FSHIP/Hardee County School Board Pharmacy Plan Summary

This plan summary outlines the basic features of the Plan and how it operates to help you receive the maximum advantage from your pharmacy benefit.

About OptumRx and Contact Info

The prescription drug program for the Hardee County School Board medical plan participants is administered by OptumRx and its affiliates. This is only a summary of the key parts of the Plan. You may contact OptumRx toll free at: 855-524-0381, visit the OptumRx website at: www.optumrx.com, or utilize the OptumRx mobile app for more details about the applicable copays and drug coverages under your Plan benefits.

What You Will Pay

Benefit Grid

Benefit Grid	What You Will Pay				Limitations, Exceptions, and Other Important Information
	In-Network Pharmacy Up to 31 day supply	In-Network Pharmacy 32-62 day supply	In-Network Pharmacy 32-62 day supply	Out-of-Network Pharmacy	
Generic Drugs (Tier 1)	$10	$20	$25	N/A	Cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
Preferred Brand Drugs (Tier 2)	$50	$100	$125	N/A	
Non-Preferred Brand Drugs (Tier 3)	$80	$160	$200	N/A	
Specialty Drugs	Follow Tier 1 - 3 above ($10/$50/$80)	N/A	N/A	N/A	

***Deductible does not apply to copays above**

Website Information

Access to additional Plan information and tools such as those listed below are accessible by visiting www.optumrx.com, or utilizing the OptumRx mobile app.

- **Pharmacy Location Services**: Find a participating pharmacy using the online pharmacy locator
- **Drug Price Check**: Identify which drugs are covered by your Plan, get an estimated cost before filling a prescription and compare estimated costs between generic and brand-name drugs
- **Tracking Out-Of-Pocket Expenses**: See current remaining Plan balances, up-to-date out-of-pocket expenses and maximum out-of-pocket expense limits

Benefit Coverage and Limitations

The Formulary is a list of medications that are covered by your Plan; however, specific coverage and/or utilization limitations may apply. Members may have specific benefit exclusions, copayments or coverage considerations that are not reflected specifically in the Formulary. The Formulary applies only to outpatient drugs prescribed to members and does not apply to medications used in an in-patient settings. If you have specific questions regarding your coverage, please contact OptumRx at 855-524-0381.

Quantity Limitations: There may be quantity limits on certain medicines. Quantity limits are based on the FDA's recommended dosing guidelines for each medication and are reviewed regularly by the Plan to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions. Requests for drug quantities above Plan limits require review and authorization by OptumRx.

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

Step Therapy: A program in which the member must try one or more prerequisite drugs before the Step Therapy drug will be covered by the Plan. This is designed for people who regularly take prescription drugs to manage ongoing medical conditions.

Example:

- **Step 1 medications:** Generic drugs that have the same health benefits as higher-cost medications.
- **Step 2 medications:** Brand-name drugs recommended if a Step 1 medication does not work for you. Step 2 medications may cost you and your Plan more than Step 1 medications.

Appeals of Adverse Benefit Determinations

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

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

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

Any member representatives must be identified and their authority verified in accordance with OptumRX policy and procedures. There are no fees or costs charged to the member for any level of appeal conducted by OptumRX on behalf of Hardee County School Board medical plan.

The member's appeal should include the following information:

- Name of the person filing the appeal
- Pharmacy benefit identification number
- Date of birth
- Written statement of the issue(s) being appealed
- Drug name(s) being requested, and
- Written comments, documents, records or other information relating to the claim.

The member's appeal and supporting documentation may be mailed or faxed to:

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

OR

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

OptumRx's Review

The review of a member's claim or appeal of an adverse benefit determination on behalf of Hardee County School Board medical plan will be conducted in accordance with the guidelines under Hardee County School Board medical plan's pharmacy benefit plan and any related laws.

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

OptumRx will provide the first-level review of appeals of adverse benefit determination for pre-service clinical Prior Authorizations (PA). Such claims will be reviewed against pre-determined clinical criteria relevant to the drug or benefit being requested under Hardee County School Board medical plan's pharmacy benefit plan. If the member's first-level appeal is denied, the member may appeal the decision and request an additional second-level review. The second-level review will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

OptumRx provides a single level of appeal for administrative denials. Upon receipt of such an appeal, OptumRx will review the member's request for a particular drug or benefit against the terms of the Plan, including preferred drug lists or formularies selected by the Plan.

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

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

Scope of Review
During its pre-authorization review, first-level review of the appeal of a pre-service clinical Prior Authorization claim, or review of a post-service claim or administrative denial, OptumRx shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim
- Follow reasonable procedures to verify the benefits determination is made in accordance with applicable Plan documents
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members, and
- Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual)

If a member appeals OptumRx's denial of a pre-service clinical claim and requests an additional second-level review by an IRO, the IRO shall:

- Consult with an appropriate healthcare professional who was not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual)
- Identify the healthcare professional, if any, whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, and
- Provide for an expedited review process for urgent care claims

Notice of Adverse Benefit Determination
Following the review of a member's claim, OptumRx will notify the member of any adverse benefit determination in writing. (Decisions on urgent care claims will also be communicated by telephone.) This notice will include:

- The specific reason(s) for the adverse benefit determination
- References to pertinent Plan provisions on which the adverse benefit determination was based
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse

benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion will be provided free of charge upon written request, and

- If the adverse benefit determination is upheld by the IRO, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Direct Member Reimbursement

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

OptumRx Essential Health Benefit (EHB) Zero Copay Medications

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

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

Diabetes Management Program

This program is designed to help members control blood sugar, A1c levels, disease progression and comorbidities. By keeping members motivated to improve their health, we can reduce complications and progression, as well as curb medical visits and hospitalizations. Call Customer Service for more information about how you can access this program. Members can expect to receive live and automated calls.