Prescription Plan Definitions

Accredo: An Express Scripts specialty pharmacy.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the member's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing member complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations. For more information, refer to Process Overviews.

Appeals process: A specific process that a member needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Members are notified of the decision and of any rights to appeal an adverse benefit decision. For ERISA plans: Under Section 502(a) of ERISA, members have the right to bring a civil action if their final appeal is denied.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the member's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

Compound: A medicine that is made of two or more ingredients that are weighed, measured, prepared, or mixed according to a prescription order.

Copay/coinsurance: The cost of a covered drug paid by the member at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Coverage review: Also known as the initial review or initial determination, this process is followed when a member requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand-name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Home delivery: A distribution channel in which the member receives a prescription drug through the mail from the Express Scripts Pharmacy[SM].

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression, or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide members with lower costs and more convenience.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, members need to use a network pharmacy to pay the amounts specified by the Plan.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and members will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as "benefit exclusion," this includes a drug or drug class that is not included in the member's benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that is available without a prescription from a doctor.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence-based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

Prescription plan FAQs

What is covered?

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and brand-name drugs. The Plan also maintains a formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money.

An expert panel of physicians and pharmacists carefully reviews the drugs on the formulary for safety, quality, effectiveness, and cost. The formulary and conditions of drug coverage under the Plan is subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the formulary or covered at any time.

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there are no alternatives to try or exceptions to coverage. The following list of benefit exclusions outlines general categories of items not covered under the Plan. Other drugs may be excluded from the formulary, as noted elsewhere in the Summary Plan Description. To check whether a medication is excluded, go to express-scripts.com or call Express Scripts Member Services.

To see if a drug is covered on the formulary,

go to express-scripts.com or call Express Scripts Member Services.

What is the difference between generic and brand-name drugs?

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists, and have been added to the Express Scripts formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the Express Scripts formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the

status of any particular drug on the Plan's formulary, log onto express-scripts.com or contact Express Scripts Member Services. A medication's inclusion on the formulary is no guarantee of effectiveness. Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

How are claims paid?

Generally, members do not need to submit claims under the prescription plan. A member pays the copay, coinsurance or other amount required by the Plan when filling a prescription. However, if a member needs to submit a paper claim for reimbursement for payment of the cost of a covered drug (for example, if the pharmacy's computer system was not working or the card was left at home), the member download a claim form from the website or call Express Scripts Member Services.

When should a retail pharmacy be used?

The retail pharmacy is the most convenient option when a medication is needed immediately, such as an antibiotic for a short-term illness or infection. Members simply present their ID card to the pharmacist, along with the doctor's written prescription if it has not been sent electronically, to receive a 30-day supply of the medicine.

Express Scripts' retail pharmacy network includes more than 70,000 participating pharmacies, including national chains as well as independent retailers. "

Some plans may not cover a medication filled at a neighborhood pharmacy because it is not "in network," but the medication will be covered at a large retail pharmacy chain or grocery store if those pharmacies are "in network." To find a participating retail pharmacy, members can visit express-scripts.com and use the Pharmacy Locator to find a list of pharmacies close to where they live or work. Members can also download the Express Scripts mobile app to find a pharmacy when they're on the go. To download the mobile app for free, search for "Express Scripts" in smartphone app stores. If members do not have computer access, they can call Express Scripts Member Services.

Prescriptions filled at a nonparticipating retail pharmacy are not covered under the Plan, which means if members fill prescriptions there, they pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's deductible or out-of-pocket maximums.

When should the home delivery pharmacy be used?

Express Scripts offers home delivery, or a mail pharmacy service, for prescriptions taken on a regular basis for long-term conditions, such as asthma, depression or high blood pressure. With home delivery, members can receive up to a 90-day supply of medicine from the Express Scripts PharmacySM, often for a lower cost than they would pay at a retail pharmacy.

Home delivery advantages

- Fewer refills and fewer trips to the pharmacy
- Free standard shipping costs included as part of the Plan

- Medicine is delivered in tamper-proof, weather-resistant packages.
- Drugs that require refrigeration are shipped in cold packs.
- Pill bottles have child-resistant safety caps, but easy-open caps may be requested when the order is placed.

How to get started with home delivery?

Express Scripts offers members a variety of convenient ways to submit new prescription orders.

- **New prescriptions** may be submitted directly from the doctor's office or through the mail.
- **Refills** can be ordered electronically using the Express Scripts mobile app or website, through the mail or by phone.

Visit express-scripts.com to learn more.

Pharmacy Program Descriptions

Drug Quantity Management (DQM) makes sure that members are getting the right amount of medication and that it is prescribed in the most efficient way. For example, the doctor may say, "take two 20mg pills each morning." If that medication is also available in 40mg pills, Express Scripts will contact the doctor about prescribing one 40mg pill a day instead of two 20mg pills. In addition, if the doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and the members will have just one copayment, not two.

DQM also makes sure that a member's prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Formulary Overview: Clinically sound, cost-effective Express Scripts formulary options help decrease prescription drug expenses when combined with a well-designed benefit plan. To ensure the clinical appropriateness of their formularies, Express Scripts physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics (P&T) Committee, which reviews and approves Express Scripts formularies.

Prior Authorization monitors both cost and safety. If a pharmacist tells a member that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug. This is similar to when a healthcare plan authorizes a medical procedure in advance.

When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different

medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered but the member wants to take it, the member will pay the full price of the medicine.

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets members get the treatment they need affordably. First-line medicines are the first step.

- First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective, and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

The first time a member tries to fill a prescription that is not for a first-line medicine, the pharmacist should explain that step therapy asks the member to try a first-line medicine before a second-line drug. Only the doctor can change the current prescription to a first-line medicine covered by the Plan.

To get a first-line medicine that the Plan covers, a member should ask the pharmacist to call the doctor and ask for a new prescription. If it is easier, the member can also call the doctor to ask for a new prescription. Also, the pharmacist should explain to the member that there's an option to choose a second-line alternative to the first-line medicine. However, because the Plan will not cover second-line drugs until after the member and the doctor have considered a first-line medicine to treat the condition, the member will pay full price for that second-line drug.

	2700 HSA Plan	PPO HSA Plan	Core PPO Plan
Copay/Coinsurance	**Retail Pharmacy (up to a 30-day supply)** 10% Generics 20% Brand Formulary 30% Brand Non-Formulary **Home Delivery / Smart 90 (up to a 90-day supply)** 10% Generics 20% Brand Formulary 30% Brand Non-Formulary	**Retail Pharmacy (up to a 30-day supply)** 20% Generics 20% Brand Formulary 20% Brand Non-Formulary **Home Delivery / Smart 90 (up to a 90-day supply)** 20% Generics 20% Brand Formulary 20% Brand Non-Formulary	**Retail Pharmacy (up to a 30-day supply)** $10 Generics $30 Brand Formulary $50 Brand Non-Formulary **Home Delivery / Smart 90 (up to a 90-day supply)** $20 Generics $65 Brand Formulary $110 Brand Non-Formulary
Deductible	**Individual** **$2,700 INN** **$5,400 OON** **Family** **$5,400 INN** **$10,800 OON**	**Individual** **$1,800 INN** **$3,600 OON** **Family** **$3,600 INN** **$7,200 OON**	**Individual** **$750 INN** **$1,500 OON** **Family** **$1,500 INN** **$3,000 OON**

Out Of Pocket*	Individual $6,000 Family $12,000	Individual $3,500 INN $7,000 ONN Family $6,500 INN $13,000 OON	Individual $3,000 INN $6,000 OON Family $6,000 INN $12,000 OON

* Out-of-pocket limits protect you in case you or a family member has a condition that requires prescriptions that would be very expensive. The limit is the most you would ever pay out of your pocket for prescription drug expenses. Once your payments reach the limit, the plan pays 100% of your prescription drug expenses for the rest of the year.

Maintenance Medications Rules

Smart90 Exclusive requires members to fill their maintenance medications at Smart90 Pharmacy or through our home delivery pharmacy, and at a 90-day supply. Members can get two 30-day courtesy fills before they must make the switch. After courtesy fills are spent, members not filling at a preferred location or for 90-days will be required to pay the full cost of the medication. Once members make the switch, they will pay one copay for a 90-day supply that is lower than the cost of three 30-day supply copays. Copays for 90-day supply for maintenance drugs are the same at Smart90 retail locations and the home delivery pharmacy, to allow members the freedom to choose the location they prefer.**

** Members typically pay the same low copay at a Smart90 retailer as they would at the Express Scripts Pharmacy (for flat copays; for percentage copays/coinsurance, copays may vary slightly at retail vs. home delivery). We encourage members to use the price check functionality on the member website before choosing a location.

Reviews and Appeals

Initial coverage review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

- **Clinical coverage review request**: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- **Administrative coverage review request**: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a **Benefit Coverage Request Form**, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to **877.328.9660** or mail to:

Express Scripts

Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request.

In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at **800.753.2851**.

How an initial coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)
Standard Post-Service*	30 days				
Urgent	72 hours**	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)

* If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days, or the claim will be denied.
** Assumes all information necessary is provided. If necessary, information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 appeal or urgent appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied.

When an initial coverage review has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of

the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination.
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Clinical appeal requests and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests

800.753.2851

877.852.4070

Urgent administrative appeal requests

800.946.3979

877.328.9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)
Standard post-service	30 days				
Urgent*	72 hours	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the adverse benefit determination.
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Clinical appeal requests and administrative appeal requests can be sent to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests


800.753.2851


877.852.4070

Urgent administrative appeal requests


800.946.3979


877.328.9660

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)
Standard post-service	30 days				
Urgent*	72 hours	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

Please note: information below for external review applies for non-grandfathered plans following HCR and using MCMC. If you fall outside those guidelines, please contact your account team for language appropriate to your situation.

When and how to request an external review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third-party utilization management company, at:

MCMC LLC
Attn: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929

Legal disclaimer

617.375.7700, ext. 28253

617.375.7683

The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

How an external review is processed

Standard external review

MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO.

Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.