agreement’s termination provisions. If Cigna HealthSpring terminates the Agreement during a Medicare Part D plan year, then, notwithstanding such termination, the Medicare Amendment/s to such Agreement and all provisions in the Agreement reasonably related to Covered Services to Medicare Contract Participants (i.e., Medicare Part D enrollees) will continue in effect until the end of such Medicare Part D plan year provided that Cigna HealthSpring notifies Pharmacy that such Medicare Part D Amendment/s and provisions will remain in effect.

Agreement Termination pertaining to Group Purchasing Organizations and Pharmacy Service Administration Organizations (GPOs/PSAOs): GPO/PSAOs will require all Pharmacies as described in the Agreement to remain in the Network at rates described in the Agreement and charge applicable cost shares for the full plan year. GPOs/PSAOs may submit requests to Cigna HealthSpring in writing to consider adding additional pharmacies or pharmacy chains as preferred to the Agreement, however, Cigna HealthSpring, in its sole discretion and in compliance with CMS, retains the right to accept or deny such requests regardless of GPO’s/PSAO’s expansion or growth of a GPO’s/PSAO’s pharmacy network. Please refer to the Agreement for additional contractual requirements not described in this Manual.
Conditions of Participation: To participate in the Network, Pharmacy must meet the following criteria:

* Abide by all terms of the Agreement including comply with all applicable state and federal laws;
* Be fully credentialed and recredentialed throughout the duration of this Program;
* Maintain and provide certificate of proof of Pharmacy malpractice liability insurance coverage for each occurrence of at least $1,000,000 and $2,000,000 in general aggregate coverage OR indication of self-insured.
* Maintain an on-line telecommunications link with the Cigna HealthSpring’s designated claims processor;
* Willing to accept pharmacy pricing and payment including acceptance of the lower of usual and customary (U&), submitted ingredient cost, and Cigna HealthSpring’s Maximum Allowable Cost (MAC) prices;
* Willing to abide by this Manual and Cigna HealthSpring’s policies and procedures;
* Willing to work with Cigna HealthSpring Pharmacy Management and managed care plans;
* Adhere to Cigna HealthSpring’s clinical and quality management guidelines;
* Willing to follow the grievance and appeals process as outlined in the Agreement and this Manual;
* Maintain a positive reputation and relationship with Cigna HealthSpring’s Medicare Contract Participants;
* Maintain Annual Medicare Part D compliance training for pharmacy staff.

Credentialing and Recredentialing: All pharmacies are credentialed before being accepted as preferred in the Program. Periodic recredentialing will be conducted by Cigna HealthSpring or its designee in accordance with Cigna HealthSpring’s standards and/or as mandated by law. Pharmacy is expected to promptly provide Cigna HealthSpring or its designee with the requested documentation in order to maintain its preferred status.

Pharmacies must be licensed by their State Boards of Pharmacy as well as registered with the National Association of Boards of Pharmacy (NABP). Pharmacy must be in good standing with the NABP, Drug Enforcement Association (DEA), Office of Inspector General (OIG), and their State Board(s) of Pharmacy through which it is licensed. Cigna HealthSpring may review State Board(s) of Pharmacy data compiled through pharmacy inspections by the Pharmacy Commission, Drug Control Agencies, and other agencies. In addition, Cigna HealthSpring may review complaints on file and actions taken by the State Board of Pharmacy regarding the pharmacy and its employed pharmacists.

Updates to the Pharmacy’s address, telephone number, etc., can be faxed to Cigna HealthSpring’s Pharmacy Network Operations at 860.226.3535 or emailed to PharmacyNetworkOperations@Cigna.com. Please allow 10 business days for updates to become effective. All updates will have prospective effective dates. In addition to notifying Cigna HealthSpring of such updates, it is imperative that your Pharmacy notifies NCPDP as well @ 480.477.1000.

Products Covered: Cigna Medicare Rx (PDP) Individual

Advertising Requests: Pharmacy must obtain prior written consent from Cigna HealthSpring on any and all advertisements that reference Cigna HealthSpring in any way regardless of the advertising medium. A copy of the ad, if printed medium, or written copy of the script, if radio, TV, or cable, must be faxed to Cigna HealthSpring’s Pharmacy Network Operations at 860.226.3535 along with the name of the pharmacy, contact name and telephone number, reason for the advertisement, duration and market(s) where the advertisement will run. Approval or denial will be communicated to the Pharmacy once internal review is completed. Advertising campaigns designed to waive or discount Participant copayments, coinsurances or deductibles will automatically be denied.

Cigna HealthSpring Website Information: Please utilize our website (www.cigna.com/pharmacists) to obtain forms, claim processing, contact information, emergency overrides and drug alerts.
Feedback: Cigna HealthSpring values any input you may have on how to make this document more useful as a tool to help you serve our Participants. Feel free to contact Pharmacy Network Operations via mail, email, or fax with your suggestions and comments.

Cigna HealthSpring
900 Cottage Grove Road – B5PHR
Hartford, CT 06152
Fax: 860.226.3535
Email: PharmacyNetworkOperations@Cigna.com

ELECTRONIC CLAIMS TRANSMISSIONS

Claim Transmission Requirements: Cigna HealthSpring’s Medicare Part D Prescription Drug Plan’s claims are processed through Catamaran’s Online System within 90 days of the fill date (or as otherwise required by law). Claim reversals and adjustments, however, must be processed within 365 days of the fill date. Pharmacy is expected to transmit all claims via the Online System within 90 days from the fill date. Cigna HealthSpring will return all UCF/paper claims to the Pharmacy for transmission via the Online System.

Currently Catamaran uses two methods for obtaining claim data via electronic protocol: dedicated phone line (host-to-host transmission) or through use of a network switch. The switch organizations recognized by Catamaran are WebMD (e.g., Envoy), National Data Corporation (NDC) and QS-1.

All claim transactions must utilize the NCPDP version D.0 Standard Point Of Sale (POS) claim layout. While Catamaran supports NCPDP versions I, II, and III, pharmacies are encouraged to submit claims in version III to receive all messaging. Each organization that acts as the switch for Catamaran has requirements that must be met for proper claim transmittal. This information should be obtained from the switch organization. These organizations can also offer point-of-sale devices.

CMS requires all pharmacies to process claims using NCPDP version D.0.

Key Data Elements to be submitted to Catamaran in order to successfully transmit a point of sale claim are:

<table>
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<tr>
<th>Data Element</th>
<th>Value</th>
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<tbody>
<tr>
<td>Catamaran Bin Number</td>
<td>017010</td>
</tr>
<tr>
<td>Carrier/Processor Control Numbers</td>
<td>CIHSCARE for Cigna HealthSpring Medicare PDP</td>
</tr>
<tr>
<td>NCPDP/NABP Number</td>
<td></td>
</tr>
<tr>
<td>Beneficiary ID</td>
<td></td>
</tr>
<tr>
<td>Person/Relationship Code</td>
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<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Rx Number</td>
<td></td>
</tr>
<tr>
<td>Date Filled</td>
<td></td>
</tr>
<tr>
<td>Prescriber ID</td>
<td></td>
</tr>
<tr>
<td>NDC</td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td></td>
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<tr>
<td>Days Supply</td>
<td></td>
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<tr>
<td>U&amp;C</td>
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<tr>
<td>Ingredient Cost</td>
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Group or account numbers are not required in order to transmit a claim. In fact, Cigna HealthSpring discourages Pharmacy from entering group or account numbers as it may result in the rejection of potentially viable claims.

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Cigna HealthSpring recognizes DAW Codes 0, 1 and 2 only. While a Dispense As Written (DAW) code is not required to be transmitted on the claim, the DAW field drives reimbursement of the prescription and the Participant’s copayment. Therefore, it is essential that this field be used appropriately. Additionally, DAW data entered by the Pharmacy is subject to retrospective audit.

**Online System Downtime Transmission Procedures:** In the rare instance that the Online System is inoperable, Pharmacy should attempt to resubmit the claim at a later date, but within 90 days of the fill date.

**Claim Reversals and Adjustments:** If the Pharmacy needs to resubmit a claim previously adjudicated through the Online System, e.g., Participant fails to pick up the prescription, Pharmacy must first submit a reversal. Reversals must be made within 365 days from the fill date. Reference the Pharmacy’s software system documentation or vendor for information about submitting a reversal. Catamaran can also assist the Pharmacy with reversing claims. Once a reversal is submitted, an adjusted claim may be transmitted. For a prescription billed to Cigna HealthSpring that is not picked up by a Participant, Cigna HealthSpring encourages Pharmacy to reverse the claim via the Online System within 14 days from the fill date. As part of its audit program, Cigna HealthSpring will audit for prescriptions that were not picked up by Participants to ensure appropriate claim reversals. If Pharmacy was unable to reverse claims over 365 days from the date of service via the Online System, call Catamaran’s Provider Relations at 877.633.4701 or Provider.Relations@Optum.com.

**ASSISTANCE AND KEY CONTACTS**

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<tr>
<th>For Assistance with:</th>
<th>Contact</th>
<th>Phone:</th>
<th>Fax:</th>
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<tr>
<td>Audit and Audit Appeals</td>
<td>Catamaran</td>
<td>866.618.6853</td>
<td>866.244.9066</td>
</tr>
<tr>
<td>Claims Processing Issues (e.g., claim rejects, non-matched pharmacy claim rejects)</td>
<td>Catamaran</td>
<td>Medicare Part D: 888.625.5686</td>
<td>Illinois Medicaid: 855.312.2285</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Texas Medicaid: 866.618.6725</td>
<td>Medicare Medicaid Alignment Initiative (MMAI): 855.577.6519</td>
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<td>Contract Questions:</td>
<td>Cigna HealthSpring</td>
<td><a href="mailto:PharmacyNetworkOperations@Cigna.com">PharmacyNetworkOperations@Cigna.com</a></td>
<td><a href="mailto:Provider.Relations@Optum.com">Provider.Relations@Optum.com</a></td>
</tr>
<tr>
<td>Preferred Pharmacies</td>
<td>Catamaran</td>
<td>Phone: 888.625.5686</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Pharmacies</td>
<td></td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
</tr>
<tr>
<td>Participant Eligibility and Benefit Verification</td>
<td>Catamaran</td>
<td>Phone: 866.618.6853</td>
<td>866.244.9066</td>
</tr>
<tr>
<td>Claims payment cycle information</td>
<td>Catamaran</td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
</tr>
<tr>
<td>Missing payments</td>
<td></td>
<td>Phone: 888.625.5686</td>
<td></td>
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<tr>
<td>Copies of reconciliation reports or cancelled checks</td>
<td></td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
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<tr>
<td>Changes to pharmacy payment address</td>
<td></td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
</tr>
<tr>
<td>Prior Authorizations</td>
<td>Cigna HealthSpring</td>
<td>877.813.5595</td>
<td>866.845.7267</td>
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<td>Reimbursement Questions for:</td>
<td>Cigna HealthSpring</td>
<td><a href="mailto:PharmacyNetworkOperations@Cigna.com">PharmacyNetworkOperations@Cigna.com</a></td>
<td><a href="mailto:Provider.Relations@Optum.com">Provider.Relations@Optum.com</a></td>
</tr>
<tr>
<td>Preferred Pharmacies</td>
<td>Catamaran</td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
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<tr>
<td>Non-Preferred Pharmacies</td>
<td></td>
<td>Phone: 877.813.5595</td>
<td>866.845.7267</td>
</tr>
<tr>
<td>Change pharmacy address</td>
<td>NCPDP</td>
<td>Phone: 480.477.1000</td>
<td>877.633.4701</td>
</tr>
<tr>
<td>Language Interpretation Line for Limited English Proficient Beneficiaries</td>
<td>Cigna HealthSpring</td>
<td>Phone: 800.806.2059</td>
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**Failed Connections:** If your system or point-of-sale device is unable to make a connection with the Catamaran Online System, contact your vendor for assistance.

**Claim Rejects due to Refill Too Soon, Quantity, Days Supply, Precertification, Drug Not Covered, Non-Formulary Drug:** Reference the Drug Utilization Review Section of this document for appropriate contacts and procedures.

**PARTICIPANT ELIGIBILITY VERIFICATION**

The Online System is designed to verify active Participant eligibility. The Participant's ID number is printed on the Cigna HealthSpring ID card. ID numbers may be the cardholder’s social security number, alternate member id number or a system-generated ID number. Be certain to verify the ID number on the Participant’s Cigna HealthSpring ID card before transmitting a claim to avoid a rejection, subsequent adjustment, or the processing of the claim under another Participant’s eligibility.

Additionally when submitting the ID number, be certain to include the appropriate 2-digit relationship code (e.g., 01, 02, etc.). Pharmacy is solely responsible for submitting accurate Participant eligibility information. If the submitted date of birth or Participant suffix does not match the Participant’s information in the Online System, the claim will be denied.

Please note the Participant’s group number is not required in order to transmit a claim via the Online System.

If a Participant has a letter stating that he or she has active coverage but has not yet received a Cigna HealthSpring ID card, attempt to adjudicate the claim as eligibility may have been loaded to the system. Call Cigna HealthSpring at 800.Cigna24 (800.244.6224) to obtain an override if the claim denies due to “Participant ineligible” (NCPDP Error Messages: 52-Non-Matched Cardholder Identification; 65-Patient is Not Covered; 67-Filled Before Coverage Effective; 68-Filled After Coverage Expired; 69-Filled After Coverage Terminated).

If eligibility cannot be determined through the Online System or the toll-free numbers provided and the Participant states that he or she is eligible for prescription benefits, the Participant must pay the Pharmacy for the prescription and submit an original receipt from the Pharmacy to the address on his or her Cigna HealthSpring ID card for potential reimbursement. Reimbursement is dependent upon the Participant’s benefit and eligibility. The receipt must be an original (copies are not accepted), legible, and contain the following information: Participant ID number, name of Participant for whom the prescription was provided, date of birth, fill date, name of drug, NDC, quantity, drug strength and amount paid. A note of explanation should also be included to substantiate out-of-pocket expense. If a Participant needs assistance, he/she may call the Customer Service Center telephone number listed on the back of his/her Cigna HealthSpring ID card.

**Processing Prescriptions for Adopted Children and Newborns:** Cigna HealthSpring’s Standard Administration and Billing procedures are as follows: All pharmacies are required to contact the Cigna HealthSpring Pharmacy Services Center @ 800.Cigna.24 (800.244.6224) to confirm eligibility on adopted children and newborns. A temporary authorization will be established so that prescriptions may be dispensed for a 30-day period. Do not submit any claims for the child under the mother's ID.

**SERVICING PARTICIPANTS AND RECOMMENDED SERVICE STANDARDS**

**Non-Discrimination:** Pharmacy agrees to ensure that its staff will provide Covered Services to all Participants in a professional and courteous manner and in accordance with the same standards and with the same time availability as offered to other Pharmacy customers. Pharmacy will ensure that its staff will not discriminate against any Participant based upon race, color, national origin, ancestry, religion, gender, marital status, sexual orientation, age, health status, handicap or source of payment.

In accordance with applicable state and federal law, Pharmacy will not discriminate against any Participant based upon the particular medication or drug to be dispensed. In instances where a pharmacist employed or
otherwise engaged by Pharmacy declines or refuses to dispense a particular medication or drug based upon personal conviction or belief, Pharmacy shall make any necessary accommodations to ensure that the medication or drug in question shall be dispensed in a timely manner in accordance with the prescriber’s instructions and the applicable benefit plan.

**Interpretation Services for Limited English Proficient Beneficiaries.** Participants have the right to an interpreter when receiving treatment and services. Cigna HealthSpring offers free telephonic interpretation through our language service vendor. To engage an interpreter once the Participant is ready to receive services, please call Cigna HealthSpring's Language Interpretation Line at 800.806.2059. You will need the Participant's Cigna ID number and your NCPDP number to confirm eligibility and access interpretation services. If a Participant prefers to use a family Participant or friend to provide interpretation services, after he/she has been told that a trained interpreter is available free of charge, the Participant's refusal to use the trained interpreter shall be documented in Pharmacy’s signature log.

**Recommended Service Standards:**

Telephone Refills placed in advance: No wait time; prescription should be ready upon pickup.  
Acute Care Prescriptions: <15 minutes  
Prescription Drop-off: <25 minutes

**Quality Assurance:** Pharmacy must fully cooperate with Cigna HealthSpring with prompt reply to any quality assurance issue pertaining to the delivery of Covered Services by the Pharmacy. Pharmacy shall follow all applicable formal procedures for quality assurance programs as may be mandated by state law. If there are no such state law mandates, Pharmacy shall follow the formal procedures for preventing and handling prescription errors as submitted by Pharmacy in its Application to participate in the Network.

**Investigations by government agencies:** Cigna HealthSpring reserves the right to immediately terminate its Agreement with a Pharmacy upon becoming aware that such Pharmacy has been investigated, within the past five years, or is currently under investigation by a Federal or state governmental agency or regulatory body. Pharmacy may submit a written appeal of the termination to Cigna HealthSpring to the address provided in the notice within 14 days of receipt of such notice. Pharmacy's appeal must include supporting documents for Cigna HealthSpring to review for consideration of reinstatement in the network.

**PRESCRIPTION DRUG LIST (DRUG LIST)**

A Drug List (also known as Formulary) is a list of covered drugs that Cigna HealthSpring selects to cover as part of Part D coverage. The drugs are selected in consultation with a team of healthcare providers which represents the prescription therapies believed to be a necessary part of a quality treatment program. Cigna HealthSpring generally covers the drugs listed in the Drug List as long as the drug is medically necessary, the prescription is filled at a preferred pharmacy, and other plan rules are followed. The Drug List is always prior approved by CMS. The Drug List can also be obtained via the Internet at: [www.cigna.com/medicare/part-d/drug-list-formulary](http://www.cigna.com/medicare/part-d/drug-list-formulary).

**PRESCRIPTION DRUG LIST (a.k.a. FORMULARY) (“DRUG LIST”) CHANGES**

The presence of medications and/or their tier placement on the Part D Drug List may have changed from the previous plan year. The Drug List covers an extensive array of medications to treat many indications. In some instances, medications that have either a direct generic equivalent or a therapeutic alternative on the Drug List may not be covered. Some medications may also be subject to step therapy, prior authorization, quantity limitations, or further clinical review. New and existing beneficiaries who are negatively affected by any Formulary restrictions will be extended coverage on their medication through the Cigna HealthSpring Medicare Part D transitional benefit policy as described below.
**PRODUCT OFFERINGS**

For a Summary Table of Cigna HealthSpring plans and cost shares, visit [www.cigna.com/medicare/part-d/plans](http://www.cigna.com/medicare/part-d/plans). Sample Participant Cigna HealthSpring ID cards are attached to this Manual. Pharmacies are expected to service all Participants carrying Cigna HealthSpring ID cards. The Participant is required to pay the difference in cost between the generic drug and brand name drug plus the brand name copayment when a multi-source brand is dispensed.

All plans are processed through Catamaran so always transmit the claim via the Online System to obtain the appropriate Participant cost share (coinsurance, copayment and deductible).

Cigna HealthSpring has different Drug Lists depending upon in which Plan the Participant has chosen to enroll.

**STANDARD BENEFIT EXCLUSIONS**

Items excluded from coverage are based on a Participant’s plan design. Pharmacy will receive a message via the Online System indicating that the item is excluded or not covered. Benefit exclusions are not related to the Formulary and one-time authorizations are not approved. However, prescribers may submit for coverage based on medical necessity. Always adjudicate the claim to determine coverage before advising a Participant that an item is not covered.

The following summary represents therapeutic drug classes that are not covered under our individual plans:

Drugs excluded under Medicare Part D:

a. Agents for anorexia, weight loss, or weight gain
b. Agents used to promote fertility
c. Agents used for cosmetic purposes or hair growth
d. Agents used for the symptomatic relief of cough and cold
e. Prescription vitamins and mineral products; except prenatal vitamins and fluoride preparations
f. Nonprescription drugs
g. Outpatient drugs for which the manufacturer seeks to require that associated test or monitoring services be purchased exclusively from the manufacturer as a condition of sale
h. Agents when used for the treatment of sexual or erectile dysfunction (ED) unless prescribed for medically accepted indications approved by the FDA other than sexual dysfunction such as pulmonary hypertension

**PRESCRIPTION DRUG COST MANAGEMENT**

Pharmacy is expected to fully support Cigna HealthSpring in its effort to manage Participant’s prescription drug costs. Participants’ copayments are often determined based on whether a generic, preferred brand or non-preferred brand is dispensed. Prescription drug costs can best be managed through the following action:

**Generic Drug Substitution:** Dispense FDA-approved generic equivalent drugs whenever possible and in accordance with federal and state laws. Please maximize generic substitution so that the Participant is not charged the difference plus his/her copayment. The lowest copayment is applicable when a generic is dispensed. Please note that if a prescription is filled with the FDA as an NDA (vs. ANDA), the Participant’s brand copayment will be reflected. Contact the prescriber if necessary in order to dispense a generic equivalent drug. Certain drugs with documented dosing problems should not be dispensed generically unless requested by the prescriber.

**Prescription Drug List Compliance:** If a generic equivalent drug cannot be substituted, contact the prescriber to determine if a drug from the Drug List can be dispensed as an alternative.

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Prescriber “Dispense As Written” Prescriptions (DAW1): If a prescription specifies “Dispense As Written,” Pharmacy may contact the prescriber to determine if a generic equivalent or drug from the Drug List can be dispensed as an alternative.

DRUG UTILIZATION REVIEW

Pharmacy must fully comply with Cigna HealthSpring’s Drug Utilization Review (DUR) procedures. All claims transmitted via the Online System must pass a series of DUR edits. The prescription is screened for dosage errors and checked against the Participant’s claim history. Pharmacy will be alerted immediately via the Online System if the claim does not pass a particular DUR edit, such as an early refill or drug interaction. Cigna HealthSpring may, from time to time, require the assistance of certain Pharmacy employees in connection with DUR. Pharmacy will require its employees to be available to fully cooperate with Cigna HealthSpring and its personnel in the performance of DUR. All DUR forms, records and other information will remain the property of Cigna HealthSpring and will be kept confidential.

Pharmacists are under no obligation to dispense a prescription which, in their professional opinion, should not be dispensed. Additionally, pharmacists are expected to exercise their professional judgment when encountering DUR messages. The Online System clinical edits are not intended nor designed to replace a pharmacist’s professional judgment or knowledge.

Claim Rejects Due To Early Refill/Refill Too Soon DUR Edit (NCPDP Error Message 79-Refill Too Soon): Participants are required to utilize at least 75% of the previous prescription before a refill may be obtained from a retail pharmacy. For claims that reject as “refill too soon,” the following actions must be taken by the Pharmacy before obtaining an override:

If the previous prescription was never filled or picked up, reverse the claim to avoid a claim reject for “refill too soon.”

If the Participant has not used at least 75% of the previous prescription, advise the Participant that it is “too early to fill the prescription” and instruct the Participant to return on the appropriate day as determined by the Pharmacy.

If an early refill is due to a dosage increase/adjustment, the Participant needs a vacation supply or the days supply on the original prescription was entered incorrectly, please call 800.CIGNA.24 (800.244.6224) to obtain an authorization.

Claim Rejects Due To Quantity or Days Supply DUR Edits (NCPDP Error Message 76-Plan Limitations Exceeded): The standard retail pharmacy benefit allows up to a 30-day supply of medication (not to exceed 180 tabs/caps) to be dispensed. If an override is needed to exceed the standard quantity per month, providing medical necessity can be established, please call 800.CIGNA.24 (800.244.6224).

PRIOR AUTHORIZATION DRUGS AND PRECERTIFICATION PROCEDURES

Prescribers are encouraged to prescribe preferred drugs whenever possible and to obtain a precertification before prescribing non-preferred drugs or preferred drugs that require precertification. In the event a claim rejects at the point of sale for “Non-Formulary Drug” or “precertification required,” the following course of action must be taken by the Pharmacy:

Claim Rejects for Precertification Required (NCPDP Error Message 75-Prior Authorization Required): Certain drugs as identified on the Drug List have restrictions based on prior therapy required. Explain to the Participant that the prescriber must contact the Cigna Prior Authorization Department/Coverage Line via fax (866.845.7267) or telephone (877.813.5595) for medical necessity review. Do not advise the Participant that the drug is not covered, as coverage is based on medical necessity.
Claim Rejects for Step Therapy Required (NCPDP Error Message 75-Prior Authorization Required):
Certain Therapeutic Classes of Drugs (ex. statins, PPI’s, ACE/ARB’s) may require filling of prerequisite drug(s) for the medication that the Participant is requesting. If there is no record of filling of the prerequisite drug(s), the claim will be denied with the "Step Therapy Required" error message. Advise the Participant that the prescriber must contact the Cigna HealthSpring Pharmacy Prior Authorization Department/Coverage Determination via fax (866.845.7267) or telephone (877.813.5595) for medical necessity review.

Claim Rejects for Non-Formulary (NCPDP Error Message 70-Non-Formulary/Product Service Not Covered): Contact the prescriber and recommend a Drug List alternative. If the Online System does not provide a Drug List alternative or you cannot find one on the Prescription Drug List at www.cigna.com/medicare/part-d/drug-list-formulary, call 800.Cigna.24 (800.244.6224). If the prescriber is unavailable or unwilling to change the prescription to a drug on the Drug List, please call 800.Cigna.24 (800.244.6224).

Weekends and After Hours: Dispense up to a maximum of 3 day supply (or one unit, e.g., one inhaler, one tube) of the medication and collect the Participant's copayment as noted on the Cigna HealthSpring ID card. Please notify the Participant that this is a one-time exception. On the next business day, call 800.Cigna.24 (800.244.6224) for assistance in processing the claim for payment. Payment is guaranteed for 3 day supply of Non-Formulary medications dispensed in good faith. Never turn a Participant away because the medication is a Non-Formulary drug. If future refills are needed, the Participant's prescriber must submit a Non-Formulary Exception Form to the Pharmacy Prior Authorization Department/Coverage Determination Center for review and possible approval. Without approval, the Participant is responsible to pay the Pharmacy in full on future refills.

In all cases, please advise the Participant that Cigna HealthSpring does maintain an exception process. His or her prescriber may submit medical information for review to request an exception or to obtain precertification on certain prescriptions.

MEDICARE PART B VS. PART D COVERAGE DETERMINATIONS

Summary of Possible Medicare Part B vs. Medicare Part D Drugs

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Part B or Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusable DME supply drugs</td>
<td>B or D</td>
</tr>
<tr>
<td>Other Injectables</td>
<td>B or D</td>
</tr>
<tr>
<td>IVIG</td>
<td>B or D</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>B or D</td>
</tr>
<tr>
<td>Epogen</td>
<td>B or D</td>
</tr>
<tr>
<td>TPN</td>
<td>B or D</td>
</tr>
<tr>
<td>Nebulizing Solution</td>
<td>B or D</td>
</tr>
<tr>
<td>Immunosuppressants</td>
<td>B or D</td>
</tr>
<tr>
<td>Oral anti-cancer</td>
<td>B or D</td>
</tr>
<tr>
<td>Oral anti-emetic</td>
<td>B or D</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>B</td>
</tr>
<tr>
<td>Antigen</td>
<td>B</td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td>B</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>B</td>
</tr>
<tr>
<td>Blood Cloting Factors</td>
<td>B</td>
</tr>
<tr>
<td>Blood Products</td>
<td>B</td>
</tr>
</tbody>
</table>

Part B vs. D coverage determinations will be managed as follows:

1. When claims for drugs that should be covered under Medicare Part B benefit are submitted, they will be rejected with NCPDP Rejection Code 70—NON-FORMULARY/PRODUCT SERVICE NOT COVERED”.

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2. Drugs that require further review to determine coverage eligibility under Part B vs. Part D will be rejected with NCPDP Rejection Code 75 – “PRIOR AUTHORIZATION REQUIRED”. Certain drugs that will reject with reject code 75 may require the pharmacist to contact the Cigna HealthSpring Pharmacy Prior Authorization Department/Coverage Determination Center for further review. For other drugs that are more commonly used for Part D eligible indications in addition to reject code 75, a Prior Authorization Code (PAC) will be provided in the free form text field. Pharmacist should carefully review the free form text message and assess eligibility for Part D coverage. When deemed eligible, the rejected claims should be resubmitted using the provided PAC code for payment under the Medicare Part D benefit.

In all situations where a drug should be processed under Medicare Part D, Prior Authorization Code (PAC) 34910 should be used pending pharmacy review that such drug is Part D eligible. The PAC 34910 applies to all pharmacies and will only work in situations where a PAC code has been requested in the requirements to be returned to the pharmacy to allow the submission of the drug as eligible for coverage under Part D.

REIMBURSEMENT

Pharmacy will be reimbursed for Covered Services based on the lesser of the Pharmacy’s U&C, submitted ingredient cost, or the Network Rates described in Exhibit A (Reimbursement-Pharmaceutical Services) to the Agreement less i) Participant’s Copayments, Coinsurances, Deductibles, and any other cost sharing amounts as determined by the Online System, ii) network transaction fees as described in Exhibit A; and iii) Additional Price Reduction (APR) or DIR described in Exhibit B to the Agreement. Pharmacies can earn APR Rebates based on clinical performance as described in the Agreement.

Average Wholesale Price (AWP): Medispan is the source for AWP which is used to calculate payments to pharmacies (except for dispense fees) and determine drug price data. Databases from Cardinal, Inc., McKesson Corporation, and/or AmerisourceBergen Corporation may also be consulted for additional information on drug availability and pricing.

Maximum Allowable Cost (MAC) List: Cigna HealthSpring manages the MAC list under this Program. The MAC list shows the maximum ingredient cost that will be paid for the listed drugs. The most current MAC list is available electronically or in print. Contact Cigna HealthSpring Pharmacy Network Operations at MACInquiry@Cigna.com to request a copy.

MAC Price Review Process: Requests for MAC price reviews should be faxed to Cigna HealthSpring Pharmacy Network Operations at 860.687.9275 or emailed to MACInquiry@Cigna.com and must include the following information:

<table>
<thead>
<tr>
<th>NABP</th>
<th>Participant ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Name</td>
<td>Rx #</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Fill Date</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>NDC</td>
</tr>
<tr>
<td>Copy of purchase invoice reflecting the per-unit acquisition price</td>
<td></td>
</tr>
</tbody>
</table>

Copayments, Coinsurances, and Deductibles: Cigna HealthSpring will deduct Participant copayments, coinsurances, and deductibles from Pharmacy reimbursement. Pharmacy is contractually obligated to collect the full amount of the Participant’s copayment, coinsurance or deductible as determined by the Online System. Copayments, coinsurances and deductibles are not eligible to be discounted or excused/ waived. Pharmacy may not collect copayments, coinsurances and deductibles in excess of Pharmacy’s U&C.

COMPOUND PRESCRIPTION CLAIMS

Multi-Ingredient Compound Prescription Definition: A compound prescription is defined as a prescription drug containing a mixture of two or more ingredients when at least one of the ingredients in the preparation is a Federal or State legend drug in a therapeutic amount. It excludes compound prescriptions administered by infusion. Preparations that include the addition of water, alcohol, or flavoring are not considered covered.

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compound prescriptions. Reconstitution of an oral antibiotic or any other similar product is not considered a compound prescription.

**Multi-Ingredient Compound Prescription Claim Submission:** Compound prescription claims should be submitted by entering compound indicator “9” and listing all of the ingredient NDCs that comprise the compound, the quantity used and submitted ingredient cost. Pharmacy will be reimbursed for compound prescriptions based on covered ingredients, i.e., Pharmacy will not be reimbursed for the non-covered ingredients. Pharmacy will be reimbursed the lesser of the Pharmacy’s U&C, submitted ingredient cost, or the Network Rates described in Exhibit A (Reimbursement-Pharmaceutical Services) to the Agreement less i) Participant’s Copayments, Coinsurances, Deductibles, and any other cost sharing amounts as determined by the Online System, ii) network transaction fees as described in Exhibit A; and iii) Additional Price Reduction described in Exhibit B to the Agreement

Compound prescription claims should NOT be transmitted using an administrative NDC code such as 99999-9999-96. All compound prescription claims submitted by your Pharmacy and paid by Cigna HealthSpring are monitored for appropriateness of submitted charges and are subject to audit. Reference the Audit Program section in this Manual for additional information related to compound prescription claims.

**Note:** While all claims submitted by Pharmacy are subject to Cigna HealthSpring’s audit review, compound prescriptions claims are more frequently flagged and reviewed to ensure appropriate billing under Medicare Part B or Medicare Part D.

**TOTAL PARENTERAL NUTRITION (TPN) CLAIMS**

Claims for TPN require prior authorization from Cigna HealthSpring and should be transmitted using the NDC of the most expensive ingredient and entering compound indicator “9”. Claims transmitted under administrative NDC (99999-9999-96) will be denied.

**Note:** While all claims submitted by Pharmacy are subject to Cigna HealthSpring’s audit review, TPN claims are more frequently flagged and reviewed to ensure appropriate billing under Medicare Part B or Medicare Part D.

**QUALITY ASSURANCE PROGRAMS AND BENEFICIARY GRIEVANCES**

Pharmacy must fully cooperate with Cigna HealthSpring quality assurance programs and as may be required by CMS, with prompt reply to any quality of care and quality of service issues pertaining to the delivery of Covered Services by the Pharmacy.

Pharmacy shall follow all applicable formal procedures for quality assurance programs as may be required by CMS or mandated by applicable state law. If there are no such CMS or applicable state law mandates, Pharmacy shall follow the formal procedures for preventing and handling prescription errors as submitted by Pharmacy in its Application to participate in the Network.

**PARTICIPANT TRANSITIONAL BENEFIT AND PROCESS**

Cigna HealthSpring administers a transition process that helps facilitate new and existing Participant’s coverage for those Participants who change from another Part D plan or continue from the previous plan year. The transitional process applies to any drug subject to a clinical edit that result in a claim denial. Types of edits include prior authorization, step therapy, quantity limits, age, or gender edits. Drugs covered through the transitional process will adjudicate at the non-preferred brand copay. The transition process will NOT apply to drugs excluded from the standard Medicare Part D benefit. Drugs potentially covered under Medicare Part B will continue to be subject to coverage determination edits.

During Cigna HealthSpring’s process of establishing a Participant’s Medicare Part D coverage, appropriate overrides are set-up as per CMS and NCPDP guidelines. If a claim rejects and the Participant and/or Pharmacy believe that the medication should be covered as a transitional benefit, please call Cigna HealthSpring at 877.813.5595 for a prior authorization.

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New Participant One-Time Transition Supply

For each drug that has a limitation, new Participants are eligible for a temporary one-time supply (up to 30
days) within the initial 90 days of their plan effective date for prescriptions filled at a network pharmacy. After
the first transitional fill supply, these drugs will no longer be covered under the transitional benefit and will be
subject to all utilization edits for the remainder of the calendar year.

Existing Participants One-Time Transition Supply

Existing Participants with a Cigna HealthSpring Medicare Part D benefit should have received the Annual
Notice of Change (ANOC) packet by September 30. The packet contains information, which the Participant
may use to determine if a Prescription Drug List (“Formulary”) medication he/she is taking will either carry a
different cost share, have limited coverage, or will be subject to prior authorization, quantity limits or step
therapy in the coming year. Participants are instructed to work with their doctors to either find appropriate
alternative therapies on the new Cigna HealthSpring Prescription Drug List (“Formulary”) or request a
formulary exception prior to January 1st. If the exception request is approved, Cigna HealthSpring will
authorize payment prior to January 1st and provide coverage beginning January 1st.

If Participants have not received approval for their formulary exception request prior to January 1st, those
Participants will be eligible to receive temporary one-time transition supplies (up to 31 days) while continuing
to work with their doctors to find appropriate alternative therapies.

Long Term Care Participants

New and existing Participants residing in long term care facilities will be eligible for a temporary transition
supply (up to a 34-day supply) with multiple refills (up to a 102-day supply) within the first 90 days of their plan
eligibility. After this transitional period has passed, the medication will be subject to all utilization edits for the
remainder of the calendar year.

Emergency supply for Participant in a Long Term Care Facility

During the first 90 days of a Participant’s enrollment, long term care residents will receive a transition supply
as described above. However, to the extent that a Participant is outside his or her 90-day transition period,
that Participant will be eligible for a 31-day emergency supply of non-formulary drugs or drugs subject to
utilization management edits while an exception is being processed. This emergency supply should only be
allowed once per calendar year, and once per Participant, per facility, per drug.

Level of Care Changes

An extended transition process will be provided in circumstances involving Level of Care changes in which a
Participant is changing from one treatment setting to another. An override for the “Refill Too Soon” edit will be
provided to allow appropriate coverage. Since there may be some period of time in which Participants with
Level of Care changes experience a temporary gap in coverage while going thought the exception process,
Participants will be eligible for up to a 30-day supply of medication while an exception is being processed.

Participant and Provider Communication

Following the first fill of a prescription during the transition period, letters will be generated and mailed to the
Participant and his/her prescriber to advise of possible future denials and to communicate the medical
necessity exception process. For those Participants residing in long term care facilities, these letters will be
generated and mailed to the retail network pharmacy instead of the Participant’s prescribing physician. We
strongly encourage the pharmacist to work with the physician to make the necessary changes or initiate the
exception process. After the transition period, all drugs subject to utilization management will be subject to
exception/prior authorization review, unless coverage approval was obtained during the transition period.

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HealthSpring depends on contract renewal.
SAFETY EDITS

Safety edits will be generated for those claims that exceed a certain quantity limit threshold above the FDA approved maximum dose. When safety edits are generated, Pharmacy should first verify the correct quantity and rebill if an error is discovered. If the quantity submitted is verified to be correct, then the Pharmacy should notify the prescriber to obtain prior authorization for coverage or receive the correct billable quantity for the prescribed drug. Cigna HealthSpring encourages Network pharmacies to carefully review the online message in the free form text field which assist with further processing of claims that are rejected due to safety edits.

LONG TERM CARE CLAIM OVERRIDE CODES

Preferred Pharmacies serving Participants residing in Long Term Care facilities should submit such Part D claims with:

Patient Residence = 03 or 09
+ Place of Service = 01

Preferred Pharmacies servicing Participants receiving with Home Infusion Therapy at Home should submit such Part D claims with:

Patient Residence = 01
+ Pharmacy Service Type = 03
+ Place of Service = 01

Preferred Pharmacies servicing Participants residing in Home Infusion Therapy at Assisted Living facilities should submit such Part D claims with:

Patient Residence = 04
+ Pharmacy Service Type = 03
+ Place of Service = 01

Preferred Pharmacies servicing residents of Assisted Living facilities as Retail should submit such Part D claims with:

Patient Residence = 04
+ Pharmacy Service Type Not = 03
+ Place of Service = 01
+ "Treat ALF as LTC Flag" = N

Leave of absence, max 7 days supply – NCPDP code 420-DK = 3

Lost Medications, max of 3 days supply – NCPDP code 420-DK=4

Therapy change (Dose change or treatment frequency change for the same drug) – NCPDP code 420- DK=5

Medically necessary (Allow billing for same drug in different dosage form) – NDCPD code 420-DK=7
MEDICARE PART D COVERAGE GAP DISCOUNTS

Brand Drugs: Effective January 1, 2015, the Coverage Gap (Gap) Discount Program provides manufacturer discounts on brand name drugs, with certain exceptions, to Part D Participants when they reach the coverage gap. The drugs must be identified as brand name drugs by the Food and Drug Administration (FDA) otherwise they are classified as generic drugs.

The 50% manufacturer brand discount applies to the negotiated price. Negotiated price = ingredient cost + sales tax. Dispensing fees and vaccine administration fees are not included in the negotiated price and, therefore, are not eligible for the manufacturer discount.

If a Participant has a plan where brand coverage is available in the Gap, the 45% brand discount applies to the copayment as long as it is an FDA classified brand drug.

If a claim straddles the Gap and initial coverage or catastrophic coverage, the manufacturer discount is only applicable to the portion of the drug cost that falls within the Gap.

The dispensing fee for any straddle claim is paid under the initial coverage or catastrophic coverage.

Participants receiving a low-income subsidy are not eligible for the manufacturer brand discount since they already receive coverage in the Gap.

If the manufacturer does not sign an agreement, CMS will not allow its drug to be covered. Reject Error Code 70 – “PRODUCT/SERVICE NOT COVERED-PLAN/BENEFIT EXCLUSION” will appear if a non-participating manufacturer’s drug is entered for claim submission.

In most instances, for non-participating manufacturers’ drug, a similar drug is available through a different manufacturer/NDC generic drugs.

Generic Drugs: Effective January 1, 2015, as part of a gradual reduction in beneficiary expenses, Participants are responsible for 65% of generic drug costs while in the Gap, depending on their benefit plan. However, there are plans in which generic coverage is available in the Gap. This results in a ‘richer’ benefit for the Participant.

MEDICARE PART D SANCTIONED PROVIDER DENIAL ERROR CODE

Effective January 21, 2010, the “sanctioned provider” edit will be reinstated for Medicare Part D claims with a reject code -71 “OIG EXCLUDED”. The denial is due to the prescriber being identified as excluded from participation in Medicare, Medicaid and all Federal health care programs by the Office of Inspector General. The Center for Medicare and Medicaid Services requires that Part D plans prevent payment for any claims for sanctioned prescribers. Please contact the affected provider to make them aware of the denial. If necessary, advise patients to obtain a new prescription from a different provider or ask them to provide the name of an alternate provider to contact to obtain an authorization for that prescription.

Prescribers and pharmacies can find more information regarding sanctioned providers at:

Online: www.oig.hhs.gov/fraud/exclusions.asp
Email: sanction@oig.hhs.gov
Phone: 410.281.3060

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COMPLIANCE WITH MEDICARE REQUIREMENTS

Pharmacy agrees to provide to CIGNA HealthSpring all information and data related to Pharmacy's provision of services under the Agreement as such services pertain to Medicare Part D required for Cigna HealthSpring compliance with audits conducted by CMS or its designees, including but not limited to, information and data on prescription drugs claims, utilization, and medication therapy management (CMS Audit Data). Pharmacy shall provide Cigna HealthSpring with CMS Audit Data promptly upon written request from Cigna HealthSpring or within such timeframes as are necessary for Cigna HealthSpring to meet CMS audit deadlines as communicated to Pharmacy by Cigna HealthSpring. Pharmacy shall provide CMS Audit Data in the form and format required by CMS or its designee. Pharmacy acknowledges and agrees that if it is unable to fully comply with Cigna HealthSpring’s requests for CMS Audit Data, whether willfully or inadvertently, that results in incomplete or missing information or data, Pharmacy shall indemnify and hold CIGNA harmless from and against any and all recoveries, fines and penalties assessed by CMS against CIGNA HealthSpring (including possible extrapolated recoveries) as a result of such incomplete or missing information or data.

Notice of “Medicare Prescription Drug Coverage and Your Rights”. Per CMS requirement 42 CFR §423.562(a)(3), Pharmacy shall either conspicuously post the notice in Exhibit B to this Manual at the Pharmacy or distribute the notice to Participants.

AUDIT PROGRAM

Overview: All claims submitted by Pharmacy and paid by Cigna HealthSpring are subject to audit including compound prescription and TPN claims. Cigna HealthSpring or its designee will conduct periodic audits of Pharmacy’s claims submission activities to ensure compliance with the Agreement and this Manual. Desktop and on-site audits are conducted. Pharmacy is contractually obligated to comply fully with the Cigna HealthSpring Audit Program and shall cooperate with all auditing activity. Pharmacy shall provide all prescription, medical, financial and administrative records pertaining to Cigna HealthSpring Participant Covered Services upon request and within the timeframes specified by Cigna HealthSpring or its designee.

Catamaran will perform periodic desktop and on-site reviews of claims submitted on behalf of Cigna HealthSpring Participants.

For claims requiring review, Pharmacy will be notified by Cigna HealthSpring or its designee and requested to provide copies of specific prescriptions and/or other substantiating data. Upon review of the documentation, Pharmacy will be notified of its results, in writing, specifying any adjustments that may be applied.

Areas of retrospective desktop review will include, but will not be limited to, the following:

<table>
<thead>
<tr>
<th>DAW Parameters</th>
<th>Possible Rx Splitting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate Therapy/Prescriptions</td>
<td>Package Billing Errors</td>
</tr>
<tr>
<td>Excessive Quantity Dispensed for Days Supply Limitations</td>
<td>Drug Billed is Different Than That Dispensed</td>
</tr>
<tr>
<td>Early Refill</td>
<td>Valid Prescriptions</td>
</tr>
</tbody>
</table>

Pharmacies selected for on-site reviews will be notified in advance of the audit. There is no preparation required for this review. The auditor will perform a compliance review noting current licensures, pharmacy staff, stock on-hand, general cleanliness of the Pharmacy, hours of operation, etc. In addition, a pre-selected number of prescriptions will be reviewed.

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Areas of on-site prescription evaluations will include, but will not be limited, to:

<table>
<thead>
<tr>
<th>DAW Notations</th>
<th>Prescribing Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard Copy Prescription</td>
<td>Cigna Program Parameters</td>
</tr>
<tr>
<td>Signature Logs</td>
<td>Return-to-Stock Prescriptions</td>
</tr>
<tr>
<td>Drug Prescribed / Dispensed</td>
<td></td>
</tr>
</tbody>
</table>

**Signature Logs:** Pharmacy is required to maintain signature logs for all prescriptions. Pharmacy is required to advise Participants that his/her signature acknowledges receipt of a prescription and allows for the release of any and all information supporting that claim for the prescription to Cigna HealthSpring. Cigna HealthSpring recognizes the use of electronic signature logs.

Signature logs must contain the following:

- date the prescription was picked up by the Participant or his/her representative;
- prescription number; and
- signature of the individual to whom the prescription was given.

During audits conducted by Cigna HealthSpring or its designee, Cigna HealthSpring will deny payment for those prescriptions where Pharmacy is unable to produce a signature evidencing the above information. Pharmacy agrees that it will not bill Participants for any such denied claims.

**Return-To-Stock Items:** As part of the Cigna HealthSpring Audit Program, Pharmacy will be audited to ensure that Cigna HealthSpring has been credited appropriately for all return-to-stock items. For prescriptions that were billed to Cigna HealthSpring but were not picked up by the Participant, Pharmacy is contractually obligated to reverse the claims via the Online System within 365 days from the fill date. The Online System is the preferred means for handling this activity.

If Pharmacy was unable to reverse return-to-stock claims over 365 days from the date of service via the Online System, call Catamaran’s Provider Relations at 877.633.4701 or Provider.Relations@Optum.com.

It is imperative that Pharmacy processes future claims in a timely manner to ensure proper return-to-stock claim reversals.

**Multi-Ingredient Compound Prescription Claims:** All claims submitted by your Pharmacy and paid by Cigna HealthSpring are subject to audit including compound prescription claims. Cigna HealthSpring will not seek to recover payment for any compound prescription claim providing that your Pharmacy can demonstrate upon audit that the compound prescription was valid and the charge for such claim does not exceed reasonable and customary charges for similar compound prescriptions. Reasonable and customary charges will be based on the sum of the ingredients’ AWPs that were in effect at the time the compound prescription was prepared.

**Long Term Care Claims:** Cigna HealthSpring will monitor Preferred Pharmacy performance through a review of paid prescription claim data. Examples of reviews that Cigna HealthSpring may conduct include, but are not limited to, the following:

- Compound prescriptions to validate the accuracy of the submitted ingredient cost
- The number of paid prescriptions in excess of defined amounts
- Claims for controlled substances
- Claim histories to detect claim submission errors (e.g., double billings and split prescriptions)

Dispense as Written (DAW) code billings to ensure that brand drugs are only billed when either prescribed

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In addition, Cigna HealthSpring will monitor performance through random audits, patient satisfaction surveys, and patient complaints.

**Audit Appeal Process:** Pharmacies that want to appeal audit results may do so in accordance with the appeal instructions outlined in the audit letter. Please submit your appeal in writing within 15 calendar days of the letter along with supporting documents to the address listed in the audit letter.

**GENERAL PHARMACY (non-audit related) APPEALS PROCESS**

* A separate appeals process must be followed by Delaware, New Jersey, Pennsylvania, and State of Washington Network Pharmacies. Please refer to your Agreement for details or email Cigna HealthSpring Pharmacy Network Operations at PharmacyNetworkOperations@Cigna.com for more information.

**Appeals Process:** Pharmacy agrees to follow the Appeals Process outlined below. Pharmacy shall continue to dispense prescriptions to Participants in good faith during and subsequent to any appeal. Pharmacy agrees that it will refrain from making disparaging comments to Participants about Cigna HealthSpring.

Most contractual and reimbursement issues can be addressed and resolved quickly by emailing Cigna HealthSpring Pharmacy Network Operations at PharmacyNetworkOperations@Cigna.com. If the issue cannot be resolved, Pharmacy must follow the Appeals Process.

Pharmacy must submit a letter via certified, return receipt mail requesting review of the issue. Provide case facts and supporting documentation (e.g., claim detail) to:

Cigna HealthSpring Pharmacy Network Operations B5PHR
Attn: Appeals
900 Cottage Grove Road
Hartford, CT 06152

Upon receipt of the communication, the case will be researched and a written response of the Cigna HealthSpring decision will be provided to Pharmacy within 30 business days. If Pharmacy disputes Cigna HealthSpring’s response, a subsequent appeal may be submitted, Attn: Complaint Committee. The Committee shall include a Cigna HealthSpring pharmacist or medical director, as applicable, should an appeal contain a clinical component. The Committee’s decision will be rendered to the Pharmacy within 30 business days. Pharmacy may exercise its rights under the Agreement if the resulting decision is not acceptable.

**Dispute Resolution:** In the event the contract or reimbursement issue is not resolved through the Appeals Process, either Pharmacy or Cigna HealthSpring may request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party’s written request for negotiation, either party may initiate arbitration by providing written notice to the other party. With respect to a payment or termination dispute, Pharmacy must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Cigna HealthSpring’s internal Appeals process unless applicable law specifically requires a longer time period to request arbitration. If Pharmacy fails to request arbitration within such 12 month period, Cigna HealthSpring’s final decision regarding the dispute under its Appeals process will be binding on Pharmacy, and Pharmacy shall not bill Cigna HealthSpring, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

**Arbitration:** If a party initiates arbitration as provided above, the proceeding shall be held in the jurisdiction of Pharmacy's principal place of business or domicile. The parties will jointly appoint a mutually acceptable

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arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after a party has given the other party written notice of its desire to submit a dispute for arbitration, then the parties shall prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service (“AHLA ADR Service”) along with the appropriate administration fee. In accordance with the Codes of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators along with a background and experience description, references and fee schedule for each. The 10 will be chosen by the AHLA ADR Service on the basis of their experience in the area of the dispute, geographic location and other criteria as indicated on the request form. The parties to the dispute will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from 1 to 9. Each party has the right to strike 1 of the names from the list. The person with the lowest total will be appointed to resolve the case. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. Arbitration shall be the exclusive remedy for the resolution of disputes arising under the Agreement. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other pharmacies or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated under the terms of the Agreement.
Exhibit A
Sample Cigna HealthSpring ID Cards

Cigna HealthSpring.

<Plan Name>
<Group Name>
Health Plan (80840) 013101-0600
Customer ID: <MemberID>
Name: <first name> <last name>
RxBIN: <RxBIN>
RxPCN: <RxPCN>
RxGroup: <RxGroup>

Cigna HealthSpring Rx™ (PDP)

Customer Service
TTY: 711
Cigna HealthSpring
PO Box 266005
Weston, FL 33326-9927
Pharmacy Providers
Help Desk: 1-888-625-5686
Website: www.cignahealthspring.com

Cigna HealthSpring Preferred (HMO)

Customer Service: 800-627-7534
Medical Claims: Cigna Medicare Services
TTY: 711
Payor ID: 62308

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Exhibit B

OMB APPROVED # 0938-NEW

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You have the right to get a written explanation from your Medicare drug plan if:

Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription.
You are asked to pay more than you think you are required to pay for a prescription.

The Medicare drug plan’s written explanation will give you the specific reasons why the prescription(s) are not covered and will explain how you can request an appeal if you disagree with the drug plan’s decision.

You also have the right to ask your Medicare drug plan for an exception if:

You believe you need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary.”
You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception. You can refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.

When you contact your Medicare drug plan, be ready to tell them:

1. The prescription(s) that you believe you need.
2. The name of the pharmacy or physician who told you that the prescription(s) are not covered.
3. The date you were told that the prescription(s) are not covered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS-10147

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