Indiana Notice of Rights
Grandfathered Plans

Prescription Drug Step Therapy Request for Protocol Exception

Certain Prescription Drug Products for which Benefits are described in your Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.uhone.com or by calling the telephone number on your health plan ID card.

These reviews would take into account any prior history of an alternative Prescription Drug Product(s) or Pharmaceutical Product(s) in a therapeutic failure, contraindication, or intolerance. Your Pharmacy Benefit Manager will notify you of our determination within three (3) business days for non-urgent care situations or within one (1) business day for urgent care situations after receiving a request.

Appeal of a Denied Protocol Exception Request for Prescription Drug Step Therapy

You may submit, orally or in writing an appeal regarding our denial of a step therapy protocol exception.

You may request an expedited review if:

- Based on a prudent layperson's judgment, the timeframe to complete a standard review could seriously risk your life, health, or ability to regain maximum function; or
- Based on your treating health care provider's judgment, the time timeframe to complete a standard review could subject you to severe pain that cannot be adequately managed.

Requests may be made orally, by fax or in writing at:

Grievance Administrator
2020 Innovation Court
DePere, WI 54115
Fax: (866) 654-6323
Phone: (800) 657-8205

The appeal will be reviewed by a health care professional chosen by us. We will make a decision on the appeal within one business day after receiving an expedited appeal or three business days after receiving a standard appeal.

Protocol Exception Criteria

A protocol exception will be granted if any of the following apply:

a. A preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the covered individual
b. A preceding prescription drug is expected to be ineffective, based on both of the following:
   (1) The known clinical characteristics of the covered individual; and

(2) Known characteristics of the preceding prescription drug, as found in sound clinical evidence;

c. The covered individual has previously received:
   (1) A preceding prescription drug; or
   (2) Another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug; and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

d. Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the covered individual because the covered individual 's use of the preceding prescription drug is expected to:
   (1) Cause a significant barrier to the covered individual's adherence to or compliance with the covered individual's plan of care;
   (2) Worsen a comorbid condition of the covered individual; or
   (3) Decrease the covered individual's ability to achieve or maintain reasonable functional ability in performing daily activities.

Relevant medical records may be requested in support of a protocol exception.

Appeal and Grievance Rights (Not including Step Therapy Denials)

You or someone acting on your behalf may submit, orally or in writing, a grievance regarding:

- A decision that a service or proposed service is not appropriate or medically necessary;
- A decision that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims;
- Matters pertaining to the contractual relationship between you and us;
- Our decision to rescind your policy; or
- A decision concerning a prior authorization request.

The grievance may be submitted to us at:

Grievance Administrator
PO Box 31371
Salt Lake City, UT 84131-0371
Fax: (801) 478-5463
Phone: (800) 657-8205

Grievances involving appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a health care professional chosen by us. The health care professional will not have been involved in the initial decision. All other grievances will be reviewed by an impartial person who was not involved in the original decision.

The grievance decision will be made within 20 working days after receipt of all information reasonably necessary to complete the review. If a decision cannot be made during that time due to circumstances beyond our control, a written notice of delay will be sent before the 20th day. The grievance decision will be made within 10 additional working days. Written notice of the grievance decision will be sent within five working days after the decision is made.

If you are not satisfied with the grievance decision, an appeal may be filed by you or a person on your behalf. The appeal may be submitted to us at the address, fax number, or phone number listed at the bottom of the previous page. Appeals involving appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of qualified individuals appointed by us. You or a person on your behalf has the right to appear, in person or by telephone, before the panel to present your case. All other appeals will be reviewed by an impartial person who was not involved in the original or grievance decision.

The appeal decision will be made within 45 calendar days after the appeal is received. Written notice of the appeal decision will be sent within five working days after the decision is made.

An external review by an independent review organization (IRO) is available if you disagree with the appeal decision for cases involving:

- A decision that a proposed or rendered service is not appropriate or medically necessary;
- A decision that a proposed or rendered service is experimental or investigational; or
- Our decision to rescind your policy.

The written request for external review must be filed within 120 calendar days after the receipt of our appeal decision. The request may be sent to us at the fax number or address listed above. It must include a completed authorization form allowing us to release necessary medical information to the IRO. The IRO will make a decision within 15 business days after the request is filed. They will send written notice of the decision within 72 hours after making the decision.

Expedited Review Procedures

For emergency or life-threatening situations, you or someone on your behalf may request an expedited (urgent) grievance orally, by fax, or in writing at:

Grievance Administrator
2020 Innovation Court
DePere, WI 54115
Fax: (866) 654-6323
Phone: (800) 657-8205

An expedited grievance involving appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a health care professional chosen by us. The health care professional will not have been involved in the initial decision. All other expedited grievances will be reviewed by an impartial person who was not involved in the original decision. The expedited grievance decision will be provided to you orally within 48 hours of receipt. We will then provide you written notice of the decision.

If you are not satisfied with the expedited grievance decision, an expedited appeal may be filed by you or a person on your behalf. The appeal may be submitted to us at the address, fax number, or phone number listed on previous page. The expedited appeal will be reviewed by a doctor who was not involved in the original or expedited grievance decision. The expedited appeal decision will be provided to you orally within 48 hours of receipt. We will then provide you written notice of the decision.

An expedited external review is available if you disagree with the expedited appeal decision involving appropriateness, medical necessity, or experimental or investigational treatment. The written request for expedited external review may be sent to us at the fax number or address

listed above. It must include a completed authorization form allowing us to release necessary medical information to the IRO. The IRO will make a decision and notify you of the decision within 72 hours after the request is filed.

For further information, please review your insurance contract, call us at (800) 657-8205, or visit the Indiana Department of Insurance's website at http://www.in.gov/idoi/3008.htm.