COMMONWEALTH OF KENTUCKY

PRESCRIPTION DRUG

SUMMARY PLAN DESCRIPTION

COMMONWEALTH ENHANCED

EFFECTIVE JANUARY 1, 2006

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PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Kentucky Employees Health Plan

   Common Name of Plan: Commonwealth of Kentucky

2. Plan Sponsor and *Employer*:

   Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   200 Fair Oaks Lane, Suite 501
   Frankfort, KY 40601
   (502) 564-0358

3. Plan Administrator and Named Fiduciary -

   Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   200 Fair Oaks Lane, Suite 501
   Frankfort, KY 40601
   (502) 564-0358

4. *Employer* Identification Number: 61-0600439

5. The Plan provides prescription drug benefits for participating *employees* and their enrolled *dependents*.

6. Plan benefits described in this booklet are effective January 1, 2006.

7. The *Plan year* is January 1 through December 31 of each year.

8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

   Commonwealth of Kentucky
   Personnel Cabinet, Office of Legal Services
   200 Fair Oaks Lane, Suite 516
   Frankfort, KY 40601
   (502) 564-7430

9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:

   Express Scripts, Inc.
   13900 Riverport Drive
   Maryland Heights, MO 63043
   Telephone: 877-597-7474

Plan Description Information Continued

10. This is a self-insured health benefit plan. The cost of the Plan is paid with contributions shared by the *employer* and *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses.

11. Each *employee* of the *employer* who participates in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be available through the Personnel Cabinet's web site at http://personnel.ky.gov/. It contains information regarding the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

16. This plan is included in the Commonwealth of Kentucky Flexible Benefits Plan, a cafeteria plan created pursuant to the Internal Revenue Code, Subsection 125.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

RETAIL COPAYMENT STRUCTURE		
	In-network	Out-of-network
First tier copayment per *prescription*	$5.00	40%
Second tier *copayment* per *prescription*	$15.00*	40%
Third tier copayment per prescription	$30.00*	40%
Retail *Prescription* Drug Maximum Supply	30 days	
MAIL ORDER COPAYMENT STRUCTURE		
First tier copayment per *prescription*	$10.00	
Second tier *copayment* per *prescription*	$30.00	
Third tier copayment per prescription	$60.00	
Mail Order Drug Maximum Supply	90 days	

*After 75 prescriptions per individual or family per calendar year, the second tier copayment will reduce by $5.00 and the third tier copayment will reduce by $10. Prescriptions filled at mail order or mail order at a retail pharmacy do not apply toward the accumulation of 75 prescriptions.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an *employee*/eligible *dependent* purchases a *brand name prescription*, and an equivalent *generic prescription* is available, the *employee*/eligible *dependent* must pay the difference between the *brand name prescription* and the *generic prescription* plus any applicable *brand prescription copayment.* This is referred to as an ancillary fee. If the physician writes on the *prescription* "dispense as written", the drug will be dispensed as such, and the *employee*/eligible *dependent* will only be responsible for the *brand name prescription copayment.*

The *Kentucky Employees Health Plan* utilizes Express Scripts 2006 National Preferred Formulary. As this formulary is subject to change through the year, you may request a copy by calling 877-597-7474 or by visiting Express Scripts web site at www.express-scripts.com.

Beginning April 1, 2006, the *Kentucky Employees Health Plan* will provide a benefit for certain over-the-counter (OTC) nicotine replacement therapies. This program will require active participation in an approved tobacco cessation program. Participants in this program will receive a benefit for these therapies at an appropriate copayment.

SPECIALTY INJECTABLE DRUGS

The *Kentucky Employees Health Plan* is utilizing *CuraScript* for specialty injectable drugs used to treat chronic conditions. *CuraScript* Pharmacy, a wholly owned subsidiary of Express Scripts, is a national provider of specialty pharmacy services offering a broad range of healthcare products and services for individuals with chronic health conditions such as, growth hormone deficiencies, hepatitis C, hemophilia, HIV/AIDS, oncology, multiple sclerosis, rheumatoid arthritis, and many others. *CuraScript* provides comprehensive patient management services including clinical case management programs, counseling, education, and social services. Medications will be ordered specifically for you and delivered to your home. *CuraScript* will allow for the first fill at any participating pharmacy. After the initial fill, all remaining medications must then be filled by *CuraScript*. *CuraScript* will handle everything about your specialty medications for you. A Patient Care Coordinator works with you to ensure you receive the care you need. Your specialty drugs will be delivered to your home within a reasonable time, usually within

24 hours. Included with your specialty drugs will be all your needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to you.

CuraScript specializes in oral and injectable specialty medications. *CuraScript* offers many products and services that you don't get from other pharmacies. Most importantly, *CuraScript*:

- assigns you a Patient Care Coordinator who serves as your personal advocate and your point of contact. This highly trained individual works closely with your physician and your insurer to obtain prior authorizations, coordinate billing with your insurer and will even contact you when it's time to refill your prescription.
- has a complete specialty pharmacy inventory with many specialty medications that aren't readily available at a local pharmacy.
- delivers your specialty medications directly to you or your doctor.
- provides you with the necessary supplies you need to administer your medications — at no additional cost.
- offers clinically based care management programs — which include consultation with your doctor — to help you get the most benefit from the specialty medications that your doctor has prescribed for you.

Additional information, including a current listing of the drugs that must be purchased through *CuraScript* can be obtained by calling 877-597-7474.

STEP THERAPY

What is Step Therapy?

Step Therapy is a program especially for people who take prescription drugs regularly for an ongoing condition, such as arthritis, asthma, or high blood pressure. It provides the treatment you need while keeping your costs as low as possible.

How does it work?

The program moves you along a well-planned path, with your doctor approving your medications. Your path starts with "first-step" drugs — usually generic drugs proven to be safe and effective. You pay the lowest copayment for these drugs. More expensive brand-name drugs — "second-step" drugs — could be covered if you've tried and can't take first-step drugs.

For example, with the stomach ulcer step therapy, generic Prilosec is an example of a first-line drug that must be tried before a second-line drug such as Prevacid or Nexium. If you use a first-line prescription drug that does not work, a second-line drug may be approved for use. In some situations, a member may be granted a prior authorization for a second-line prescription drug if specific medical criteria have been met without the trial of a first-line prescription drug.

The Kentucky Employees Health Plan has contracted with Express Scripts to provide the Step Therapy. Express Scripts utilizes their guidelines and they work with your doctor to determine the most appropriate prescription drugs for you to use. The Commonwealth does not have the authority to override a decision made by Express Scripts.

Break in Therapy

If you have been taking a drug that requires step therapy and, for any reason, the prescription drug is not filled within 130 days from the last fill, it will be considered a break in therapy and you must begin step therapy again, unless your doctor calls and receives prior authorization.

Examples of prescription drugs requiring Step Therapy:

Effective January 01, 2006

Step Therapy Program	Medication
High Cholesterol	Lipitor, Caduet, Lescol, Lescol XL, Pravachol, Advicor, Altoprev, Crestor, Vytorin
High Blood Pressure	Norvasc, Cardene SR, Sular, DynaCirc CR, Covera-HS, Veralan PM, Procardia XL, Plendil

*****This list is not comprehensive or inclusive of all affected drugs.

- ***Please note that this list may change during the plan year.***

Effective April 01, 2006

Step Therapy Program	Medication
High Blood Pressure	Lotrel, Altace, Lotensin, Avapro, Cozaar, Aceon, Vasotec, Benicar
Stomach Ulcers	Nexium, Prevacid, Prevacid SoluTab, Prilosec, Protonix, Aciphex, Zegerid
ADD/ADHD	Strattera
Antidepressants	Celexa, Effexor XR, Lexapro, Prozac, Sarafem, Paxil, Paxil CR, Zoloft
Topical Dermatitis	Protopic, Elidel
Asthma, COPD	Singulair, Accolate
Anti-inflammatory	Arthrotec, Mobic, Ponstel, Celebrex
Diabetes	Glucophage XR, Glumetza, Fortamet, Riomet

*****This list is not comprehensive or inclusive of all affected drugs.

- ***Please note that this list may change during the plan year.***

PRIOR AUTHORIZATION

Some drugs on the pharmacy benefit plan will need prior authorization, which means Express Scripts will need to make sure these prescriptions meet certain conditions for coverage. If authorized, the *prescription* drug will fall under the corresponding *copayment* levels, and the prior authorization will be good for one year from the date of the prior authorization (with the exception of weight loss drugs) After the timeframe for the prior authorization is exhausted, your physician must call Express Scripts to request another prior authorization. If a *prescription* drug is not authorized, the *prescription* drug will not be covered.

Drugs requiring a prior authorization include, **but are not limited to**, the following:

- Adipex**
- Amevive
- Aralast
- Aranesp
- Buproban*
- Bontril**
- Botox (non-cosmetic)
- Didrex**
- Diethylpropion**
- Diflucan (excluding 150 mg tablet)
- Enbrel
- Epogen
- Fastin**
- Fluconazole (excluding 150 mg tablet)
- fluconazole powder
- Forteo
- Genotropin
- Genotropin Miniquick
- Geref
- Geref Diagnostic
- Humatrope
- Humira
- Ionamin**
- itraconazole 100 mg capsule
- Kineret
- Lamisil tablet
- Melfiat**
- Meridia**
- Myobloc
- Nicotrol*
- Norditropin
- Norditropin NordiFlex
- Nutropin
- Nutropin AQ
- Nutropin Depot
- Penlac 8% solution
- Phendimetrazine**
- phentermine**
- Prelu-2**
- Procrit
- Pro-fast**
- Prolastin
- Protropin
- Provigil
- Raptiva
- Regranex
- Remicade
- Retin-A
- Revatio
- Saizen
- Serostim
- Sporanox capsule
- Synagis
- Tazorac
- Tenuate**
- Tenuate dospan**
- Tev-tropin
- Topamax
- tretinoin
- Xenical**
- Xolair
- Zemaira
- Zonegran
- Zorbtive
- Zyban*

Please note that this list may change during the plan year.

* The Kentucky Employees Health Plan will cover the cost of certain smoking cessation drugs that require a written prescription to purchase. Your doctor must call for prior authorization for these prescriptions. The co-pay for these prescription drugs will be at the appropriate tier for a one month supply and are not eligible for the maintenance drug program. Members will only receive a 3 month supply each calendar year.

** Effective August 15, 2006, the Kentucky Employees Health Plan will only cover these prescription drugs if the member is enrolled in the Weight Management Program with Humana (Active Health). To qualify for the Weight Management Program, you must have a Body Mass Index (BMI) of greater than thirty (30). For additional information regarding the Weight Management Program, call 1-877-597-7474.

Prior Authorization Hotline

The most efficient way to initiate a prior authorization review is to ask your physician to contact Express Script's prior authorization hotline at 800-241-1390. If the request is approved, an override code is provided for the pharmacist to enter and the claim is processed. If the request is not approved, this information is provided, and a follow-up letter is sent to the physician and member.

Prior Authorization Form

This form can be faxed to Express Scripts for review. To get the form, you can call Express Scripts at 877-KY-SPIRIT (877-597-7474). Requests should be made by the physician, or if the pharmacist has enough information, he or she can complete the form.

To verify if a *prescription* drug requires *prior authorization*, call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com.

QUANTITY LEVEL LIMITS (QLL)

Some *prescription* drugs may be subject to Quantity Level Limits (QLL) such as quantity or duration. *QLL* will determine the monthly drug dosage dispensed and/or the number of months the drug usage is usually needed to treat a particular condition.

QLL makes sure you receive the medication you need in the quantity considered safe and the quantity that is recommended by the drug manufacturer, the U.S. Food & Drug Administration (FDA) and clinical studies.

How the program works:

At the pharmacy, you might be told that you're asking for a refill too soon; that is, you should still have some of your medication on hand. In this case, simply ask your pharmacist when you can get your next refill. If your prescription is written for a larger amount than your plan covers:

- You can ask your pharmacist to give you the amount that your plan covers. You will pay the appropriate copayment each time.
- Or, your pharmacist can ask your doctor to change your prescription to a higher strength, when one is available. For instance, you might take one 40 mg pill instead of two 20 mg pills. This way, you meet your plan's quantity limit, you get the daily dose you need and you have fewer copayments.
- Or, if your doctor doesn't agree with the limit, he or she can call Express Scripts to request a prior authorization, which may let you get a greater quantity.

Quantity limits can help you get the prescription drugs you need safely and affordably. To verify if a *prescription* drug is subject to *QLL*, call 877-597-7474 or visit the *Plan Manager's* website at www.express-scripts.com.

PRESCRIPTION DRUG BENEFITS

RETAIL PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. Your Humana health insurance identification (ID) card will provide the information for you to present to your pharmacy.

Present your ID card at a *participating pharmacy* when purchasing a *prescription. Prescriptions* dispensed at a retail *pharmacy* are limited to a 30 day supply per *prescription* or refill.

MAIL ORDER PHARMACY

Your *prescription* drug coverage also includes *mail order pharmacy* benefits, allowing participants an easy and convenient way to obtain *prescription* drugs. If you have your prescription filled by the Express Scripts mail order pharmacy, your prescriptions will be shipped to your home address saving you time and money. Utilizing the mail order benefit will save you money by providing you a ninety (90) day supply of prescription drugs for the cost of a sixty (60) day supply.

Only prescription drugs classified by First Data Bank as maintenance drugs will be eligible for mail order pharmacy benefits. Additionally, the mail order option shall not permit the dispensing of a controlled substance classified in Schedule II – either through Express Scripts mail order or the retail pharmacy offering mail order benefits.

Retail pharmacies may participate in the mail order benefit provided they meet the terms and conditions for participation established by Express Scripts, including price, dispensing fee and copayment requirements of a mail order option.

In order for a new prescription drug to qualify for the mail order option, you must have at least three (3) thirty (30) day supplies filled at the retail pharmacy or one ninety (90) day supply within the last six (6) months.

If you fill a ninety (90) day prescription (either at mail or retail) and for any reason it is more than 180 days from the date of the fill, you will not be allowed to fill that prescription at the mail order benefit without first having three (3) thirty (30) day supplies filled again.

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by your physician and are limited to a maximum of a:

- 90 day supply per *prescription* or refill for a drug received from a *mail order pharmacy*; or
- 30 day supply per *prescription* or refill for *self-administered injectable medications* ; or
- 90 day supply per prescription or refill for a drug received from a retail pharmacy that has agreed to participate in the “mail order at retail” benefit. For a listing of participating pharmacies that will honor the mail order at retail, go to the Personnel Cabinet’s web site at http://personnel.ky.gov/stemp/dei/06planyear/benefits.htm.

Additional *mail order pharmacy* information can be obtained by calling 877-597-7474 or by visiting the *Plan Manager’s* website at www.express-scripts.com.

NON-PARTICIPATING PHARMACY

Your pharmaceutical benefits are managed through a network of participating pharmacies. If you choose to fill a prescription at a non-participating pharmacy, you will be subject to the following guidelines.

When you use a *non-participating pharmacy*, you must pay the *pharmacy* the full price of the drug and submit the *pharmacy* receipt to Express Scripts at the address listed below. You will be responsible for any *prescription* cost differential between the cost of the *prescription* and the cost of the negotiated price *prescription* at a *participating pharmacy* after the charge has been reduced by the applicable *copayment*.

You will have 180 days from the date the prescription is filled to file the prescription to Express Scripts.

Mail *pharmacy* receipts to:

Express Scripts
P. O. Box 66773
St. Louis MO 63166-6773
ATTN: Claims Department

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered *prescription expenses incurred* by you or your covered *dependents*. Benefits for expenses made by a *pharmacy* are payable as shown on the Schedule of Prescription Drug Benefits.

You are responsible for payment of:

- The *copayment;*
- The cost of medication not covered under the *prescription* drug benefit;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

If the dispensing *pharmacy's* charge is less than the *copayment*, you will be responsible for the lesser amount. The amount paid by the *Plan Manager* to the dispensing *pharmacy* may not reflect the ultimate cost to the *Plan Manager* for the drug. Your *copayment* is made on a per *prescription* or refill basis and will not be adjusted if the *Plan Manager* or your *employer* receives any retrospective volume discounts or *prescription* drug rebates.

PRESCRIPTION DRUG COVERAGE

You must call 877-597-7474 or visit the *Plan Manager's* website at www.express-scripts.com to verify whether a *prescription* drug is covered or not covered under the Plan.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *physician* for the treatment of a covered *illness* or *bodily injury*; and

2. Be dispensed by a *pharmacist*.

Contrary to any other provisions of the Plan, *prescription* drug expenses covered under the Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan. Any *expenses incurred* under provisions of the Prescription Drug Benefit section do not apply toward your medical deductible or out-of-pocket limits. Any *expenses incurred* under the medical benefit do not apply toward your *prescription* drug out-of-pocket limits.

The *Plan Manager* may decline coverage of a specific medication until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

PRESCRIPTION DRUG EXCLUSIONS

Expense incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under the Plan (call 877-597-7474 or visit the *Plan Manager's* website at www.express-scripts.com to verify whether a *prescription* drug is covered or not covered under the Plan);
2. *Legend drugs* which are not recommended and not deemed necessary by a *physician*;
3. More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more *physician* and dispensed by one or more retail *pharmacies*;
4. Charges for the administration or injection of any drug;
5. Drug delivery implants;
6. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use," or experimental drug, medicine or medication, even though a charge is made to you;
7. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *physician*;
8. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. *Hospital*;
   b. Skilled nursing facility; or
   c. Hospice facility;
9. Any drug prescribed for intended use other than for:
   a. Indications approved by the FDA; or
   b. Recognized off-label indications through peer-reviewed medical literature;
10. *Prescription* refills:
    a. In excess of the number specified by the *physician*; or
    b. Dispensed more than one year from the date of the original order;
11. Any drug for which a charge is customarily not made;
12. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medication; and other non-medical substances, unless otherwise specified by the Plan;
13. Dietary supplements, nutritional products, fluoride supplements, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the Plan;
14. Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* not covered under the Plan;
15. Any drug prescribed for an *illness* or *bodily injury* not covered under this Plan;
16. Any portion of a *prescription* or refill that exceeds a thirty (30) day supply (or a ninety (90) day supply for a *prescription* or refill that is received from a *mail order pharmacy*);
17. Any portion of a *prescription* refill that exceeds the drug specific *dispensing limit*, is dispensed to a *covered person* whose age is outside the drug specific age limits, or exceeds the duration-specific *dispensing limit*, if applicable;
18. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under the Plan; or
    b. After the date the *covered person's* coverage under the Plan has ended;
19. Any costs related to the mailing, sending, or delivery of *prescription* drugs;
20. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;
21. *Prescription* or refill for drugs, medicines, or medications that are spilled, spoiled, or damaged;

22. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over-the-counter drugs), except insulin; or
    b. Available in *prescription* strength without a *prescription*;
23. Any drug or biological that has received an "*orphan drug*" designation, unless approved by the Plan Administrator;
24. Any amount you paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
25. More than one *prescription* within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more *physician* and dispensed by one or more *pharmacies*, unless received from a *mail order pharmacy*. For drugs received from a *mail order pharmacy*, more than one *prescription* within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the *physician*).

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Information regarding eligibility and enrollment, including COBRA is located in your Health Insurance Summary Plan Description (SPD). Please refer to that SPD for this information. To obtain a copy of your Health Insurance SPD, you may long on to Humana's web site at www.humana.com or the Personnel Cabinet's web site at http://personnel.ky.gov/**.**

CLAIM INFORMATION

NOTICE OF CLAIM

Written notice of claim must be given to the *Plan Manager* without delay, but no later than required by the Proof of Loss provision. Notice may be given to the *Plan Manager* as described in the How to File a Prescription Drug Claim section.

PROOF OF LOSS

You must give written proof of loss within 180 days after the date of loss, except if you were legally incapacitated.

HOW TO FILE A PRESCRIPTION DRUG CLAIM

You will receive an identification (ID) card which will contain information regarding your coverage. Present your ID card to *pharmacy* to fill a *prescription*. You can mail your bill(s) to the *Plan Manager* at the address indicated below. Claim forms are available by calling 877-597-7474. Mail prescription drug claims to:

Express Scripts, Inc.
P. O. Box 66778
St. Louis, MO 63166-6773
ATTN: Claims Department

Be sure each prescription drug claim includes the patient name, *prescription* number, name of drug, name of *physician* and date filled and date purchased.

PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *pharmacy*, unless the *Plan Manager* is advised in writing that you have already paid the bill. If you have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. You will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. You or the provider of *services* will be contacted if additional information is needed to process your claim.

When an *employee's* child is subject to a *qualified medical child support order*, the *Plan Manager* will make reimbursement of eligible expenses paid by you, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the *qualified medical child support order*.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for you and your *dependents* as required under state Medicaid law.

Benefits payable on behalf of you or your covered *dependent* after death will be paid, at the Plan's option, to any *family member(s)* or your estate.

The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

Coordination of Benefits

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical, pharmacy or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. *Employer*, trustee, union, *employee* benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any *eligible expense*, a portion of which is covered under one of the plans covering the person for whom *claim* is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the Plan and any other plans included under this provision.

ORDER OF BENEFIT DETERMINATION

In order to pay *claims*, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

Coordination of Benefits Continued

If a plan other than this Plan does not include provision 3, then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:

    a. The plan of a parent who has custody will pay the benefits first;

    b. The plan of a step-parent who has custody will pay benefits next;

    c. The plan of a parent who does not have custody will pay benefits next;

    d. The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with *Medicare* will conform to Federal Statutes and Regulations. In the case of *Medicare,* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the injuries or losses which necessitate *covered expenses*

is jointly owned by the Plan and the *beneficiary*. The Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with the Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by the Plan. The *beneficiary* will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the *Plan Manager* and when asked, assist the *Plan Manager* by:

- Authorizing the release of medical information including the names of all providers from whom you received medical attention;
- Obtaining medical information and/or records from any provider as requested by the *Plan Manager*;
- Providing information regarding the circumstances of your *illness* or *bodily injury*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *illness* for which another party may be liable to pay compensation or benefits; and
- Providing information the *Plan Manager* requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *illness* for which the information is sought, until the necessary information is satisfactorily provided.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Plan Manager* in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the *Plan Manager* that you may have a claim, providing the *Plan Manager* relevant information, and signing and delivering such documents as the *Plan Manager* reasonably request to secure the Plan's recovery rights. You agree to obtain the Plan's consent before releasing any party from liability for payment of medical expenses. You agree to provide the *Plan Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which you seek to recover compensation for your *bodily injury* or *illness* and its treatment.

You will do whatever is necessary to enable the *Plan Manager* to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

You agree that you will not attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Plan Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

The following provisions are to protect your legal rights and the legal rights of the Plan.

CONTESTABILITY

The Plan has the right to contest the validity of your coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or

2. Made to you or any party on your behalf where the Plan determines the payment to you or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against you if the Plan has paid you or any other party on your behalf.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines you received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *illness* was sustained in the course of or resulted from your employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify the *Plan Manager* of any Workers' Compensation claim you make, and that you agree to reimburse the Plan as described above.

MEDICAID

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would

otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

CONSTRUCTION OF PLAN TERMS

The Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of the Plan; such construction and prescription by the Plan shall be final and uncontestable.

PRIVACY OF PROTECTED HEALTH INFORMATION

In order for the Plan to operate, it may be necessary from time to time for health care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, the *Plan Manager* and other service providers that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, *Plan Manager*, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan

records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality.

In addition, you should know that the *employer* / Plan Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.

- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than **180 days** after the date of loss, except if you were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.

- Claims submissions must be complete. They must contain, at a minimum:

    a. The name of the *covered person* who incurred the *covered expense*;
    b. The name and address of the health care provider;
    c. The diagnosis of the condition;
    d. The procedure or nature of the treatment;
    e. The date of and place where the procedure or treatment has been or will be provided;
    f. The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
    g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

Presentation of a *prescription* to a *pharmacy* does not constitute a claim. If a *covered person* is required to pay the cost of a covered *prescription* drug, however, he or she may submit a claim based on that amount to the *Plan Manager*.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Pharmacy claims and correspondence should be mailed to:

Express Scripts
P. O. Box 66773
St. Louis, MO 63166

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with the Plan's procedural requirements, the *Plan Manager* will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a health care provider only with the consent of the *Plan Manager*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Plan Manager*, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, benefits will be paid to that health care provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the Plan, the *Plan Manager* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Plan Manager*, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.

- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

CLAIMS DECISIONS

After submission of a claim by a *claimant*, the *Plan Manager* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The *Plan Manager* will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Plan Manager* will exercise its judgment, with deference to the judgment of a physician with knowledge of the *claimant's* condition. Accordingly, the *Plan Manager* may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the *Plan Manager* as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by the Plan. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    a. The Plan's receipt of the specified information; or

    b. The end of the period afforded the *claimant* to provide the specified additional information.

CONCURRENT CARE DECISIONS

The *Plan Manager* will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. The *Plan Manager* will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the *Plan Manager* as soon as possible, taking into account the medical exigencies. The *Plan Manager* will notify a *claimant* of the benefit determination, whether adverse or not within 24 hours after receipt of the claim by the Plan, provided that the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

POST-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time, but not later than 30 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. The *Plan Manager* will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

Participating pharmacies will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, the *Plan Manager* will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. If you have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. You will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. You or the provider of *services* will be contacted if additional information is needed to process your claim.

When an *employee's* child is subject to a medical child support order, the *Plan Manager* will make reimbursement of eligible expenses paid by you, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for you and your *dependents* as required under state Medicaid law.

Benefits payable on behalf of you or your covered *dependent* after death will be paid, at the Plan's option, to any *family member(s)* or your estate. The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to the *Plan Manager*, in person, or by mail, postage prepaid.

However, a *claimant* on appeal may request an expedited appeal of an adverse *urgent care claim* decision orally or in writing. In such case, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational or for research purposes* or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

TIME PERIOD FOR DECISIONS ON APPEAL

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the *Plan Manager* has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)
Pre-Service Claims	Within a reasonable period, but not later than 30 days after the *Plan Manager* has received the appeal request.
Post-Service Claims	Within a reasonable period, but not later than 60 days after the *Plan Manager* has received the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending on the type of claim involved.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will state the specific reason or reasons for the adverse determination and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim on appeal. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *medical necessity, experimental, investigational or for research purposes* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the *claimant* on appeal will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination;

2. Submitted, considered or generated in the course of making the benefit determination;

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;

4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on.

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the Plan. If the *Plan Manager* fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process. After exhaustion, a *claimant* may pursue any other legal remedies available to him or her.

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

DEFINITIONS

Ancillary Charge – a charge in addition to the copayment which the member is required to pay a Participating Pharmacy for a covered brand name prescription drug product for which a generic substitute is available as identified on the Maximum Reimbursement Amount ("MRA") List. The Ancillary Charge is calculated as the difference between the Client Contract Rate for the brand name prescription product dispensed and the price of the generic substitute.

Beneficiary means you and your covered *dependent(s)*, or legal representative of either, and anyone to whom the rights of you or your covered *dependent(s)* may pass.

Bodily injury means injury due directly to an accident and independent of all other causes.

Brand name medication means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the *Plan Manager*.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Chemical Equivalents – multi-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and meet existing FDA physical/chemical standards.

Compound drugs – a drug prepared by a pharmacist using a combination of drugs in which as least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Concurrent DUR – on-line, real time edits using the claims database to help identify potential drug-related problems. Alerts are transmitted from Express Scripts to the dispensing pharmacist at a participating pharmacy (retail and mail) and allow Express Scripts to document the intervention and outcomes that occur. Concurrent DUR modules available include edits for drug-drug interactions, maximum daily dose, therapeutic/ingredient duplication, drug-age management, drug protocol management by gender, and other relevant drug-related problems. These edits should not be confused with numerous other edits in the Express Scripts system to limit days supply, early refill requests, quantity per day limit.

Copayment means the amount to be paid by you toward the cost of each separate *prescription* order or refill of a covered drug when dispensed by a *participating pharmacy*.

Covered expense means *services* incurred by you or your covered *dependents* due to *bodily injury* or *illness* for which benefits may be available under the Plan. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions.

Covered person means the *employee* or any of the *employee's* covered *dependents*.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any *pre-existing condition* limitation period applicable to you or your *dependents* under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Definitions Continued

Dependent -- A member's unmarried child(ren) who is either a:

A. Qualifying Child: defined as the member's child, including foster child(ren), grandchild(ren), or step-child(ren) who:
   1. has the same principal abode as the member for over half the year,
   2. is under the age of 19 as of the close of the calendar year, or
      is under the age of 24 and a student as of the end of the calendar year, or
      is permanently or totally disabled without regard to age, and
   3. who has not provided over half of his or her own support during the calendar year in which the taxpayer's taxable year begins;

   OR

B. Qualifying Relative: defined as the member's unmarried child(ren) including foster child(ren), grandchild(ren) or step-child(ren), who
   1. has the same principal abode as the member and is a member of the member's household,
   2. has income less than $3,200 for the 2005 tax year,
   3. received over half of his/her support from the member during the calendar year in which the member's taxable year begins, and
   4. is not any other person's qualifying child.

A child will not qualify as a member's qualifying child or qualifying relative in three instances: (1) if a member is the dependent of a taxpayer, then the member may not have a qualifying child or relative, (2) if a child files a joint return with his/her spouse, then that individual cannot be a dependent of another person, or (3) the child is not a citizen or resident of the United States or a resident of Canada or Mexico.

Dependents may only be covered under one (1) state sponsored plan. Unless both employees agree in writing, the employee with custody shall have first option to cover the dependent children.

Permanently or totally disabled means the child is unable to work to support themselves due to a mental or physical disability that started before the age limit and is medically certified by a physician and that were covered under the Plan when the disability occurred. The Vendor(s) may require proof of such dependent's disability no more than once a year. A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of continuous or indefinite duration. The Vendor(s) must approve total disability.

Dispense as Written (DAW) – a physician directive not to substitute a product.

Drug list means a list of drug products, approved by the *Plan Manager*, that are available for use by you.

Employee means you, as an *employee*, when you are permanently employed and paid a salary or earnings and are in an *active status* at your *employer's* place of business.

Employer means the sponsor of the Group Plan or any subsidiary(s).

Expense incurred means the fee charged for *services* provided to you. The date a *service* is provided is the *expense incurred* date.

Express Scripts CuraScript program – a specialty pharmacy management program specializing in the provision of high-cost biotech and other drugs used to treat long-term chronic disease states via CuraScript pharmacy.

Family member means you or your spouse, or you or your spouse's child, brother, sister, parent, grandchild or grandparent.

Generic medication means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by the *Plan Manager*.

Illness – means a disturbance in function or structure of your body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for prescription drug coverage more than 30 days after the eligibility date.

Legend drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: Caution: Federal Law Prohibits dispensing without *prescription*.

Level 1 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 1 drugs*.

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 2 drugs*.

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 3 drugs*.

Maintenance medication means *prescription* drugs, medicines or medications that are:

1. Generally prescribed for treatment of long-term chronic *illness* or *bodily injuries*; and

2. Purchased from the *pharmacy* contracted by the *Plan Manager* to dispense drugs.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Multi source brand – means a drug sold/marketed by two or more manufacturers or labelers.

National Drug Code (NDC) – a national classification system for identification of drugs. Similar to the Universal Product Code (UPC).

Non-participating pharmacy means a *pharmacy* which has not entered into an agreement with the *Plan Manager* to participate as part of the Express Scripts Pharmacy Network.

Over-the-Counter (OTC) drug – a drug product that does not require a Prescription Order under federal or state law.

Participating pharmacy means a *pharmacy* which has entered into an agreement to participate as part of the Express Scripts Pharmacy Network to dispense covered drugs to you and your covered *dependents* and to accept as payment the *copayment* amount to be paid by you and the amount of the benefit payment provided by the Plan.

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Plan Manager means Express Scripts. The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Pre-existing condition means a physical or mental condition for which *you* have received medical attention (medical attention includes, but is not limited to: *services* or care) during the six month period immediately prior to the *enrollment date* of *your* medical coverage under the Plan. *Pre-existing conditions* are covered after the end of a period of twelve months after the *enrollment date* (first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*).

Pre-existing condition limitations will be waived or reduced for *pre-existing conditions* that were satisfied under previous *creditable coverage*.

Prescription means a direct order for the preparation and use of drug, medicine or medication. The drug, medicine or medication must be obtainable only by *prescription*. The order must be given verbally or in writing by a *physician* (prescriber) to a *pharmacist* for the benefit of and use by a *covered person*. The *prescription* must include:

1. The name and address of the *covered person* for whom the *prescription* is intended;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the *prescription* was prescribed; and

4. The name, address and DEA number of the prescribing *physician.*

Prior authorization (PA) – the *process of obtaining certification of coverage for certain Prescription Drug Products, prior to their dispensing*.

Qualified medical child support order means a state court order or judgement, including approval of a settlement agreement which:

1. Provides for support of a covered *employee's* child;

2. Provides for health benefit coverage to the child;

3. Is made under state domestic relations law;

4. Relates to benefits under this Plan; and

5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

It also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by the Omnibus Budget Reconciliation Act of 1993.

Quantity Level Limit – means coverage of selected drugs covered under the Plan are limited to specified values over a set period of time. These values include, but are not limited to, drug quantity, day supply, number of refills and sponsor paid dollars.

Self-administered injectable drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and intended for use by you.

Services means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Single source brand – a drug that is available from only one source, usually the innovator that invented it. These drugs are patent protected brand name drugs for which no generic exists.

Therapeutic Equivalent – a medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not chemical equivalents.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for prescription drug coverage within 31 days of the eligibility date.

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability you or your employed covered spouse are at all times prevented by *bodily injury* or *illness* from performing each and every material duty of your respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that you or your employed covered spouse are at all times prevented by *bodily injury* or *illness* from engaging in any job or occupation for wage or profit for which you or your employed covered spouse are reasonably qualified by education, training or experience;

3. For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

Unit Dose Medications – medications packaged in individual unit-of-use blister packs. Unit dose medications tend to be more expensive. Pharmacies providing medications to long-term care facilities are often required to dispense in unit dose packaging.