Date: September 2024

To: All Active and non-Medicare Retired Participants covered under the Indemnity Prescription Drug Plan

From: Board of Trustees

Subject: AFL Hotel and Restaurant Workers Health & Welfare Trust Fund Subject: **Indemnity Prescription Drug Plan: Claims and Appeals Procedures**

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As a reminder, under the Indemnity Prescription Drug Plan, only prescription drugs and items listed on the Plan's list of covered drugs ("Formulary") that meet the Formulary criteria and restrictions are covered. The Formulary is reviewed throughout the year and is subject to change. **Drugs and items not listed on the Formulary are not covered unless medically necessary and you or your prescribing physician obtains a prior authorization approved by the Trust Fund's Pharmacy Benefits Manager, Express Scripts, Inc. ("ESI")**.

To determine if a prescription drug is covered or for assistance with prior authorization, you may contact ESI for assistance by calling ESI Member Services toll free at 1-866-568-4973 (available 24 hours daily, 7 days a week) or by going online at www.express-scripts.com

Effective February 1, 2024, the following claims and appeals procedures apply to the Indemnity Drug Plan:

Initial coverage review by Express Scripts

You or your prescribing physician may request an initial clinical coverage review or administrative coverage review from Express Scripts.

• 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, your prescribing physician must submit the request electronically. Information about electronic options can be found at express scripts.com/PA.

To request an initial administrative coverage review, you or your designated representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling ESI Customer Service at (866) 568-4973.

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 your 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, your prescribing physician must submit specific information to Express Scripts for review. For an administrative coverage review request, you or your designated representative must submit information to Express Scripts to support their request. The initial determination and notification to you and your prescribing physician 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)	Automated call (and letter, if call unsuccessful)	Letter
Standard Post-Service*	30 days		
Urgent	72 hours**	Automated call and letter	Live call and letter

* 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 you or your designated 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
Fax: 877.852.4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 877.328.9660

If your 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 you or your provider believes the your 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:
Phone: 800.753.2851 Fax: 877.852.4070
Urgent administrative appeal requests:
Phone: 800.946.3979 Fax: 877.328.9660

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, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe	**Notification of Decision**

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

* 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 you or your designated 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
Fax: 877.852.4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 877.328.9660

If your 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 you or your provider believes your 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:
Phone: 800.753.2851 Fax: 877.852.4070
Urgent administrative appeal requests:
Phone: 800.946.3979 Fax: 877.328.9660

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, panel of clinicians or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	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)	Automated call (and letter, if call unsuccessful)	Letter
Standard Post-Service	30 days		
Urgent*	72 hours	Automated call and letter	Live call and letter

* 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.

Final Appeal

If you wish to appeal the denial of any claim for benefits by Express Scripts, Inc., you have 180 days following your receipt of a Notice of Denial to file an appeal with the Board of Trustees. Generally, all internal appeal rights must be exhausted prior to filing an appeal with the Board of Trustees. The Board of Trustees has appointed the Benefits and Appeals Committee to hear all appeals of denied claims.

An appeal may be initiated by you or your authorized representative. Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees

Benefits and Appeals Committee
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Or, send a fax to: (808) 537-1074

You may ask for an expedited appeal of an urgent care claim by calling the Trust Administrator at (808) 523-0199 or 1 (866) 772-8989 (toll free).

The appeal will be conducted by the Benefits and Appeals Committee in accordance with the APPEALS procedures described on pages 108 - 109 of your SPD booklet.

Disclosure of Grandfathered Status

The Trust Fund believes its group health plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Benefit & Risk Management Services, Inc., at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817-5315 or 1-808-523-0199. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.