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Companion Life Insurance Company Network Access Plan Express Scripts Network

Companion Life Insurance Company (Companion Life) uses a leased managed pharmacy network arrangement with Express Scripts Holding Company (Express Scripts). Providers in the Companion Life Insurance Company network contract through Express Scripts. Providers participating in the Express Scripts Network agree to provide pharmacy services according to Express Scripts, state and federal requirements. The Colorado Division of Insurance requires us to provide you with this Network Access Plan. The Network Access Plan describes your pharmacy plan's provider network and related topics.

TABLE OF CONTENTS

PAGE

NETWORK COMPOSITION, IDENTIFICATION OF PROVIDER CRITERIA

Pharmacies must meet applicable CMS and state performance criteria in order to be eligible to participate in Express Script's Part D Pharmacy Network.

Our network pharmacies are contractually required to:

- Submit usual and customary (U&C) prices on all claims
- Participate in our audit programs to ensure accuracy and prevent fraud
- Display drug utilization review (DUR) messages and respond or act upon these messages appropriately
- Support formulary compliance and stock all drugs included on the formulary
- Comply with benefit design and eligibility verification
- Adjudicate claims online in the current National Council for Prescription Drug Programs (NCPDP) format
- Dispense generic substitutes when permitted by state law and according to clients' benefit designs
- Accept set reimbursement levels and dispensing fees
- Agree to accept the full payment with the exception of member contributions, as determined by the plan design (for example, copayments, deductibles, and ancillary fees)
- Agree to collect the copayment and other applicable fees from members at the point of service

Express Scripts' Medicare Part D pharmacy network meets all any willing provider requirements as outlined by Centers for Medicare & Medicaid Services (CMS) retail access requirements, including those related to home infusion (HI) providers; long-term care (LTC) providers to include institutes for mental disease, intermediate care facilities for the mentally handicapped, or interim care facilities; and Indian Health Service, Indian Tribe and Tribal Urban Organization, and Urban Indian Organization (ITU) pharmacies.

Express Scripts will have available standard contracting terms and conditions for requesting pharmacies no later than September 15th of each year for the immediately succeeding benefit year.

Express Scripts supplements its (on its behalf or behalf of its Client PDPs or Client MA-PDs as applicable) contracted pharmacy network with non-retail pharmacies, including pharmacies offering home delivery via mail order and institutional pharmacies.

Our Medicare Part D Network is an open network, meaning a pharmacy may contact Express Scripts to request a contract at any time. Express Scripts is willing to contact any pharmacy upon request; recruitment requests from clients, beneficiaries, or pharmacies receive immediate attention and are acted upon in accordance with our credentialing policies regarding network participation and contract terms. The amount of time it will take to add the pharmacy to our network is contingent on the pharmacy accepting the contract and returning it for processing.

Each pharmacy provider can participate in the voluntary 90-day supply at retail option. Acceptance of this option is not required to participate in Express Scripts' Medicare Part D Network.

Unique Pharmacies

In accordance with CMS expectations, Express Scripts maintains an effective recruitment process for contracting HI, LTC, and ITU providers to deliver services as part of our Medicare Part D Network. The recruitment process is outlined below:

- *HI Providers* — HI pharmacies are identified using the National Council for Prescription Drug Programs (NCPDP) Pharmacy Database File and Express Scripts' existing HI commercial

contracts. We invite identified pharmacies to join our Medicare Part D Network. Client-specific recruitment efforts will be undertaken as necessary.

- *LTC Providers* — Express Scripts requests that our clients identify all beneficiaries who reside in LTC facilities, as well as provide the information for all pharmacies serving the LTC facilities. If these pharmacies do not already participate in our Medicare Part D Network as LTC pharmacy providers, our Supply Chain team will recruit the pharmacies for the client.
- *ITU Providers* — ITU pharmacies are contracted individually based on information provided by Indian Health Services, in conjunction with leveraging Express Scripts' experience contracting with these types of providers. On a quarterly basis, our Supply Chain Retail Strategy team will notify client of any new tribal organizations that have signed a Medicare Part D ITU contract with Express Scripts.

NETWORK STANDARDS AND ADEQUACY

At Express Scripts, we always meet and often exceed Centers for Medicare & Medicaid Services (CMS) standards to ensure our network pharmacies are easily accessible to your beneficiaries, including those in urban, suburban, and rural settings. CMS standards require that:

- In urban areas, at least 90% of Medicare beneficiaries in the client's service area as submitted to CMS, on average, live within two miles of a pharmacy participating in Express Scripts' Medicare Part D network.
- In suburban areas, at least 90% of Medicare beneficiaries in the client's service area as submitted to CMS, on average, live within five miles of a pharmacy participating in Express Scripts' Medicare Part D network.
- In rural areas, at least 70% of Medicare beneficiaries in the client's service area as submitted to CMS, on average, live within 15 miles of a pharmacy participating in Express Scripts' Medicare Part D network.

Express Scripts provides all Medicare health plan clients a geo access report along with the corresponding network pharmacy list to ensure all Centers for Medicare & Medicaid Services (CMS) access standards for urban, suburban, and rural are met within a given network.

For our Medicaid health plan clients, with any network offering, we will run network access reports to ensure that your pharmacy network meets the pharmacy network access requirements outlined by each respective state Medicaid agency.

Home Infusion Access

Express Script's Network will have at least the minimum number of Home Infusion Pharmacies contracted. Home Infusion network pharmacies will be confirmed on an annual basis prior to annual CMS bid submissions.

Home Infusion pharmacies will meet the following accessibility criteria

1. Deliver home infused drugs in a form that can be easily administered in a clinically appropriate fashion;
2. Provide infusible Part D drugs for both short-term acute care and long-term chronic care therapies;
3. Ensure that the professional services and ancillary supplies necessary for the provision of home infusion therapy are in place before dispensing home infusion drugs, consistent with the quality assurance requirement for Part D sponsors described in 42 CFR 423.153(c) and;

4. Provide covered home infusion drugs within 24 hours of discharge from an acute setting, unless the next required dose, as prescribed, is required to be administered later than 24 hours after discharge.

Convenient Long Term Care (LTC) Access

Express Scripts Part D Pharmacy Network provides convenient access to network LTC Pharmacies for all members residing in an LTC facility. Institutions for Mental Disease and Intermediate Care Facilities for the Mentally Retarded are considered to be LTC facilities.

Express Scripts will offer a contract to any LTC Pharmacy operating in a Part D plan's service area that is willing to participate in their Part D Pharmacy Network so long as the LTC Pharmacy is capable of meeting the performance and service criteria specified by CMS.

In order to demonstrate convenient access to LTC Pharmacies, Part D sponsors will provide a list of all contracted LTC Pharmacies to be submitted to CMS. CMS will use this list of all contracted LTC Pharmacies, submitted to CMS by the Part D sponsors, to evaluate whether the Part D Pharmacy Network provides convenient access to LTC Pharmacies. Part D sponsors are required to submit an updated list of all contracted LTC Pharmacies as part of the annual Part D reporting requirements. Express Scripts does not rely on out of network access to meet the LTC Pharmacy convenient access standards. All of a Part D plan's members who reside in an LTC facility will receive their Part D benefits through LTC Pharmacies in the Part D Pharmacy Network.

Express Scripts' written contracts with network LTC pharmacies include the CMS specified performance and service criteria for LTC pharmacies. Express Scripts will support Part D sponsors, as requested, with analysis regarding their LTC residents as it relates to pharmacy access. If a Part D sponsor advises of contracting requirements, Express Scripts will manage as part of the normal recruitment process.

Indian Health Service, Indian Tribe and Tribal Urban Organization and Urban Indian Organization (I/T/U)

A Part D sponsor must offer standard contracting terms and conditions to all I/T/U Pharmacies in its service area. Indian Health Services (IHS) is 100% contracted under a single, evergreen Provider Agreement. If CMS makes any changes to the model agreement, Express Scripts recontracts with IHS as needed.

Annually or upon client request, Express Scripts attempts to contract existing Tribes or Urban Organizations which are not currently contracted. Express Scripts contracts with network I/T/U Pharmacies will contain standard contracting terms and conditions conforming to the model addendum provided by CMS

NETWORK MONITORING AND CORRECTIVE ACTION PROCESSES

The Express Scripts retail pharmacy audit team utilizes highly effective audit techniques to monitor compliance while maintaining a superior pharmacy network through diligent oversight and education. System edits facilitate the detection of errors. Advanced steps in the process target stores and claims with high risk factors.

Our Network Audit program ensures our pharmacy network conforms to billing practices as outlined in the Pharmacy Provider Agreement and Pharmacy Network Provider Manual. We examine a sample of claims via desk, phone, and onsite audits daily. In addition, all high-dollar claims are subject to further scrutiny for billing compliance.

Other techniques employed to monitor pharmacy network compliance include:

- Initial credentialing and re-credentialing

- Retail account management team support and oversight
- Pharmacy scorecards.

Telehealth is not applicable to Pharmacy benefits.

The Centers for Medicare & Medicaid Services (CMS) requires the coverage of out-of-network claims in an emergency situation. If a member needs to utilize a non-participating pharmacy due to an emergency, he or she can submit a paper claim for reimbursement.

When necessary, such as when a member uses an out-of-network pharmacy or a member cannot reasonably access one of our network pharmacies, the member may be asked to pay for a prescription in full and submit a direct reimbursement claim form to Express Scripts. The direct claim adjudication process — also known as the paper claim adjudication process — begins when claims are received, imaged, stamped with the date received, sorted, and batched at our claims processing facility. The process concludes with the member receiving either reimbursement or documentation as to why a claim was rejected.

We offer a great deal of flexibility to meet your preferences in how we handle member submitted claims. For example, some clients want us to simply pay the amount the member paid (the Usual and Customary [U&C] price) less the applicable copay. Some clients want us to pay the "lower of" the U&C paid by the member or the contracted rate, less the copay. Other plans may want us to pay the "lower of" amount less the copay and less the additional paper claims processing fee client will pay.

In instances of non-compliance, breach, or safety concerns, it is necessary to terminate a provider's agreement with Express Scripts. These issues are addressed on an as-needed basis including appropriate notice to providers, clients, and members as required by the contract and applicable law. We have the right to immediately terminate our agreement with a provider upon written notice based on specific provisions including, but not limited to, performance, licensure, fraud, or the potential of health risks to members. Whenever possible, Express Scripts provides notice to clients and members up to 30 days in advance.

We notify clients of changes in the composition of the pharmacy network that disrupts their members. During the period preceding termination, the account manager will provide the client with a list of impacted members and processes the notification to all members that have utilized the terminating pharmacy(ies) based on the claims history of the past 90 days. This also applies to pharmacies removed from the network as a result of fraud or non-compliant providers in breach of their Pharmacy Provider Agreement.

REFERRAL PROCESS

Referrals are not applicable to pharmacy benefits

COMMUNICATIONS

At Express Scripts, we strive to make the member experience as smooth as possible. In addition to our communications campaign that includes announcements informing members of upcoming changes and other important information, our transition plan includes:

Transfer services

- Communications before and after network go-live
- Curated toolkits offer member-facing promotional materials for client's use. The toolkit includes:

- Ready-to-use content for your internal channels such as emails, newsletters, or your intranet.
- Posters and table tents to describe and draw attention to the benefits of using an in-network pharmacy. Print and display these in common areas.
- Digital screens and banners crafted to post on LinkedIn to inform internal and external channels about this new way to access medications and save money.

PATIENTS WITH SPECIAL NEEDS

1. Translation Services

For people whose primary language is not English, we offer language assistance services through interpreters and other written languages. For free translation services, please call 888-249-5194. Access TTY services by dialing 711.

2. Members with Diverse Cultural and Ethnic Backgrounds

Your plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

3. Members with Physical and Mental Disabilities

For people with disabilities, we offer free aids and services, such as sign language interpreters, Braille, large print, audio, and accessible electronic formats. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you will get extra time to take any action if there's a delay in fulfilling your request.

If you believe that your plan has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance, by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

APPEALS AND GRIEVANCE

Who Can file a grievance

A member, including a member with an effective date in the future, their authorized or appointed representative, or a former member may file a grievance. A non-member may not file a grievance unless the non-member is an authorized or appointed representative.

A member may have a representative who is either appointed by the member or authorized under the state or other applicable law to act on behalf of the member in obtaining a grievance, coverage determination, or in dealing with any of the levels of the appeals process. In the event that a non-member requests to file a grievance, Express Scripts will transfer the grievance case to the appropriate department so that the appropriate next step can be determined. If the Grievance process is not delegated to Express Scripts, the communications will be forwarded to the Companion Life. If Express Scripts is the delegated grievance entity for the plan sponsor, Express Scripts will determine if a valid Authority of Representation document is on file for the purported representative. If a valid document is on file, the case will be processed using the date the grievance

was received as the start date for turn around time purposes. If a valid document is not on file, outreach to obtain the representative documentation will be made in writing to both the member and the purported representative. Processing of the grievance case from a purported representative will not begin until receipt of the appropriate representative documentation by the plan sponsor or by Express Scripts as the delegate entity, whichever is earlier. If the documentation is not received by the 44th calendar day after receipt of the grievance, the case will be dismissed and the member and the purported representative will be notified of the Dismissal in writing.

Request Classification

1. Upon receiving a verbal or written communication from a member, Express Scripts will promptly determine if the communication is an inquiry, a grievance or a request for coverage and inform the member what procedures will apply to their request.
2. Communications that are classified as inquiries will either be handled by the customer service representative using their normal procedures or forwarded to the appropriate individual or department for appropriate processing.
3. Communications that are classified as coverage requests will be transferred to the appropriate Coverage Determination department for further processing. If the Coverage Determination process is not delegated to Express Scripts, the communications will be forwarded to Companion Life.
4. Communications that are classified as grievances will be documented and, as necessary, routed to the appropriate department for processing If the grievance is resolved on the same call on which is it received, the customer service representative will document the member's grievance and the steps taken for resolution. If the grievance cannot be resolved on the same call on which it is received, the customer service representative will document the members grievance and the steps already taken for resolution and transfer the grievance to the appropriate department for further processing. If the Grievance process is not delegated to Express Scripts, the communications will be forwarded to Companion Life. If the grievance impacts the member's quality of care, or the member requested a response in writing, the grievance will not be verbally resolved on the same call and will be documented and transferred to the appropriate department for further processing. If the Grievance process is not delegated to Express Scripts, the communications will be forwarded to Companion Life.

Grievance Research and Decision

1. If the Grievance process is delegated, Express Scripts will research grievances not resolved on the same call to determine what remediation or action, if any, should be taken to address the member's dissatisfaction.
2. Express Scripts will notify the member, and where appropriate the member's representative, of its decision as expeditiously as the case requires, based on the member's health status, but no later than 30 days after the date the verbal or written grievance is received. The written or verbal notification of the decision will address all issues raised in the grievance case. The 30 day timeframe will be calculated from the date the grievance is received from the member or appointed or authorized representative by the plan sponsor holding the contract with CMS or by Express Scripts as the delegated grievance vendor for the plan sponsor, whichever is earlier. For the purpose of assessing the timeliness of a plan's completion of a grievance, the day a plan receives the request is not counted as "day one." "Day one" is the day after receipt of the request. Timeframes measured in hours must be met within the number of hours indicated The grievance decision will be communicated according to the following guidelines:
   • A grievance received in writing will be responded to in writing.

• A grievance submitted verbally may be responded to either verbally or in writing, unless the member requests a written response.
• A Quality of Care grievance, regardless of the manner in which it was received, will be responded to in writing. The response will include a description of the member's right to file a complaint with the BFCC-QIO.

3. Express Scripts uses a CMS-approved notice consistent with the CMS-issued model Notice of Plan's Decision Regarding a Grievance when notifying members in writing of grievance disposition.
4. The grievance will be considered decided and closed on the date when either the verbal notification is made to the member or the written notification is deposited in a courier drop box (e.g., USPS mailbox).

Expedited Grievances:

If the coverage determinations and appeals are delegated to Express Scripts, all member, authorized representative or prescriber requests to expedite a coverage determination or redetermination, except those concerning payment of drugs already furnished, will be approved. If Express Scripts ever denies a request for an expedited coverage determination or redetermination, Express Scripts will inform the member of their right to file an expedited grievance if the member disagrees with Express Scripts' decision not to expedite their request. Express Scripts must respond to a member's expedited grievance within 24 hours if the complaint involves:

- A refusal by Express Scripts to grant a member's request for an expedited coverage determination, or an expedited predetermination; and
- The member has not yet purchased or received the drug that is in dispute.

If the coverage determinations and appeals processes are not delegated to Express Scripts, but grievance research and disposition is delegated, Express Scripts will not be responsible for the identification, research and/or disposition of expedited grievances.

COORDINATION AND CONTINUITY OF CARE

Express Scripts follows Centers for Medicare & Medicaid Services (CMS) guidelines for member notification. Members are notified of a terminating pharmacy at least 30 days in advance and are provided with the names of alternative pharmacies nearby. Additionally, members can use our pharmacy locator tool to search for alternate pharmacies.

In instances where Express Scripts terminates a pharmacy for cause (i.e. instances of fraudulent activity), Express Scripts will notify members upon termination of pharmacy from the network. Due to the egregiousness of some pharmacy terminations advance notice of the termination is not always possible.

Express Scripts offers a fully compliant transition product that ensures temporary medication supplies are available to both new and continuing members. This temporary coverage includes Part D drugs that are not on the plan's formulary; drugs previously approved for coverage under an exception after the exception expires; and drugs requiring a prior authorization, step therapy, or quantity limit override. Temporary supplies not requiring pharmacist intervention are available during the member transition eligibility window and for emergency fills. Level of care overrides are available upon request from the pharmacist and validation of the change in setting. We provide both member and prescriber transition notifications and have a process to notify prescribers via fax to expedite the notification process.