HEALTHAlliance Benefit Plan

PRESCRIPTION DRUG PROGRAM DESCRIPTION FOR:

ALLIANCESELECT $1500 PLAN B PPO
ALLIANCESELECT $2000 PLAN C PPO
ALLIANCESELECT $3175 PLAN D PPO
ALLIANCESELECT $6850 PLAN E PPO

EFFECTIVE DATE: July 1, 2021

NOTE: THE PRESCRIPTION DRUG PROGRAM IS NOT ADMINISTERED BY WELLMARK BLUE CROSS BLUE SHIELD (BLUE CROSS). IT IS ADMINISTERED BY RXBENEFITS AND EXPRESS SCRIPTS. TERMS AND CONDITIONS APPLICABLE TO THE MAJOR MEDICAL BENEFIT ARE NOT NECESSARILY APPLICABLE TO THE PRESCRIPTION DRUG BENEFIT.

General Information

The HEALTHAlliance Benefit Plan prescription drug program, administered by RxBenefits through Express Scripts, helps you pay for covered prescription drug expenses for you and your covered Dependents anywhere in the United States (the "Prescription Drug Program"). Use the information on your prescription identification card to access your benefits under the Prescription Drug Program.

This Prescription Drug Program description applies only to the prescription drug program that accompanies the Plan's major medical benefit designated both as "AllianceSelect" or "PPO" and as having one of the individual deductibles and letter codes stated in the chart below under "Network Benefits," "Overview." Of those medical benefit options, the particular medical benefit option in which you are enrolled is referred to herein as the "Medical Benefit." Upon enrollment in the Medical Benefit, you are automatically enrolled in this Prescription Drug Program. However, prescription drug benefits described in this section are administered separately from the medical benefits provided under the Plan. Coverage under the Prescription Drug Program will terminate at the same time that coverage under the Medical Benefit terminates.

The Prescription Drug Program offers three primary options to help you pay for the covered prescription drugs you purchase: participating retail pharmacies, mail order, and the Accredo Specialty pharmacy. When you purchase a covered prescription drug through one of these options, you will be responsible for paying the applicable co-pay amounts, and the Prescription Drug Program will pay as provided in this Prescription Drug Program Description.

The following rules apply to co-pays under the Prescription Drug Program:

- The co-pay amounts apply separately to each prescription drug that is filled.
- The co-pay for prescription drugs will not be applied toward satisfaction of the Annual Deductible under the Medical Benefit.
- The co-pay for Network, mail order maintenance and Accredo Specialty prescription drugs will be applied toward satisfaction of the out-of-pocket maximum for the Medical Benefit.

To contact RxBenefits call 1-800-334-8134. Member Services can give you information about coverage of a particular prescription drug, co-payment amounts, refill information and Network pharmacies. Additional helpful information can be found on the Express Scripts website, www.expressscripts.com, or on the RxBenefits website, rxb.promptpa.com.

Network Benefits

Overview

The Prescription Drug Program pays benefits only after you have satisfied the applicable deductible and paid the applicable co-pay. The co-pay for covered prescription drugs you purchase through a Network retail pharmacy or the mail order pharmacy are based on a three-tier design: generic, preferred brand name, and non-preferred brand name. Each tier has a different co-pay for which you will be responsible. Once the applicable out-of-pocket maximum is met, the covered prescriptions are paid at 100%.

Major Medical Plan Option	Annual Deductible (individual/family)	Out-of-Pocket Maximum (individual/family)
AllianceSelect $1500 Plan B PPO	$100/$200	$3,000/$6,000
AllianceSelect $2000 Plan C PPO	$100/$200	$5,000/$10,000

AllianceSelect $3175 Plan D PPO	$100/$200	$6,350/$12,700
AllianceSelect $6850 Plan E PPO	$100/$200	$6,850/$13,700

Tier	Retail Co-pay (1-30-day supply)*	Mail Order Co-pay (90-day supply)*	Accredo Specialty Pharmacy Co-pay
Generic	$10 co-pay (deductible waived)	$20 co-pay (deductible waived)	N/A
Preferred Brand Name	$25 co-pay after deductible	$50 co-pay after deductible	$100 co-pay
Non-Preferred Brand Name	$45 co-pay after deductible	$90 co-pay after deductible	$200 co-pay

* Prescriptions filled at participating retail pharmacies are typically for a 30-day supply. Mail Order is typically a 90-day supply. Supplies of greater than 30 days may be obtained at select retail pharmacies, but you will be charged a separate retail co-pay for each full or partial 30-day supply represented by the supply obtained. For example, if you obtain a 60-day supply at retail you will pay two (2) 30-day retail supply co-pays.

NOTE: The retail and mail order drug co-pay amounts are reviewed annually and are subject to change each Plan year with or without advance notice.

Retail Network Pharmacy Benefit

If you need your prescription filled immediately, use any Network retail pharmacy across the United States that has a contract with Express Scripts for negotiated discounted prescription drug prices, providing cost-effective benefits (referred to herein as a "Network" pharmacy).

A complete list of participating pharmacies may be obtained by accessing the Express Scripts website at https://www.express-scripts.com/. Select "Find a Pharmacy" from the menu under "Prescriptions." Enter the ZIP code or city/state where you wish to find a pharmacy. Click "Locate Pharmacy."

If you purchase a covered prescription drug at a Network retail pharmacy you can receive up to a 90-day supply of that prescription drug, but you will be required to pay a separate co-pay for each full or partial 30-day supply represented by the supply obtained. See the chart above under the heading "Overview" in the section entitled "Network Benefits" for the applicable co-pay amount.

To fill a prescription at a Network pharmacy:

- ask your Physician to write the prescription for up to a 90-day supply for the drug that is clinically appropriate. Please note that for certain prescription drugs the Prescription Drug Program imposes a unit dose limit—for example, anti-diabetic and antifungal agents. The Prescription Drug Program will not pay any benefit for a prescription drug you purchase in excess of the applicable unit dose limit;
- present your prescription identification card so the Network pharmacy can verify your participation in the Prescription Drug Program;
- if your Physician has specified a brand name drug and there is no generic drug, you will pay the appropriate brand name co-pay;
- if your Physician has specified a generic drug, you will pay the generic drug co-pay.

NOTE: Generics are preferred by your Plan. Dispense as Written (DAW) instructions may be honored; but if you receive a brand-name prescription when an equivalent generic is available, the Prescription Drug Program will pay the generic-level benefit and you will pay the difference in price between the two medications in addition to any brand-name co-pay.

If you purchase a covered prescription drug at a Network pharmacy and do not provide your identification card when you make your purchase, you must file a claim under the Prescription Drug Program to be reimbursed for the portion of the cost payable by the Prescription Drug Program for the prescription drug you purchased. You will be reimbursed based on the Express Scripts negotiated cost of the prescription drug less the amount of the appropriate co-payment under the Prescription Drug Program. You can obtain a claim form on the Express Scripts website or by contacting RxBenefits Member Services by phone at 1-800-334-8134.

Preventive Drugs

Certain items identified by your plan as preventive care are covered in full and not subject to the deductible or co-pay amounts indicated.

Specialty Drugs

Specialty Drugs are pharmaceutical products, with many requiring injection or non-oral methods of administration, which may have special shipping or handling requirements. Examples of some of the disease categories include cancer, multiple sclerosis, Hepatitis C, rheumatoid arthritis, cystic fibrosis, infertility, RSV prophylaxis, Gaucher disease, growth hormone deficiency, hemophilia and immune deficiency.

Accredo Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to covered individuals along with supplies, equipment, and care coordination. Specialty drugs are limited to a 30-day supply per fill and are only covered if dispensed by Accredo Specialty Pharmacy.

Compounded Drugs

Compound drugs are only covered under the Prescription Drug Program if they satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Furthermore, compound drugs are covered under the Prescription Drug Program only to the extent Express Scripts determines that the cost of such compound drugs is reasonable. For example, and without limiting the generality of the foregoing, if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, then the cost will not be considered reasonable and is not covered by this Prescription Drug Program. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under the Prescription Drug Program.

You will be responsible for paying the applicable co-pay, which will be based on the generic, preferred or non-preferred drug ingredient. Remember, you will have to pay the full cost of the compounded drug to the pharmacy and then will be reimbursed by the Prescription Drug Program for any amount payable under the program.

Prescriptions for compounded drugs must be filled at Network retail pharmacies. The compounded drug must include at least one ingredient that is a prescription legend drug, meet the provisions listed in the subsection of this section entitled “What Is Covered” and not be excluded by the provisions listed in the subsection entitled “What Is Not Covered.” You should review those subsections prior to submitting your prescription to a pharmacy so you will understand what amount, if any, of the cost of the compounded drug will be reimbursed by the Prescription Drug Program.

Non-Network Benefit

If you choose to obtain a covered prescription drug at a non-Network retail pharmacy, you are required to pay the full cost of the covered prescription drug up-front, after which you may request reimbursement. You must file a claim under the Prescription Drug Program to be reimbursed for the portion of the cost payable by the Prescription Drug Program for the prescription drug you purchased from a non-Network pharmacy. You will be reimbursed based on the amount Express Scripts determines is the Allowed Amount, less the amount of the appropriate co-pay under the Prescription Drug Program. You can obtain a claim form on the Express Scripts website or by contacting RxBenefits Member Services by phone at 1-800-334-8134.

The Allowed Amount for non-Network prescription drug claims is determined by Express Scripts in its sole discretion, and in most all cases the Allowed Amount for non-Network drugs is less than the Allowed Amount for the same

prescription if filled at a Network pharmacy. In no event will the Allowed Amount include any amounts for which you are not actually charged and/or amounts not actually paid for out of pocket by the Participant.

In addition to the applicable co-pay, if you purchase a prescription drug from any source other than a Network pharmacy or through the mail order program described herein, you will be responsible for paying 100% of the non-Network provider's billed charges in excess of the Allowed Amount.

Finally, note that there is no out-of-pocket maximum for non-Network prescription drugs, and amounts you pay for non-Network prescription drugs will not count toward the Medical or Prescription Drug Program deductible or out-of-pocket maximum.

Mail Order Maintenance Benefit

RxBenefits has a mail order pharmacy program through Express Scripts for maintenance medications called Maintenance Medication Coverage. Maintenance medications are those prescription drugs you take for long-term (more than 30 days) non-emergency treatment.

Through the mail order pharmacy program, you can receive up to a 90-day supply of a prescription drug at one time, making your drugs more cost effective. You will be charged the appropriate co-pay at the time you place your order.

Follow the steps below to have a prescription filled through the mail order program:

- ask your Physician to write your prescription for up to a 90-day supply plus a maximum of three 90-day refills. The actual unit dose limit is a 90-day supply each time you have the prescription filled;
- to initiate your mail order prescription please visit Express Scripts at www.express-scripts.com and follow the prompts to get started. You may also initiate a mail order claim via the Express Scripts Phone app available at the Apple and Google Play app stores.
- if your Physician has specified a brand name or specialty drug and there is no generic drug, you pay the appropriate brand name or specialty co-pay, as applicable;
- if your Physician has specified a generic drug, you pay the generic co-pay, as applicable; and
- call RxBenefits Member Services at 1-800-334-8134 or visit www.express-scripts.com every three months thereafter to have the prescribed refills mailed to you. You will only pay the applicable co-pay for that 90-day supply of the prescription.

NOTE: Generics are preferred by your Plan. Dispense as Written (DAW) instructions may be honored; but if you receive a brand-name prescription when an equivalent generic is available, the Prescription Drug Program will pay the generic-level benefit and you will pay the difference in price between the two medications in addition to any co-pay.

What Is Covered

Prescription drugs and compounded medications are covered under the Prescription Drug Program only when medically necessary, approved by the Federal Drug Administration (FDA) and accompanied by a prescription from a Physician. Not all prescription drugs are covered, however; the Prescription Drug Program only covers prescription drugs that are on a specific formulary, or list of covered drugs, maintained by Express Scripts.

Prior Authorization

Under the terms of the Prescription Drug Program, all claims for prescription drug benefits exceeding $1,000 per supply of 34 or fewer days or $3,000 per supply of 35 days or more require prior authorization. In addition, Express Scripts may require that your Physician submit a request to RxBenefits for prior authorization ("PA") that a benefit is payable under the Prescription Drug Program for in drugs prescribed to you such as drugs for sleep disorders, multiple sclerosis, drugs to treat cancer, and human growth hormone. A list of drugs for which prior authorization is required may be obtained from RxBenefits at: 1-800-334-8134. If your doctor has not received a PA when you go to fill the

prescription, your pharmacist should let you know. You may discuss prior authorizations by phone with RxBenefits at: 1-800-334-8134. Prior authorizations may be initiated on the RxBenefits website, rxb.promptpa.com

Covered Drug Limitations

Covered Drug Limitations ("CDL") is a program to make sure you receive your drugs in the amount or quantity considered safe. It also helps control the cost of extra supplies that could go to waste in your medicine cabinet. The program follows guidelines developed by the U.S. Food & Drug Administration (FDA). These guidelines recommend the maximum quantities considered safe for prescribing certain medications. When you go to the pharmacy for a prescription medication with a quantity limitation, your co-pay will only cover the quantity allowed by the plan, and a Prescription Drug Program benefit is only payable up to the CDL limit Express Scripts establishes. If you are prescribed a quantity over the recommended guideline the prescribing doctor can change the prescription to the recommended quantity for processing through Express Scripts; if necessary your doctor may contact Express scripts to request an exception. Otherwise, you would be responsible for the full drug cost. Examples of drug categories subject to CDL limitations include, but are not limited to narcotic pain medications, sleep medications, drugs to treat migraine headaches, and drugs that treat cancer.

For information about whether a specific prescription drug is covered under the Prescription Drug Program or requires prior authorization or is subject to CDL limits, access the Express Scripts customer service website at www.express-scripts.com or call RxBenefits Member Services by phone at 1-800-334-8134.

Prescription Drugs and Changes to the Formulary

The Prescription Drug Program provides benefits for only certain drugs on a list called a "Formulary." The Formulary includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or are as effective as and less costly than similar medications. Non-preferred Brand name Non-Formulary drugs may also be covered under the Prescription Drug Program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Program's Formulary. The Program's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to https://www.express-scripts.com/frontend/open-enrollment/ntlplsntlprff/plans/5d5301edc03c390064343eb5.

Drugs that are excluded from the Program's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by RxBenefits and Express Scripts on the basis that the drug requested is (1) medically necessary and essential to the Covered Person's health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the Covered Person. If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Participants selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Participant's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier. Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step-therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Step Therapy

The step therapy program manages prescription-drug waste within specific therapy classes by guiding patients to first-line medications before "stepping up" to more costly second line medications. Within specific therapy classes, several

clinical effective medications are often available to treat the same condition. Step therapy takes advantage of these opportunities to direct a patient to a clinically effective, lower-cost medication. Evidence-based clinical protocols for each step therapy module ensure patients receive cost-effective therapy that is clinically appropriate for their condition. The step therapy program minimizes impact to Participants at the point of sale by applying automation to reject claims only for Participants whose history does not show use of first-line products. RxBenefits require step therapy before any benefit is payable.

What Is Not Covered

The following nonexclusive list of drugs or items are not covered under the Prescription Drug Program and no part of the cost for such drugs or items will be paid or reimbursed under the program:

- Formulary Exclusion List including low clinical value drugs, me too drugs, new to market drugs and non-essential drugs
- OTC Products
- Standard OTC Equivalents
- Insulin Pumps
- Anti-Obesity/Anorexiants
- Fertility (Injectable and Intra-Vaginal)
- Hair Growth Stimulants
- Nutritional Supplements
- Medical Foods
- Inhaler Assisting Devices
- Injectable/Implantable Medications
- Allergy Extracts
- Diaphragms & Cervical Caps
- IUDs

Additional exclusions apply. See the supplement, National Preferred Formulary Exclusions, available at https://www.express-scripts.com/frontend/open-enrollment/ntlplsntlprff/plans/5d5301edc03c390064343eb5.

The fact that a drug is not covered does not mean you are denied treatment. You have the right to purchase an excluded product at your own cost if the product is excluded under this Plan; however, the product will be the full billed price and the Prescription Drug Program will not pay any benefit. If you have any questions about coverage, call RxBenefits at 1-800-334-8134.

Prescription Drug Program Identification Cards

You will receive an identification card to be shared among all enrolled members of your family (each a "Participant") to assist in accessing your benefits under the Prescription Drug Program. Additional identification cards are available by request made to Express Scripts. If you need to fill a prescription before your card arrives, simply provide the following, along with your member number or Social Security number to the pharmacy:

RXBIN: 610014
RXGRP: [ ]
Issuer: Express Scripts
RxBenefits Member Services: 800-334-8134
Pharmacy Helpdesk: 800-922-1557

It is important that you present your identification card each time you have a prescription filled at a retail pharmacy so your eligibility can be verified and you will be charged only the applicable co-pay and will not have to file a claim for reimbursement under the program.

Prescription Drug Utilization Review

Prescription drug use does not have unlimited coverage. As with all medical and hospital services, prescription drug utilization is subject to determinations of medical necessity and appropriate use. Prescription drug utilization review may be concurrent, retrospective or prospective.

Concurrent drug utilization review generally occurs at the time of service and may include electronic claim audits to protect patients from potential drug interactions or a drug-therapy conflicts or overuse/under-use of medications.

Retrospective drug utilization review generally involves claim review and may include communication by the Prescription Drug Program and/or a utilization review company with the prescribing physician to coordinate care and verify diagnoses and medical necessity. It may include a peer review by a physician of like specialty to the prescribing physician reviewing the medical and pharmacy records to determine medical necessity.

Should medical necessity not be determined by the peer-review physician, the treating physician and Participant will be notified and provided with the peer review results. The Participant and treating physician will be forwarded information on the appeals process as outlined in this Prescription Drug Program section.

Prospective drug utilization review may include, among other things, physician or pharmacy assignment in which one physician and/or pharmacy is selected to serve as the coordinator of prescription drug services and benefits for the eligible Participant. The Participant will be notified in writing of this and will be required to designate a physician and pharmacy as his/her providers.

Prescription Drug Program Claims and Appeals Procedures

Introduction

RxBenefits is the Claims Administrator of the Prescription Drug Program and will process all claims and appeals under the Prescription Drug Program in accordance with requirements under ERISA.

Claims Procedures

If you present your Prescription Drug Program identification card at the time you purchase a covered prescription drug at a Network pharmacy or you purchase a maintenance drug through the mail order pharmacy program, the Network pharmacy or mail order pharmacy will take into account the benefits payable to you under the Prescription Drug Program and will charge you only the applicable co-payment payable by you for the prescription drug.

However, if you do not provide your identification card when you purchase a covered prescription drug at a Network pharmacy, or if you purchase a covered prescription drug at a non-Network pharmacy, or if you purchase a qualifying compounded drug, you must file a claim under the Prescription Drug Program to be reimbursed for the portion of the cost payable by the Prescription Drug Program for the drug you purchased.

You can contact RxBenefits Member Services at: 1-800-334-8134 to obtain the required claim forms for reimbursement or go to the website www.express-scripts.com to print a claim form. Mail all your fully completed forms and pharmacy receipts to:

RxBenefits Inc.
P.O. Box 382377
Birmingham, Alabama 35238-2377

TIMELY FILING OF CLAIMS: A claim for benefits under the Prescription Drug Program must be submitted no later than 90 days after the date of purchase of the prescription drug. Otherwise, the Prescription Drug Program will not pay any benefits with respect to such prescription drug

The initial request by the pharmacy or prescribing physician that a medication be covered or be covered at a higher benefit level (e.g., lower co-pay or higher quantity) is an initial coverage review. Initial coverage reviews are of two types.

Clinical Coverage Review Request

A clinical coverage review request is 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. The preferred method to request an initial clinical coverage review is for the prescriber or dispensing pharmacist to call the RxBenefits Coverage Review Department at 1-800-334-8134. Alternatively, the prescriber may submit a completed coverage review form to Fax 1-888-610-1180 ATTN: Appeals Department. Forms may be obtained online at rxb.promptpa.com. Requests may also be mailed to RxBenefits Attn: Appeals Department P.O. Box 382377, Birmingham, AL 35238-2377. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

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.

Administrative Coverage Review Request

An administrative coverage review request is a request for coverage of a medication that is based on the Plan's benefit design. To request an initial administrative coverage review, the Participant or his or her representative must submit the request in writing to RxBenefits Attn: Appeals Department, P.O. Box 382377, Birmingham, AL 35238-2377.

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 patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1 800-334-8134.

Coverage Review Processing

In order to make an initial determination for a clinical coverage review request, the prescriber, Participant or pharmacy must submit specific information to RxBenefits for review. For an administrative coverage review request, the Participant must submit information to RxBenefits 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 As soon as reasonably possible but no later than:	Notification of Decision Approval	 Denial
Standard Pre-Service	15 days (retail) 5 days (home delivery)	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful
Standard Post-Service	30 days	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful

Urgent	72 hours	If to Participant: automated call and letter If to provider: fax, then letter if unsuccessful	If to Participant: live call and letter If to provider: fax, then letter if unsuccessful

Explanation of Benefits (EOB)

When RxBenefits, the Claims Administrator, makes a determination under the Prescription Drug Program regarding a claim for benefits you have submitted by mail (as opposed to claims submitted on your behalf by a network retail pharmacy), the Claims Administrator will inform you of its determination regarding that claim by sending you an EOB after processing the claim. The EOB will explain what portion of the claim was paid by the Prescription Drug Program and will let you know if there is any portion of the claim that is not payable by the program. If any claim is denied in whole or in part, the EOB will include the reason for the denial or partial payment.

If your claim is denied in whole or in part, the EOB will include:

- The specific reasons the claim was denied;
- Reference to the specific Prescription Drug Program provisions upon which the decision is based;
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the Prescription Drug Program's appeal procedures, if any, and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision- making, either (1) a copy of such rule, guideline, protocol, or other criterion, or (2) a statement that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the adverse decision on the claim was based upon a medical necessity, experimental treatment, or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Prescription Drug Program to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you, upon request.

RxBenefits, the Claims Administrator, will notify you of the Prescription Drug Program's benefit determination within a reasonable time period, as described in the tables below.

Appeal Overview

<u>If Your Claim is Denied</u>

If your claim for benefits under the Prescription Drug Program is denied, in part or in whole, you may call RxBenefits Customer Service at 1-800-334-8134 to see if RxBenefits can help you resolve to your satisfaction your issues and questions regarding the denial without you having to file a formal appeal. This procedure is voluntary. You are not required to call RxBenefits before filing a formal appeal. If RxBenefits cannot resolve your issues with respect to the denial of your claim over the phone, you may file a formal appeal, as described below, to appeal RxBenefits determination.

<u>How to Appeal a Denied Claim of an adverse benefit determination regarding a claim.</u>

If you wish to appeal a denied claim for benefits under the Prescription Drug Program you or your authorized representative must submit an appeal of that benefit determination within 180 days of receiving the EOB (or other adverse benefit determination) regarding such 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:

- the Participant-patient's name and identification number as shown on the Express Scripts identification card;
- date of birth
- the prescription, including the drug name(s) and the provider's reasons for prescribing the drug at issue in the claim;
- the provider's name;
- a copy of the claim for benefits and the Explanation of Benefits denying the claim; the reason you disagree with the denial; and
- any documentation or other written information to support the appeal, including prescriber statements/letters, bills or any other documents.

Clinical appeal requests must be sent to:

RxBenefits
Attn: Clinical Review Department
P.O. Box 382377
Birmingham, Alabama 35238-2377
Fax: 888-610-1180

Administrative appeal requests must be sent to:

RxBenefits
Attn: Appeals Department
P.O. Box 382377
Birmingham, Alabama 35238-2377
Fax: 888-610-1180

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 patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax: phone 1-800-334-8134 or by fax 1-888-610-1180.

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.

First-Level Appeal Determination

RxBenefits will conduct a full and fair review of your appeal. The appeal will be reviewed by an appropriate individual(s) who did not make the initial Benefit determination. An RxBenefits appeals analyst reviews and determines appeals relating to non-clinical benefits (e.g., eligibility determinations, co-pay issues, explicit exclusions under the Prescription Drug Program). A health care professional with appropriate expertise who was not consulted during the initial benefit determination process reviews appeals requiring clinical knowledge (e.g., physician, panel of clinicians, trained prior authorization staff member or independent third-party utilization management company).

You may submit written comments, documents, records, and other information relating to the claim at issue in the appeal. All comments, documents, records, and other information submitted by you relating to the claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such claim.

You will be provided, upon request to the Prescription Drug Program and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim at issue in the appeal.

If the first level appeal involves an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular drug or other item is experimental, investigational, or not medically necessary or appropriate, the appeal reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the first level appeal, nor the subordinate of any such individual.

Once the review is complete, if RxBenefits upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

First-level appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe As soon as reasonably possible but no later than:	Notification of Decision Approval	 Denial
Standard Pre-Service	15 days	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful
Standard Post-Service	30 days	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful
Urgent	72 hours	If to Participant: automated call and letter If to provider: fax, then letter if unsuccessful	If to Participant: live call and letter If to provider: fax, then letter if unsuccessful

Second-Level Appeal

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the Participant 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:

- the Participant-patient’s name and identification number as shown on the Express Scripts identification card;
- date of birth
- the prescription, including the drug name(s) and the provider’s reasons for prescribing the drug at issue in the claim;
- the provider's name;
- a copy of the claim for benefits and the Explanation of Benefits denying the claim; the reason you disagree with the denial; and

- any documentation or other written information to support the appeal, including prescriber statements/letters, bills or any other documents.

Second-level appeal requests must be clearly marked "Level 2 Appeal" and sent by mail or fax:

RxBenefits
Attn: Appeals Department
P.O. Box 382377
Birmingham, Alabama 35238-2377
Fax: 888-610-1180

Second-level appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe As soon as reasonably possible but no later than:	Notification of Decision Approval	 Denial
Standard Pre-Service	15 days	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful
Standard Post-Service	30 days	If to Participant: automated call, then letter if unsuccessful If to provider: fax, then letter if unsuccessful	If to Participant: letter If to provider: fax, then letter if unsuccessful

Independent Physician Specialist Review

If your second-level appeal involved medical judgment, rescission or a decision based on medical information, and your second-level appeal was denied in whole or in part, you may file an application for external review under the Prescription Drug Program. No other benefit determination made by RxBenefits under the Prescription Drug Program may be appealed in an application for external review.

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. An application for independent review must be filed with RxBenefits 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 legal holiday, the deadline will be the next business day. All internal appeal rights must be exhausted prior to requesting an external review. The response time from the IRO may be up to 45 days.

To submit an external review, the request must be mailed or faxed to RxBenefits.

RxBenefits
Attn: Clinical Review Department
P.O. Box 382377
Birmingham, Alabama 35238-2377
Fax: 888-610-1180

For an application for external review, the following will occur:

Standard External Review: 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 RxBenefits written notice of its decision.

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 where 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 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.

You may submit written comments, documents, records, and other information relating to the claim at issue in the appeal. All comments, documents, records, and other information submitted by you relating to the claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such claim or the first level appeal.

You will be provided, upon request to the Prescription Drug Program and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim at issue in the appeal.

An external review will not afford deference to the initial adverse benefit determination or the first- or second-level appeals.

Exhaustion of Administrative Processes Required

If not timely appealed, decisions by RxBenefits or the IRO, as the case may be, are final and binding. Before a suit can be filed in any court, Participants must exhaust all remedies and processes provided by this Plan.

ERISA Information

Plan Administrator

The Plan Sponsor of the Plan is the Trustees of the HEALTHAlliance Benefit Plan, and Iowa Benefit Administrators, LLC is the Plan Administrator, which has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Iowa Benefit Administrators, LLC
10430 New York Ave, Ste F
Urbandale, IA 50322

Claims Administrator

RxBenefits is the Plan's Claims Administrator. The Claims Administrator has the discretionary authority to adjudicate prescription drug claims and to otherwise handle the day-to-day administration of the Plan's prescription drug coverage through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's agent for service of process is:

Trustees of the HEALTHAlliance Benefit Plan
Attn: FUELIowa President & CEO
10430 New York Ave, Ste F
Urbandale, IA 50322

Legal process may also be served on the Plan Administrator.

Other Administrative Information

The Plan is a self-insured, unfunded welfare Plan and the administration is provided through the Claims Administrator.

Plan Name:	HEALTHAlliance Benefit Plan
Plan Number:	501
Employer ID:	42-6167033
Plan Type:	Welfare Benefits Plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company Contributions to Trust
Source of Benefits:	Trust