CITY OF BEAUMONT

PRESCRIPTION DRUG PROGRAM

Outpatient prescription drugs shall be covered under the **Prescription Drug Program** only unless otherwise specified. The **Prescription Drug Program** is available to the City of Beaumont's full-time active employees working more than 30 hours per week, retirees under age 65 and retirees over age 65 not covered by Medicare in one of the civilian employees retired under Employers Early Retirement class, Police officers who are eligible for and retired on or after April 1 1984, under Texas Municipal Retirement System (TMRS), and firefighters who are eligible for and retired on or after April 1, 1984 under the Beaumont Fireman's Relief and Retirement Fund and their respective dependents that are enrolled as eligible members in City of Beaumont's Group Health Plan. These individuals are **"covered persons"** in respect to the Plan. Retirees over age 65 covered under Medicare are not eligible for coverage under the Plan.

EXPRESS SCRIPTS serves as the claims administrator of the prescription drug plan.

The application of **copays** under the **Prescription Drug Program** shall not be considered a **covered expense** under the **Medical Expense Benefit**.

The Plan offers **covered person**(s) several ways to utilize their prescription benefits to purchase prescriptions using a Participating Retail Pharmacy or Home Delivery.

Definitions:

- **Brand Drug** means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by Express Scripts.

  You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

- **Co-Payment** or **copay** or **co-insurance** means a specified percentage or dollar amount of a covered pharmacy charge that must be satisfied by the **covered person** before the Plan will begin paying benefits for the covered service. The application of **copay** under the Prescription Drug Program shall not be considered a **covered expense** under the Medical Expense Benefit.

- **Covered person** means a person who is eligible for coverage under the **Prescription Drug Program**, or becomes eligible at a later date, and for whom the coverage provided by this **Plan** is in effect.

- **Formulary** is a list of FDA-approved prescription drugs and supplies developed by EXPRESS SCRIPTS's Pharmacy and Therapeutics Committee, which is selected and adopted by the Plan. Not all drugs are covered on the Formulary.
- **Generic Drug** is a prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or Prescriber and must be clearly designated by the pharmacist or **Prescriber** as generic.
- **Participating Network Pharmacy** is a network of retail pharmacies contracted by **EXPRESS SCRIPTS** that allows the purchase of prescription drugs at a discount for a **covered person** under the Plan. Covered medications are available to be filled at EXPRESS SCRIPTS Participating Retail Network of Pharmacies for a 30-day supply or for eligible maintenance medications at a Participating Retail Network- 90 pharmacy for a longer day supply (31 **to** 90-day supply).
- **Non-participating Pharmacy** is a pharmacy that is not contracted with EXPRESS SCRIPTS. If a nonparticipating pharmacy is used, the **covered person** must pay the entire cost of the prescription, including **copay**, and then submit the receipt to EXPRESS SCRIPTS, for reimbursement. The **covered person** will be responsible for the **copay**, plus the difference in contracted rates between the **Participating Network Pharmacy** and **Non-Participating Pharmacy**. A direct member reimbursement form can be downloaded from the web site at www.express-scripts.com and remember to attach the receipt to the completed form. The receipt should contain all the necessary information, however, the NDC # of the drug, RX number, the day supply, physician's DEA# are all required.
- Separate from Express Scripts Retail Network, many national chain pharmacies offer their own 30-day supply of generic prescriptions for $4 and a 90-day supply for $10. The **covered person** will always pay the lower of copay, retail cost, or discounted contracted price. It's important to show your ID card so the **covered person** pays the lowest possible cost.
- **EXPRESS SCRIPTS Mail Services Program (Home Delivery)** allows those on eligible maintenance medications to enjoy the convenience of having these medications delivered directly to their home.
- **Prescriber** means, as required by state law, a licensed, certified and accredited health care professional or facility such as a physician (M.D. or D.O.), dentist, nurse practitioner, pharmacist or pharmacy.

- **Specialty Medications** are generally defined as high-cost medications designed to treat complex conditions like multiple sclerosis, rheumatoid arthritis, hepatitis C, cystic fibrosis, cancer, etc. These medications are typically self-injectable, oral, or infused and require special handling, patient education/counseling and restricted distribution channels.
- **Specialty Pharmacy Program** is a program that dispenses **Specialty Medications** to a **covered person** and assists the **Prescriber** with managing chronic disease. The medication must be dispensed by EXPRESS SCRIPTS's Specialty Pharmacy, Accredo. **Specialty Medications** treat chronic disease such as multiple sclerosis, rheumatoid arthritis, hepatitis C, cystic fibrosis, cancer, etc. The medications are shipped overnight to **covered person's** home or another location requested by the **covered person**. Supplies are included, if applicable, at no extra charge. As a **covered person** identified as a member taking **Specialty Medications**, a representative will contact the **covered person** to enroll in the Specialty Pharmacy Program. Additionally, a representative from the **Specialty Pharmacy Program** may call from time-to-time to facilitate any on-going prescription needs and ensure the **covered person** will be home on the shipping date. If the **covered person** has any questions about the **Specialty Pharmacy Program**, please call EXPRESS SCRIPTS's Specialty Pharmacy, Accredo, at 1-866-716-8339. A trained representative is available Monday thru Saturday 8 am to 10 pm EST.
- **Patient Assistance Programs** are manufacturer programs, state assistance programs, foundational programs, etc. that assist members in paying for high-cost specialty medications.
- **Specialty drugs** are considered non-essential health benefits under the plan. Any amount known to be paid by any sources of copay assistance will not be considered as true member copay or out of pocket and will not accumulate toward any deductibles or out-of-pocket maximums.
- Any of the manufacturer's programs, state or foundational patient assistance programs are subject to change or can be discontinued.

Prescription Drug Copays

Copays	Retail 30 Day Supply	Retail 90 31-90 Day Supply	Mail Order 90 Day Supply
Generic	30% with a $5 minimum copay	30% with a $15 minimum copay	30% with a $10 minimum copay
Brands with no Generic available	30% with a $15 minimum copay	30% with a $45 minimum copay	30% with a $30 minimum copay
Brands with a Generic available	30% with a $25 minimum copay	30% with a $75 minimum copay	30% with a $60 minimum copay
$0 Copays for the following			
Over-the-counter (OTC) nasal sprays that includes OTC Nasacort, OTC Flonase, and their OTC generics*	$0	$0	$0
Tobacco Cessation (includes over-the-counter products*)	$0	$0	$0
Brand	$0	$0	$0
Generic	$0	$0	$0
Bowel Preps for colorectal screenings	$0	$0	$0
Specialty Pharmacy (limited to a 30-day supply per fill)	Brand Copay: $100 Generic Copay: $50		

*Covered over-the-counter medications require a written prescription from your physician in order to be $0 copay.

Generic Only Program

"Generic Only Program" means a **covered person** will pay the difference in the price between the brand and generic medication plus the brand copayment if the **covered person** or their **Prescriber** requests a brand name medication to be dispensed when a generic medication is available. This generic program applies to the Retail, Mail and Specialty Pharmacy Options.

Covered Medications - must be obtained with a written prescription.

- Legend drugs which under applicable federal and state laws require a prescription by a **Prescriber** or certain other licensed practitioners.
- Acne topical preps. Coverage for a **covered person** over age 30 requires a Prior Authorization.
- Anaphylaxis Therapy such as EpiPen.
- ADD & ADHD medications.
- Diabetic oral medication, insulin and insulin syringes.
- Diabetic pump supplies, continuous glucose monitors
- Diabetic Blood glucose strips, lancets and alcohol swabs.
- Diabetic glucose monitors. Limited to one per year.
- Migraine medications.
- Contraceptives, to include oral, injectable, patches, or vaginal rings.
- Contraceptive devices to include diaphragms and IUDs.
- Compounded medications in which at least one ingredient is a prescription legend drug (see limit below). Pain compounds are excluded.
- Covered over-the-counter (OTC) Nasacort 24HR, Flonase OTC and Rhinocort OTC nasal spray (with a prescription from the physician)
- Erectile dysfunction, oral and injectable medications.
- Tobacco cessation medications and over-the-counter nicotine substitutes such as gum, patches and lozenges with a written prescription.
- Respiratory assisting devices such as Aerochamber.
- Specialty medications with prior authorization approval.
- Vaccines, immunizations and toxoids covered under the Affordable Care Act.

- Vitamins, prescription only for prenatal care.
- Topical Corticosteroids are covered up to $500 per script.

Covered Medications – those services, supplies or Pharmaceutical Products, which the Plan determines to be:

- Medically Necessary;
- described as Covered in this Schedule,
- provided to a Covered Person who meets the Plan's eligibility requirements, as described in this Schedule in Introduction;
- not otherwise excluded in this Schedule, *Outpatient Prescription Drugs or Express Scripts Formulary.*

Medically Necessary – Prescription services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Plan and administered by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider;
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

Preventive Health Services – Drug Coverage

The following provisions are preventive health services, as named by the Affordable Care Act. (This information is subject to change, based on additional guidance from federal agencies). The medications below are provided at no cost to the **covered person** (tobacco cessation is subject to a limit of two sessions per year, approximately 6 months of treatment). However, the **covered person** must have a written prescription from the **Prescriber** for any over-the-counter covered products.

- Aspirin

  Men - age 45 to 75 years. No prior authorization required, quantity limit 100 for 30-day supply, generic only, over-the-counter requires prescription.

  Women - age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. No prior authorization required, quantity limit 100 for 30 day supply, generic only, over-the-counter requires prescription.

- Breast cancer prevention

  Generic medications, such as raloxifene or tamoxifen that treat high-risk women.

- Folic Acid

  Women, planning or capable of pregnancy up to age 55, no prior authorization required, quantity limit 100 for 30-day supply, generic only, over-the-counter requires prescription.

- Iron Supplements

  Children, age 6-12 months, no prior authorization required, no quantity limits, brand or generic are covered, both prescription or over-the-counter requires prescription.

- Oral Fluorides

  Pre-school children older than 6 months, age limit less than or equal to six (6) years of age, no prior authorization required, no quantity limit, brand and generic, prescription products only.

- Tobacco Cessation

  No prior authorization of tobacco cessation products. Prescription brand or generic as prescribed for tobacco cessation. Over-the-counter products such as patches, gum or lozenges require a written prescription. Inhaled/inhaler version is excluded.

- Vaccines and immunizations

  The following vaccines and immunizations are covered: Hepatitis A, Hepatitis B, Herpes Zoster (Shingles) over age 50, Haemophilus Influenza Type B, Human Papillomavirus (HPV), Influenza, Inactivated Poliovirus, Measles, Mumps, Rubella,

Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Rotavirus, and Varicella.

- Generic Statins that Lower Cholesterol

  Rosuvastatin, Atorvastatin, Lovastatin, Simvastatin, Fluvastatin, Pravastatin; restricted to ages greater than or equal to 40 and less than or equal to 75.

Limitations (Refills, Age Restrictions, Quantity Limits)

This limit applies only when a **covered person** incurs a covered prescription drug charge. As the prescription drug market continues to rapidly evolve, these limitations may be altered at any time by the Plan. Drugs may be added or deleted from the list as clinical criteria change or new drugs come to market. The covered drug charge for any one prescription may be limited in the following ways:

- Refills only up to the number of times specified by a Prescriber.
- Refills up to one year from the date of the order by a Prescriber.
- Certain non-narcotic pain medications such as Mobic, Ultram or Toradol are subject to quantity limits.
- Anaphylaxis therapy such as Epipen and Twinject are subject to quantity limits.
- Blood glucose monitors are limited to one per year.
- Sleep hypnotics such as zolpidem are limited to 15 pills per 30-day fill or 45 per 90 day fill.
- Anti-virals (Tamiflu and Relenza are limited to retail only and are subject to quantity limits of one treatment per 180 days).
- Tobacco cessation products are limited to 180 days annually.
- Compounds limited to $300 maximum cost per prescription.
- Erectile dysfunction medications are subject to quantity limits of 8 tabs or injectable syringes per 30-day fill.
- Migraine Medications (injectable, inhaled or oral) are subject to quantity limits.
- Specialty medications are limited to a 30-day supply per fill.

For questions regarding the Prescription Drug Program covered drugs or exclusion or the quantity/age/gender limits, please call Express Scripts Customer Service toll free number for the Plan is at 1-844-526-8319. The Customer Service representatives can assist 24 hours a day and 7 days a week.

Prior Authorizations (PA)

Prior Authorization (PA) assists in ensuring the appropriate usage of certain medications by applying FDA approved indications and manufacturer's guidelines to the utilization of certain medications. EXPRESS SCRIPTS has identified those medications that have a high potential for serious side effects, high costs, or high abuse potential. Other types of prior authorizations, include, but are not limited to, medications that exceed quantity limitations, age limitations, and/or require clinical determinations for appropriate utilization. Certain medications require prior authorization (approval before they will be covered). EXPRESS SCRIPTS, in their capacity as pharmacy benefit manager, administers the clinical prior authorization process on behalf of the Plan.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the **Prescriber**, or the **covered person** by calling toll free 1-844-526-8319, 24 hours a day, seven (7) days a week.

To confirm whether you need prior authorization and/or to request a prior authorization form, call EXPRESS SCRIPTS's Customer Service Call Center at 1-844-526-8319, 24 hours a day, seven (7) days a week. Please have the following information available when initiating your request for prior authorization:

Name of your Medication
Prescriber's Name
Prescriber's Phone Number
Prescriber's Fax Number, if available
Rx member identification number (found on your ID card)

Prior authorization review for non-specialty medications will be provided within 3 business days, not including weekends and holidays. Prior authorization reviews for specialty medications will be provided within 7 business days, not including weekends and holidays. Once approved, you may fill your prescription at any Participating Network Retail Pharmacy or the Mail Service Pharmacy. If a medication is a **Specialty Medication**, it must be dispensed through the **Specialty Pharmacy Program**. If the prior authorization request is denied, the EXPRESS SCRIPTS Clinical Pharmacy Department mails a denial letter explaining the denial reason to the person who initiated the request, typically, the **Prescriber**.

Step Therapies

Certain prescriptions require the use of an equally effective, less expensive, first line agent before a more expensive alternative will be considered for coverage.

Medications include, but are not limited to:

- **Oral acne medications**: A **covered person** must first try and fail a one-month course of generic demeclocycline, doxycycline, minocycline, and tetracycline solid dosage forms (e.g., capsules, tablets), generic Avidoxy, generic Oraxyl, generic Ocudox and generic Morgidox before a brand medication will be approved.

- To determine if a **covered person**'s medication requires a trial of a first line agent, please call EXPRESS SCRIPTS at 1-844-526-8319, 24 hours a day, seven (7) days a week. The **covered person** must have the name of the medication, EXPRESS SCRIPTS member identification number and the Group ID number from the EXPRESS SCRIPTS identification card within reach. Your pharmacist can also assist by calling the pharmacy hot line for Express Scripts.

Expenses Not Covered- Exclusions

(Not all exclusions are listed. Contact Express Scripts regarding other exclusions.)

These exclusions may change at any time as the prescription market continues to evolve and new medications are approved and released. The Plan will not cover a charge for any of the following:

- Abortifacients, pregnancy termination drugs such as RU486 or Mifeprex.
- Absorica.
- Administration – Any charge for the administration of a covered prescription drug except as approved for vaccinations under the **Prescription Drug Program**.
- All Brand Proton Pump Inhibitors such as Dexilant. Prescription generics are covered.
- Amrix.
- Anabolic steroids.
- Antifungal nail polish such as Jublia, or Kerydin. Generic ciclopirox is covered.
- Any prescription medication or refills for lost, stolen, spilled, spoiled or damaged drugs.
- Appetite suppressants – A charge for appetite suppressants, dietary supplements or weight loss medications.

- Arestin.
- Auvi-Q.
- Bensal HP.
- Biological sera, blood or blood plasma, allergy serums.
- Brand Corticosteroid Nasal Sprays (prescription generics and certain over-the-counter steroid sprays are covered).
- Brand Sleep Hypnotics.
- Bulk chemical powders used in compounds such as baclofen, ketamine, gabapentin, and fentanyl.
- Chlorzoxazone 250mg, 375mg, 750mg.
- Clarinex (and generic desloratadine) and Xyzal (and generic levocetirizine.
- Compound kits used for pain.
- Conzip.
- Cosmetic Drugs such as hair growth, hair reduction or facial wrinkle agents.
- Devices – devices of any type, even though devices may require a prescription. These include but are not limited to therapeutic devices, artificial appliances, braces, support garments, other non-medical substances regardless of intended use or any similar device.
- Doxepin 5% cream, Prudoxin and Zonalon.
- Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits.
- Drugs or medications that are to be taken by the **covered person**, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
- Drugs that do not require a Prescriber's written prescription such as over-the-counter medications except those expressly listed above under Covered Prescription Drugs.
- Drugs used to treat HSDD - Hypoactive Sexual Desire Disorder such as Addyi and Vyleesi.
- Dsuvia.
- Duchenne Muscular Dystrophy (DMD) such as Amondys 45, Exondys 51, Vyondys 53, Viltepso.
- Duexis and Vimovo (including their prescription generics) or other combo medications that contain an over-the-counter or generic equivalent product such as ibuprofen or Pepcid AC or naproxen.

- Endari.
- Evkeeza.
- Experimental, Investigational, or non-FDA-approved Drugs or drugs prescribed for experimental, non-FDA-approved indications even though a charge may be made to the **covered person**.
- Fluoride supplements except those covered under Affordable Care Act for children.
- Fortamet and its generic.
- Gemtesa.
- Gene Therapy such as Luxturna and Zolgensma.
- Gimoti.
- Glumetza and its generic.
- Gocovri and Osmolex (alternative amantadine is covered).
- Gralise.
- Horizant.
- HP Acthar Gel except for infantile spasm age 2 and under.
- Hyperalimentation Products – parenteral feeding supplies.
- Hypodermic syringes and/or needles- other than those listed as specifically included such as for specialty medications or insulin.
- Hysingla, Zohydro.
- Imcivree.
- Infertility – any charge for injectable, intravaginal or oral medications.
- Inhaled nicotine replacement. Patches, gum and lozenges are covered.
- Kuvan and Palynziq.
- Legend minerals (Hematinics), or vitamins whether FDA approved or non-FDA approved, except pre-natal legend vitamins or those vitamins required by Affordable Care Act.
- Lorzone (all strengths).
- Microsomal triglyceride transfer proteins such as Juxtapid or Kynamro.
- Naprelan and generic naproxen sodium ER.
- Nascobal (B-12 generic injectable is covered).
- Non-insulin syringes with or without needles.
- Non-legend drugs, other than as specifically listed herein.

- Nutritional supplements.
- Pennsaid.
- Plasma, blood products or biological sera such as allergy serums.
- Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent, as defined in the Prescription Drug Glossary in this section, to another covered Prescription Drug or covered over-the-counter drug.
- Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent, as defined in the Prescription Drug Glossary in this section, to another covered Prescription Drug or covered over-the-counter drug;
- Prescription drugs which may be properly received without charge under local, state, or federal programs.
- Prescription generic Omeprazole Sodium Bicarbonate.
- Pristiq
- Qroxin.
- Ravicti.
- Rayos.
- Refills – any refill that is requested more than one year after the prescription or any refill that is more than the number of refills ordered by the Prescriber.
- Restasis.
- Seysara.
- Silver nitrate creams such as Quinja or Alcortin A.
- Sitavig.
- Sprix Nasal.
- Synvexia.
- Topical, intranasal, brand injectable androgens. The Plan will cover generic injectable and generic oral prescriptions only.
- Treatment of Gaucher's. Covered under medical plan.
- Vanos Cream 0.1% and the generic Fluocinonide Cream 0.1%.
- Vitamins - FDA approved or non-FDA approved such as Niacor, Mebolic, Revesta, Xyzbac and Zyvit.
- Worker's compensation drug claim.
- Ximino and its generic.

- Yohimbine. Not FDA approved.
- Yosprala and Durlaza.

APPEALING A DENIED POST- SERVICE PRESCRIPTION DRUG CLAIM

The **"named fiduciary"** for purposes of an appeal of a denied Prescription Drug Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is EXPRESS SCRIPTS, the Pharmacy Benefits Manager.

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person**:

1. The **covered person** has a right to submit documents, information and comments and to present evidence and testimony.
2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
3. Before a final determination on appeal is rendered, the **covered person** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the **Plan** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the **covered person** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.
5. The review by the **named fiduciary** will not afford deference to the original denial.
6. The **named fiduciary** will not be:
    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
    a. The **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment; and
    b. The **professional provider** utilized by the **named fiduciary** will be neither:

i. An individual who was consulted in connection with the original denial of the claim, nor

ii. A subordinate of any other professional provider who was consulted in connection with the original denial.

8. If requested, the **named fiduciary** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

9. The reviewing pharmacist will make a determination on the approval or denial within 30 days of receiving the appeal request and communicate the decision to the appealing party.

The request for review or urgent appeals may be mailed or faxed to:

EXPRESS SCRIPTS
Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-935-6103
Fax: 1-877-852-4070

Urgent Appeals (defined by law) is a service that, in the opinion of the **covered person**'s Prescriber, the **covered person**'s health is in serious jeopardy or the **covered person** may experience severe pain that cannot be adequately managed without the medication while the **covered person** waits for the decision on the review. These types of appeals are responded to in 72 hours or less. Urgent appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call identifies the appeal as urgent. Urgent Appeal Phone number is1-800-753-2851.

Coverage Review Forms are available on Express Scripts web site at www.express-scripts.com/services/physicians.

EXTERNAL APPEAL

A **covered person**, or the **covered person**'s authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the **named fiduciary** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. **Medical necessity**;
2. Appropriateness;
3. **Experimental** or **investigational** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a **covered expense**.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.}

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the claims processor will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

a. Medical judgment; or
b. Rescission of coverage under this Plan.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the **covered person** to perfect the external review request by the later of the following:
    a. The four (4) month filing period; or

b. Within the forty-eight (48) hour time period following the **covered person**'s receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the **covered person** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the **plan administrator** (or its designee) and the **covered person** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the **covered person**, the **Plan** and **claims processor**, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) the right to request an expedited external review upon the **covered person**'s receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the **covered person** or the **covered person**'s ability to regain maximum function and the **covered person** has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the **covered person** or the **covered person**'s ability to regain maximum function or if the final denial involves any of the following:
    a. An admission,
    b. Availability of care,
    c. Continued stay, or

d. A health care item or service for which the **covered person** received **emergency services** but has not yet been discharged from a **facility**.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.
2. Send notice of the Plan's decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the **covered person**'s medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the **plan administrator** (or its designee) and the **covered person** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

Employer:
City of Beaumont
801 Main, Suite 320
Beaumont, TX 77701