

Indiana Notice of Rights Non-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.myallsavers.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) 291-2634

The appeal will be reviewed by a health care professional chosen by us. We will notify you of the appeal decision including supporting rationale 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 must be sent to us within 180 days of the date you receive our denial. It may be submitted to us at:

Grievance Administrator
PO Box 31371
Salt Lake City, UT 84131-0371
Fax: (801) 478-5463
Phone: (800) 291-2634

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.

For services not yet rendered, the grievance decision will be made within 15 calendar days after receipt. Written notice of the grievance decision will be sent the earlier of five business days after the decision is made or 15 calendar days after the grievance was received. For all other grievances, the decision will be made within 20 working days after the grievance was received. Written notice of the grievance decision will be sent the earlier of five working days after the decision is made or 30 calendar days after the receipt of the grievance. If we are unable to make

a decision within 20 working days due to circumstances beyond our control, a written notice of delay will be sent before the 20th day. We will then make the grievance decision and notify you of the decision within a total of 30 calendar days after receipt.

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 above. 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 involving medical judgment will be reviewed by a health care professional chosen by us. The health care professional will not have been involved in the initial or grievance decision. Any other appeal will be reviewed by an impartial person who was not involved in the original or grievance decision.

For services not yet rendered, the appeal decision will be made within 15 calendar days after receipt. Written notice of the appeal decision will be sent the earlier of five business days after the decision is made or 15 calendar days after the appeal was received. For all other appeals, the decision will be made no later than 30 calendar days after the appeal is received. Written notice of the appeal decision will be sent the earlier of within five working days after the decision is made or 30 calendar days after the appeal was received.

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

An expedited grievance may be requested for an urgent care claim for services you have not yet received. An urgent care claim is:

- Any claim that a doctor with knowledge of the medical disease or illness determines is an urgent care claim for which the time periods making non-urgent care decisions could seriously risk your life, health, or ability to regain greatest function.
- In the opinion of a doctor with knowledge of your medical disease or illness, any claim for medical care or treatment for which the time periods for making non-urgent care decisions would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Any claim for medical care or treatment for which the time periods for making non-urgent care decisions could seriously risk your life, health, or ability to regain greatest function. Whether a claim is an urgent care claim will be determined by an individual acting on our behalf applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

You or someone on your behalf may request an expedited grievance orally, by fax, or in writing at:

Grievance Administrator
2020 Innovation Court
DePere, WI 54115
Fax: (866) 654-6323
Phone: (800) 291-2634

An expedited grievance will be reviewed by a doctor chosen by us. The doctor will not have been involved in the initial 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 above. The expedited appeal will be reviewed by a doctor who was not involved in the initial 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. The IRO is to 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>.