

Member Appeals Procedure

Prescriptive has established the Member Appeals Procedure provided below to enable a full and fair review of any adverse benefit determination. This Member Appeals Procedure may be modified by Prescriptive to maintain compliance with applicable law. Prescriptive will not use or apply medical professional judgment in the execution of the Member Appeals Procedure, and Prescriptive's review is limited to compliance with each members' Plan-specific design as determined by their plan sponsor or employer.

Appeals must be submitted via agreed Plan-specific instructions or in accordance with instructions provided in the appeal form published by Prescriptive and available on the Prescriptive public website.

Levels of Appeal

1. First Appeal

- The Member or Member's representative may request in writing, using the Appeals Request Form published on Prescriptive's public website, an appeal within 90 days of receiving notice of a negative benefit determination.
- First appeals shall be reviewed by Prescriptive employee(s) that were not involved in the initial adverse benefit determination.
- Prescriptive shall provide the Member a written response within 30 days of receipt of the Member's request for review of a negative benefit determination, including any further appeal rights.

2. Second Appeal:

- The Member or Member's representative may request in writing, using the Appeals Request Form published on Prescriptive's public website, an appeal within 90 days of receiving a written notice of a negative benefit determination following a First appeal review.
- Second appeals shall be reviewed by Prescriptive employee(s) who were not involved in any previous related adverse benefit determination.
- Prescriptive shall provide the Member a written response within 30 days of receipt of the Member's request for a Second review of an adverse benefit determination including, in the event of a negative benefit determination, any further appeal rights including the right to a third-party review by a certified Independent Review Organization (IRO).

3. External Appeal (IRO)

- The Member or Member's representative may request in writing, using the Appeals Request Form published on Prescriptive's public website, an appeal within 90 days of the Plan's final notice of review resulting in an adverse benefit determination (the "External Review Period").
- The IRO shall be an independent organization that employs medical professional with appropriate clinical background. The IRO employee making the decision will

- have not been involved in prior negative benefit determination related to the Member's appeal. The IRO shall have no financial interest with Prescriptive or the outcome of their independent review.
- The IRO shall, within 6 days of receipt of the External Appeal request, provide notice to the Member or Member's representative of any deficiencies in the request. The Member shall have until: (i) the end of the External Review Period, or (ii) 48 hours after receipt of the notice of any such deficiency, whichever is later, to cure the deficiency.
 - The IRO shall provide the Member or the Member's representative, together with Prescriptive, a written response within 45 days of receipt of the External Appeal request, including:
 - The IRO's decision regarding benefit eligibility
 - A description of the IRO's rationale for their determination
 - The IRO's decision shall be the final benefit determination

Expedited (Urgent) Appeals

An Expedited Appeal for urgent care may be requested, provided it is initiated within the timeframes first outlined above, if the Member or the Member's provider believes that the time required for making a standard appeal review determination could have serious negative impact or jeopardize the Member's health.

- Expedited First and Second Appeals
 - The Member, Member's representative or the Member's provider may request an Expedited Appeal in writing or orally via the instructions published on Prescriptive's public website.
 - Prescriptive shall respond to Expedited Appeals as soon as possible, but no later than within 72 hours of receipt of the request.
 - In the event of a negative benefit determination resulting from an Expedited Appeal, Prescriptive shall provide the Member a written notification, in addition to any prior oral notification, including any further appeal rights.
- Expedited External Appeal (IRO)
 - The Member, Member's representative or the Member's provider may request an Expedited External Appeal in writing or orally, via the instructions published on Prescriptive's public website.
 - The IRO shall respond to Expedited Appeals as soon as possible, but no later than within 72 hours of receipt of the request.
 - In the event of a negative benefit determination resulting from an Expedited External Appeal, the IRO shall provide the Member or the Member's representative, together with Prescriptive, a written response, in addition to any prior oral notification, including:
 - The IRO's decision regarding benefit eligibility
 - A description of the IRO's rationale for their determination
 - The IRO's decision shall be the final benefit determination