

SUMMARY PLAN DESCRIPTION
FOR THE
THE UNIVERSITY OF AKRON PRESCRIPTION DRUG PLAN

Effective: January 1, 2015

Restated: January 1, 2017

This document replaces and supersedes any prior summary plan descriptions relating to the The University of Akron Prescription Drug Plan.

TABLE OF CONTENTS

	Page
Table of Contents	1
Facts About The Plan	2
Introduction	3
Definitions	4
Available Benefits	6
Contributions and Funding	6
Eligibility	6
Enrollment and Coverage	7
Special Enrollment Rights	8
Plan Enrollment Changes	10
Claims Procedure	11
Internal Appeal Procedures	13
External Appeal Procedures	14
Coordination of Benefits	16
Subrogation and Reimbursement	17
Termination of Coverage	18
Cobra Continuation Coverage	19
HIPAA Privacy Compliance	25
Administration of the Plan	28
Appendix	31
Additional Coverage	36
Benefits At A Glance	37

FACTS ABOUT THE PLAN	
Name of the Plan	The University of Akron Prescription Drug Plan
Employer/Plan Sponsor/ Plan Administrator	The University of Akron 185 E. Mill St. Akron, OH 44325-0602
Employer Identification Number	34-6002924
Effective Date of the Plan	January 1, 2017
Plan Number	Rx 6088
Type of Plan	The Plan is a benefit plan that provides prescription drug coverage.
Plan Year	January 1 – December 31
Funding Medium and Type of Administration	The benefits available under the Plan are self-funded. The University of Akron has contracted with a Pharmacy Benefit Manager, CVS Caremark to process claims and provide administrative services to the Plan. CVS Caremark does not serve as an insurer. It processes claims, requests and receives funds from the University to pay the claims, and then makes payment on the claims to pharmacies and other health care providers.
Pharmacy Benefit Manager	CVS Caremark 2211 Sanders Road Northbrook, IL 60062 (888) 202-1654 www.caremark.com
Agent for Legal Service	Service of process may be made upon the Plan Administrator at: The University of Akron 185 E. Mill St. Akron, OH 44325-0602
For More Information	If you have any questions about the Plan or need more information than this booklet contains, you may contact the Benefits Office at 330.972.7090.

INTRODUCTION

The University of Akron (the "University") has established The University of Akron prescription drug plan (the "Plan") in order to provide prescription drug benefits to its Eligible Employees and their Eligible Dependents.

Purpose of this Booklet

This booklet summarizes the main provisions of the Plan and serves as the summary plan description (SPD) relating to the benefits provided under the Plan.

You should read this SPD carefully and share it with your family members who are covered under the Plan. It is your responsibility to become familiar with the terms of the Plan and to ask questions if you do not understand how the requirements impact you. If you have any questions about your benefits, please contact the Benefits Department.

The purpose of this Plan Summary is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for prescription benefits.

Nothing in the Plan or in this booklet is intended to provide employees, former employees or their dependents with a vested right to any benefits and/or any rights to continued employment.

Plan Interpretation

The Plan Administrator has the discretionary authority to construe, interpret and administer the Plan. The decisions of the Plan Administrator shall be final and binding. The Plan Administrator may also amend or terminate the Plan, in whole or in part, at any time and for any reason. [The Plan Administrator has, however, delegated decision-making authority to the Pharmacy Benefit Manager with respect to benefit claims and appeals. With respect to benefit claims and appeals, the decision of the Pharmacy Benefit Manager shall be final and binding.]

DEFINITIONS

The following words and phrases shall have the following meanings when used in this SPD, unless a different meaning is plainly required by the context:

“Adverse Benefit Determination” means a rescission of Plan coverage, or a denial, reduction, or termination of, or a failure of the Plan to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual’s eligibility to participate in the Plan.

“Appendix” refers to the description of Plan benefits and costs attached hereto.

“ATAA” refers to the alternative trade adjustment assistance, including an additional opportunity to elect COBRA Continuation Coverage, available under the Trade Act of 2002.

“CHIP” refers to a state’s Children’s Health Insurance Program.

“COBRA” refers to the Consolidated Omnibus Budget Reconciliation Act of 1985.

“COBRA Continuation Coverage” refers to the temporary extension of Plan coverage that is available under COBRA.

“Code” refers to the Internal Revenue Code of 1986, as amended.

“Covered Dependent” refers to an Eligible Dependent who is covered under the Plan.

“Covered Employee” refers to an Eligible Employee who is covered under the Plan.

“EBSA” refers to the Employee Benefits Security Administration established by the Department of Labor.

“Eligible Dependents” refers to:

- Your spouse to whom you are lawfully wed and with respect to whom you possess a valid marriage license;
- your child(ren) under age 26 regardless of marital status;
- your unmarried child(ren) 26 years or older, provided they are dependent upon you and, upon attainment of age 26, are mentally or physically incapable of self-support as determined by the Plan Administrator. Eligibility terminates when the individual is no longer mentally or physically incapable of self-support; and
- A child placed with you for adoption when you have a legal obligation for support. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

“Eligible Employees” refers to those employees of the University who have satisfied the eligibility provisions hereunder and are eligible to participate in the Plan.

“Employer” refers to The University of Akron.

“FMLA” refers to the Family and Medical Leave Act of 1993, pursuant to which the Employer is required to provide leave to certain employees.

“HIPAA” refers to the Health Insurance Portability and Accountability Act of 1996, as amended.

“IRO” means an independent review organization, an independent entity that reviews certain claim appeals for the Plan.

“Notice” or “Notice of Privacy Practices” refers to the document that describes your privacy rights under HIPAA and identifies the instances in which the Plan may use or disclose your PHI.

“Participant” means any Eligible Employee or Eligible Dependent who has enrolled and participates in the Plan.

“PHI” refers to protected health information, as defined by HIPAA.

“Plan” refers to the The University of Akron Prescription Drug Plan.

“Plan Administrator” refers to The University of Akron.

“Plan Sponsor” refers to The University of Akron.

“Plan Year” means the 12-month accounting period of the Plan, which begins on January 1 and ends on December 31.

“Post-Service Claim” is any claim for prescription drug benefits that is not a Pre-Service Claim or an Urgent Claim.

“Pre-Service Claim” means a request for approval of a prescription drug benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations of certain prescription drugs.

“Participating Network Pharmacy” means a pharmacy that has entered into a contract with CVS Caremark to participate in its network and to provide prescription drugs at discounted rates.

“Pharmacy Benefit Manager” refers to the entity selected by the Plan Sponsor to process claims and perform certain other administrative services in connection with the Plan, which, in this case, is CVS Caremark.

“Privacy Officer” refers to the person designated by the Plan to oversee the Plan’s compliance with privacy-related laws, rules and regulations.

“QMCSO” or “Qualified Medical Child Support Order” means a judgment, decree or order requiring that a Participant obtain Plan coverage on behalf of his/her child.

“Summary Health Information” means information (i) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and (ii) from which individual identifiers have been deleted.

“SPD” or “Summary Plan Description” refers to this booklet, which describes the benefits available under the Plan and the terms and conditions applicable to the receipt of those benefits.

“TAA” refers to the trade adjustment assistance, including an additional opportunity to elect COBRA Continuation Coverage, available under the Trade Act of 2002.

“University” means The University of Akron.

“Urgent Care Claim” means a claim for prescription drugs or treatment where a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you

or your Covered Dependent to regain maximum function, or, in the opinion of your physician or your Covered Dependent's physician, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

"USERRA" refers to the Uniformed Service Employment and Reemployment Rights Act of 1994, as amended.

"Waiting Period" means the period that must pass, once you become eligible to participate in the Plan, before your coverage will begin. The Plan imposes a Waiting Period of first of the month following date of hire.

AVAILABLE BENEFITS

A description of the prescription drug benefits available under the Plan, including the costs associated with such benefits, is provided in the attached Appendix, which is incorporated by reference into this booklet.

CONTRIBUTIONS AND FUNDING

University Contributions

Any University contributions toward the cost of Plan coverage shall be determined by the University. The University may pay all, a portion, or none of the cost of Plan benefits.

Employee Contributions

The University shall determine the amount of contributions, if any, required from employees. These contribution amounts are subject to change from time to time, as determined by the University. The University will generally distribute a schedule of required contributions relating to coverage of Eligible Employees and their Eligible Dependents prior to the Plan Year (or other period of coverage) for which the schedule is to be effective. No employee shall be required to contribute to the Plan as a condition of employment with the University.

Pre-Tax Contributions

An important feature of the Plan is that employee contributions toward the cost of Plan coverage are made with "pre-tax" dollars. This means that your share of the cost of Plan coverage is deducted from your wages or salary paid by the University before federal income and social security taxes are applied. Because your share of the benefit cost is deducted first, you do not pay taxes on that portion of your gross income from the University. This will result in a real tax savings to you which helps offset your share of the cost of such benefits. All Eligible Employees must complete the enrollment process in order to pay for any benefits with pre-tax dollars.

Plan Funding

Plan benefits are intended to be provided from the University's general assets. The University is not obligated to establish a separate trust or fund with respect to the Plan.

ELIGIBILITY

You are eligible to participate in the Plan if you are an "Eligible Employee" who has met all of the eligibility and participation requirements under the Plan.

Eligible Employees

To be an Eligible Employee, you must:

- be a full time employee of the University working 40 hours per week;
- be a variable hour employee who averages at least 30 hours per week. (The University employs many variable hour employees. A variable hour employee is an employee that the University, based on facts and circumstances, cannot determine if the employee is reasonably expected to work an average of 30 hours of service per week. Because the University cannot reasonably determine whether a variable hour employee is full-time, the University uses the 12 month measurement and stability periods provided for in the Affordable Care Act regulations. All variable hour salaried and hourly employees will be required to report their hours of service on a weekly basis. If the University determines an employee averaged at least 30 hours per week (or at least 130 hours per month) during the standard measurement period, the University will treat the employee as a full-time employee during the subsequent “stability period” regardless of the number of hours worked by that employee. If an employee has no hours of service during a measurement period that includes an educational break that is at least four consecutive weeks, the University will determine the employee’s average, exclusive of the break period.)

Eligible Dependents

The following individuals are also eligible for coverage under the Plan:

- Your spouse to whom you are lawfully wed and with respect to whom you possess a valid marriage license;
- your child(ren) under age 26 regardless of marital status;
- your unmarried child(ren) 26 years or older, provided they are dependent upon you and, upon attainment of age 26, are mentally or physically incapable of self-support as determined by the Plan Administrator. Eligibility terminates when the individual is no longer mentally or physically incapable of self-support; and
- A child placed with you for adoption when you have a legal obligation for support. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

Warning: Enrolling an ineligible individual, failing to advise the Plan when a Covered Dependent is no longer eligible or otherwise failing to comply with the Plan’s requirements for eligibility will constitute fraud or an intentional misrepresentation of a material fact that will trigger a rescission (a retroactive termination) of Plan coverage. Upon such a rescission, you will be responsible for reimbursing the Plan for any benefits that have been improperly paid by the Plan.

ENROLLMENT AND COVERAGE

As an Eligible Employee who has satisfied the eligibility conditions, you may need to enroll formally before you may participate in and receive coverage under the Plan.

Initial Eligibility (New Employee or Newly Eligible Employee)

When you first become eligible to participate in the Plan, you will have the opportunity to select coverage for yourself and your Eligible Dependents. You must formally enroll in the Plan and agree to pay any required contributions before you will become a Participant in the Plan. You must complete the

enrollment process within the time period specified by the University. If you do not return the complete your enrollment before the enrollment deadline, you will be enrolled for single coverage as a default election. If you do not enroll yourself (or your Eligible Dependents) in the Plan at the time you initially satisfy the eligibility requirements of the Plan, you must generally wait until the next annual open enrollment period to enroll for such coverage under the Plan.

Effective Date of Coverage

If you return the required documentation to the University on or before the enrollment deadline, your Plan coverage will be effective upon the first of the month following your date of hire, as of the first day of the Plan Year, as of the first day of the stability period following the measurement period in which you satisfy the Plan's eligibility requirements. If you have elected to enroll your Eligible Dependents in the Plan, their coverage will also be effective on that date.

Late Enrollment

If you do not enroll in the Plan when you are first eligible to enroll, and you are not entitled to special enrollment (as discussed below), you will not be permitted to enroll for coverage under the Plan until the next annual open enrollment period.

Annual Open Enrollment

Each year that you continue to be eligible for Plan coverage, you will have the opportunity to decide if you want to participate in the Plan by completing the open enrollment process.

Enrollment through a Qualified Medical Child Support Order

The Plan also provides coverage as required by the terms of a Qualified Medical Child Support Order ("QMCSO"). This coverage applies even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that may otherwise exist for dependent coverage. If the University receives a valid QMCSO and you do not enroll the child as required, the custodial parent or state agency may enroll the affected child. Additionally, the University may withhold from your paycheck any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency, or an order or a judgment from a state court or administrative body directing the University to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The University follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the child support order qualification procedures, please contact the University.

SPECIAL ENROLLMENT RIGHTS

In certain circumstances, you and/or your Eligible Dependents may have an opportunity to enroll for Plan coverage outside of the Plan's standard enrollment periods. (The Plan's standard enrollment periods include the period immediately following your initial eligibility and the Plan's annual open enrollment period, as described above). Thus, you and/or your Eligible Dependents may not be required to wait until the next open enrollment period to be enrolled for coverage under the Plan.

Loss of Other Coverage

Special enrollment rights are available to certain individuals who previously declined Plan coverage and wish to enroll themselves and/or one or more of their Eligible Dependents in the Plan. If you are eligible to participate in the Plan, you (and your Eligible Dependents) will be entitled to special enrollment if all of the following conditions are met:

- A. You (or your Eligible Dependent) did not elect health coverage when you were first eligible to do so, because at that time:
 1. you were (or your Eligible Dependent was) covered under a group health plan or had insurance at the time coverage under the Plan was previously offered; and
 2. if required to do so, you stated in writing at the time you declined such coverage that the reason you were declining such Plan coverage was because you (or your Eligible Dependent) had other coverage; and
 3. you lose (or your Eligible Dependent loses) eligibility or coverage due to:
 - (a) termination of employment in a class eligible for such coverage;
 - (b) reduction in hours of employment;
 - (c) death of an employee;
 - (d) divorce or legal separation;
 - (e) the exhaustion of COBRA continuation coverage;
 - (f) employer contributions toward the coverage being terminated;
 - (g) an individual ceasing to be a dependent under the plan (such as by attaining the maximum age to be eligible as a dependent child);
 - (h) termination of a benefit package option;
 - (i) the plan no longer offers coverage to a class of similarly situated individuals that includes you (or your Eligible Dependent); and
- B. You request special enrollment within 30 days of the date of the loss of coverage for one of the reasons stated above.

In each of these cases, coverage under the Plan will become effective no later than the first day of the first calendar month following the Plan Administrator's receipt your completed enrollment form requesting special enrollment.

Acquisition of a New Dependent

Special enrollment rights are also available if you acquire a dependent through marriage, birth, adoption or placement for adoption. You and your Eligible Dependents will be entitled to special enrollment as follows:

- A. **Employee Only:** If you are eligible but have not enrolled in the Plan, you may enroll upon your marriage, or upon the birth, adoption, or placement for adoption of your child.
- B. **Spouse Only:** If you are already enrolled as a Participant, you may enroll your spouse at the time of his/her marriage to you. You may also enroll your spouse if you are already enrolled and you acquire a child through birth, adoption, or placement for adoption.

- C. **Employee and Spouse:** If you are eligible but have not enrolled in the Plan, you may enroll yourself and your spouse upon your marriage or upon the birth, adoption, or placement for adoption of your child.
- D. **New Dependent:** If you are already enrolled as a Participant, you may enroll a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.
- E. **Employee and New Dependent:** If you are eligible but have not enrolled in the Plan, you may enroll yourself and a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.
- F. **Employee and Spouse and New Dependent:** If you are eligible but have not enrolled in the Plan, you may enroll yourself, your spouse and a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.

In each of these cases, you must request special enrollment within 30 days of the date of the marriage, birth, adoption or placement for adoption, as applicable.

Coverage will be effective (i) in the case of your marriage, as of the date of such marriages; (ii) in the case of your child's birth, as of the date of such birth; or (iii) in the case of your child's adoption or placement for adoption, the date of such adoption or placement for adoption.

Medicaid or CHIP Eligibility or Loss of Eligibility

Special enrollment rights also apply if an Eligible Employee or Eligible Dependent either (i) becomes eligible for employment assistance, with respect to Plan coverage, under Medicaid or CHIP, or (ii) loses coverage under Medicaid or CHIP due to loss of eligibility for such coverage.

You must request special enrollment within 60 days after the date of the eligibility determination or the termination of Medicaid or CHIP coverage, as applicable.

PLAN ENROLLMENT CHANGES

Once you make your election for a Plan Year or in your initial year of eligibility, for the remaining portion of the Plan Year, you generally cannot change or revoke your election until the beginning of the next Plan Year unless you have a qualified change in status.

Use of Claim Form

Your Plan ID card will also contain important information, including claim filing directions and contact information for the Plan's Pharmacy Benefit Manager. If you use a pharmacy that is not a Participating Network Pharmacy, or if you do not have your Plan ID card at the time of your purchase at a Participating Network Pharmacy, you may be required to pay for the entire cost of the prescription drug at the time of purchase. In that case, you may file a claim to recover from the Plan the amount payable by the Plan (if any) in connection with your prescription drug purchase.

You may obtain a claim form from the Plan's Pharmacy Benefit Manager (CVS Caremark) by calling (888) 202-1654. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

Furthermore, if you believe you are being denied any rights or benefits under the Plan and you wish to seek those benefits, you, or your authorized representative on your behalf, must file a written claim and

submit it to the Pharmacy Benefit Manager at CVS/Caremark Claims Department, PO Box 52136, Phoenix, AZ 85072-2136. [The Pharmacy Benefit Manager will review your claim and notify you of its determination under the procedures described below.]

Following Plan Procedures

You should follow the procedures described in this section to request your benefits under the Plan. If your request is denied, you may appeal your claim under the claims procedures below.

Decisions on Coverage

Any questions regarding your claims under the Plan should be directed to the Pharmacy Benefit Manager or the University Benefits Department. Benefits under the Plan will be paid after the Pharmacy Benefit Manager decides that you are entitled to such benefits.

Deadline for Filing

All claims relating to benefits covered under the Plan must be filed within the 12-month period following the date on which the service/prescription drug is received.

CLAIMS PROCEDURES

Notification of the Plan's Determination

Once your claim is submitted to the Plan, the Pharmacy Benefit Manager will make a decision with respect to your claim. If your claim is wholly or partially denied, the Pharmacy Benefit Manager will notify you of that decision in a writing which will contain: (i) specific reasons for the claim's denial, (ii) specific reference to relevant Plan provisions, (iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if you wish to appeal the Pharmacy Benefit Manager's decision.

In addition to the information above, the notice will also contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination. Also, if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided to you upon written request at no charge.

Timing of Notification

Notification regarding your claim will be given within the following timeframes, depending on the type of claim you submitted:

- A. ***Urgent Care Claims*** – within 72 hours after receipt of your claim, unless you do not provide enough information for the Pharmacy Benefit Manager to determine whether or to what extent benefits are payable under the Plan. If this occurs, the Pharmacy Benefit Manager will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Pharmacy Benefit Manager will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An “urgent care claim” is a claim for prescription drugs care or treatment where a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or, in the opinion of your physician or your Covered Dependent's physician, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

- B. **Pre-Service Claims** – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Pharmacy Benefit Manager, but only if the Pharmacy Benefit Manager notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A “pre-service claim” is a request for approval of a prescription drug where receipt of the prescription drug is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations for certain prescription drugs.

- C. **Post-Service Claims** – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Pharmacy Benefit Manager's control if the Pharmacy Benefit Manager notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A “post-service claim” is any claim for prescription drug benefits that is not a pre-service claim or an urgent claim.

- D. **Ongoing Treatment** – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an Adverse Benefit Determination. The Pharmacy Benefit Manager must notify you within a reasonable time prior to the reduction or termination of services.

Ongoing Urgent Care. If you request to extend urgent care beyond the approved period of time or number of treatments, the Pharmacy Benefit Manager will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply.

Other Ongoing Care. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service claim or post-service claim, as applicable.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable Plan review period.

INTERNAL APPEAL PROCEDURES

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal the denial and request a review of your claim. Your appeal must be received by the Pharmacy Benefit Manager within 180 days after your receipt of the notice of denial.

When you submit your appeal, you may also submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeals should include the following information:

- name of the Participant who is the subject of the appeal;
- the Participant's CVS Caremark ID number;
- the Participant's date of birth
- a written statement of the issue(s) being appealed;
- name of the drug(s) being requested; and
- written comments, documents, records or other information relating to the claim being appealed.

Your appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax Number for Appeals: (866) 443-1172

Note that the Plan provides for an expedited review process with respect to urgent care claims. You may request an expedited appeal of an Adverse Benefit Determination orally or in writing. The expedited process allows you to transmit and receive information from the Plan by telephone, facsimile or other similar expedited means. [Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.]

Notification of the Plan's Determination; Timing

If your appeal is received by the appropriate deadline, the Pharmacy Benefit Manager will independently review your appeal and any additional information that you submit. The Pharmacy Benefit Manager will notify you of its decision regarding your appeal within the following timeframes:

- A. **Urgent Care Claims** – as soon as possible, but no later than 72 hours after receipt of your appeal.

- B. ***Pre-Service Claims*** – within a reasonable period, but no later than 30 days after receipt of your appeal.
- C. ***Post-Service Claims*** – within a reasonable period, but no later than 60 days after receipt of your appeal.

With respect to any appeal that is based in whole or in part on a medical judgment, including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Pharmacy Benefit Manager delegates its decision-making authority to one of its outside vendors. In rendering its decision on Plan coverage, the outside vendor, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Pharmacy Benefit Manager will identify the medical or other experts who provided advice to the Plan with respect to your claim. The Pharmacy Benefit Manager currently uses the following vendors for such appeals: Medical Review Institute, MES Solutions, National Medical Review, and Managing Care Managing Costs. However, the outside vendors used by the Pharmacy Benefit Manager may change from time to time.

If your appeal is denied, the Pharmacy Benefit Manager will send you a statement containing: (i) specific reasons for the denial, (ii) specific references to relevant Plan provisions, (iii) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim. In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination. If the appeal notice does not contain such explanation, it will contain a statement indicating that this explanation is available upon written request and at no charge.

The Pharmacy Benefit Manager will provide to you, free of charge, any new or additional evidence or any new or additional rationale, that is considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. In order to give you an opportunity to respond to such new or additional evidence or the new or additional rationale, this evidence or rationale will be provided to you in advance of the date on which you are to receive a decision on your appeal (as described above). You may review your claim file and present evidence and testimony relevant to your claim.

EXTERNAL APPEAL PROCEDURES

Possible Right to External Appeal

If your appeal is denied, you may pursue an external review of your claim by an independent, third party if your claim denial involved either medical judgment (such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that the treatment is experimental or investigational) or a rescission of coverage.

Standard External Review

If you wish to pursue an external appeal, you must file a request for an external appeal within four months of the date your appeal was denied.

The request for an external appeal should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

The request for an external appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-3092
Fax Number: (866) 689-3092

Within five days after its receipt of a request for an external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an independent review organization ("IRO"), together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include such information with the request for an external appeal.

Except in the case of an expedited external appeal, as described below, the assigned IRO will provide you and the Plan with written notice of its decision on your external appeal within 45 days of its receipt of your request. If the IRO needs additional information to make a decision; this time period may be extended as permitted by law. The IRO's notice to you shall also include such other information as required by applicable law.

Expedited External Appeal

The external appeal process will be expedited if you meet the criteria for an expedited external appeal, as defined by applicable law. For example, if you have received an Adverse Benefit Determination that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, you may expedite your external appeal as well. Similarly, if you have received a final denial of your claim under the internal appeal procedures and you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or your claim involved an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency treatment, but have not been discharged from a facility, you may expedite your external appeal.

You or your physician may request an expedited external appeal by calling [the Customer Care number on your Plan ID card.] The request should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

Alternatively, a request for an expedited external appeal and the supporting documentation may be faxed to the Pharmacy Benefit Manager at:

CVS Caremark
External Review Appeals Department
Fax number: (866) 443-1172

All requests for an expedited external appeal must be clearly identified as “urgent” at the time of submission.

Immediately upon its receipt of a request for an expedited external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an IRO, together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an external appeal.

The assigned IRO will provide you and the Plan with notice of its decision on your external appeal as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external appeal. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and the Plan with written confirmation of its decision. The IRO’s notice shall also include such other information as required by applicable law.

Final Decision of IRO

If the final independent decision of the IRO is to approve payment/coverage of the benefit that was previously denied, the Plan will accept the decision and provide coverage for your prescription drug in accordance with the terms and conditions of the Plan. If the final independent decision of the IRO is that payment/coverage will not be made or provided, the Plan will not be obligated to provide coverage for the prescription drug.

Please contact the Plan Administrator or the Pharmacy Benefit Manager for more information on filing an external appeal.

Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim and appeal procedures provided by the Plan, as described above. Any legal action by a person claiming Plan benefits or seeking redress relating to the Plan must be filed within 24 months of the date the eligible charge/claim was incurred.

COORDINATION OF BENEFITS

Certain types of plans coordinate the payment of benefits. Benefits paid by the Plan will be coordinated with benefits payable under other plans, including:

- plans provided by an employer, union, trust or similar plan;
- other group health plans that cover you or your dependents; and

- governmental programs or coverage required by law (i.e., Medicare and no-fault automobile insurance).

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a benefit (if any). When benefits are coordinated, the plans decide which plan pays first (i.e., primary), which pays second (i.e., secondary), etc. Below are the guidelines the Plan uses to determine which plan is primary.

- If a plan has no coordination-of-benefits provision, coordinates benefits according to different rules, is a plan required by law (i.e., Workers' Compensation) or a no-fault motor vehicle insurance or third party liability policy, it is primary.
- The plan covering the person as an employee, rather than as a dependent, is primary and pays benefits first. The plan covering an active employee pays first before the plan covering a laid-off or retired employee.
- If both parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan does not follow the birthday rule, then the rules of that plan determine the order of benefits. If the other plan uses the gender rule, the father's plan is primary.
- In the case of a divorce or separation, the plan of the parent (who has not remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.
- If the parent with custody remarries, his/her plan pays benefits first, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.

If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.]

SUBROGATION AND REIMBURSEMENT

In certain circumstances, you or your Covered Dependents (or the heirs, executors, or beneficiaries of you or your Covered Dependents) may have an obligation to reimburse the Plan for payments made to or on behalf of you or your Covered Dependents. In particular, if you or your Covered Dependents are entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you (such as under a policy of insurance), the Plan shall, to the extent of such payment, be subrogated to all your rights or your Covered Dependents' rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. In addition, you and your Covered Dependents agree to reimburse the Plan for any benefits paid under the Plan, and any out-of-pocket expenses incurred by the Plan, the Plan Administrator, or the University, in pursuing such recovery, out of any monies recovered from such third party as the result of judgment, settlement or otherwise. This reimbursement obligation is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement, or judgment and is not

subject to offset or reduction by reason of any legal fees or other expenses incurred by you or your Covered Dependent in securing such recovery.

The subrogation and reimbursement obligation will apply to any full or partial recovery from a third party, even if you or your Covered Dependents have not been “made whole” for the loss accruing because of the alleged negligent, willful or other conduct of the third party. Further, the Plan’s right of reimbursement shall be in first priority over you and your Covered Dependents to the extent of any benefits paid under the Plan. If you receive payment as part of a settlement or judgment from any third party as a result of an illness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits paid by the Plan.

You agree to notify the University and the Pharmacy Benefit Manager, in writing, of any benefits paid under the Plan that arise out of any illness or injury that was caused by a third party.

By filing a claim for and/or accepting benefits under the Plan, you and your Covered Dependents are deemed to have consented to such subrogation and right of reimbursement of the Plan. You and your Covered Dependents are also deemed to have agreed to cooperate with the Plan, the Plan Administrator, the University, and the Pharmacy Benefit Manager in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter into a subrogation and reimbursement agreement with the Plan upon the request of the Plan Administrator, the University or the Pharmacy Benefit Manager. You and your Covered Dependents may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your Covered Dependents may be delayed, withheld, or denied unless you and your Covered Dependents cooperate fully and enter into the requested reimbursement agreement.

TERMINATION OF COVERAGE

Termination of Employee Coverage

Your participation in the Plan will terminate upon the earliest of:

- the date of termination of the Plan;
- the date you revoke your election to participate in the Plan (whether pursuant to your annual enrollment or as otherwise permitted);
- the last date of the period for which the Employee has made a payment;
- the date which you cease to be eligible for coverage under the Plan;
- on the last day of the stability period following the measurement period in which you fail to satisfy the eligibility conditions for full-time employee status;
- the date on which the termination of employment occurs; or
- immediately if you (or a person seeking coverage on your behalf), perform an act, practice, or omission that constitutes fraud; or you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

Termination of Dependent Coverage

Generally, your Covered Dependents' coverage ends when your coverage ends. However, if you die while covered under the Plan, your dependents will continue to be covered until the last day of the second month following the month of death. In addition, your dependents' coverage also ends:

- on the date of termination of the Plan;
- upon the discontinuance of coverage for dependents under the Plan;
- when such Eligible Dependent becomes covered as an Employee under the Plan;
- the date of termination of the Employee's coverage under the Plan;
- the date of the last period for which the Employee has made a contribution;
- in the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:
 - cessation of such inability;
 - failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - upon the Child's no longer being dependent on the Employee for support.
- The end of the month a dependent is no longer eligible for coverage. This is according to the definition of eligible dependent under the Definition Section; or
- immediately if you (or a person seeking coverage on your behalf), perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

COBRA Rights Triggered

Under certain circumstances, even though your participation in the Plan has terminated, you may be permitted to continue to participate in the Plan at your own cost. See the COBRA Continuation Coverage section below for more details.

COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage is a temporary extension of health coverage, available to you and to other members of your family who are covered under the Plan, at group rates in certain instances where coverage under the Plan would otherwise end. **This information is intended to provide notice and explain, in a summary fashion, COBRA Continuation Coverage, when it may become available to you and your family, and what you must do to continue your health care coverage under the Plan, including what to do to protect the right to receive it.** This information gives you only a summary of your COBRA Continuation Coverage rights. Both you and your spouse, if any, should take the time to read this information carefully.

The Plan Administrator, as listed in the front of this booklet, is responsible for administering COBRA Continuation Coverage.

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and other Covered Dependents of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

Rights of Employees

If you are an employee of the University and covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because of:

- a reduction in your hours of employment; or
- the termination of your employment (for reasons other than gross misconduct on your part).

Rights of Spouses

If you are the spouse of the Covered Employee, you will become a qualified beneficiary if you lose coverage under the Plan for any of the following reasons:

- the death of your spouse;
- a termination of your spouse's employment (for reasons other than his/her gross misconduct) or a reduction in your spouse's hours of employment;
- divorce or legal separation from your spouse; or
- your spouse becomes enrolled in Medicare (Part A, Part B or both).

Rights of a Children

In the case of a child of the Covered Employee, the child will become a qualified beneficiary if the child's coverage under the Plan is lost for any of the following reasons:

- the death of the Covered Employee;
- the termination of the Covered Employee's employment (for reasons other than the Covered Employee's gross misconduct) or a reduction in the Covered Employee's hours of employment with the University;
- the Covered Employee becomes enrolled in Medicare (Part A, Part B or both);
- parents' divorce or legal separation; or
- the child ceases to be an Eligible Dependent under the Plan.

Separate Elections

If there is a choice among types of coverage under the Plan, each person eligible for COBRA Continuation Coverage is entitled to make a separate election among the types of coverage. Thus, a Covered Dependent spouse or Covered Dependent child is entitled to elect COBRA Continuation Coverage even if the Covered Employee does not make that election. Similarly, a Covered Dependent spouse or Covered Dependent child may elect a different coverage from the coverage elected by the Covered Employee.

Notification of the Plan Administrator

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [commencement of a proceeding in bankruptcy with respect to the University] or enrollment of the employee in Medicare (Part A, Part B or both), the University must notify the Plan Administrator of the qualifying event within 30 days of such event.

For the other qualifying events (divorce or legal separation of you and your spouse, or a Covered Dependent child's loss of eligibility for coverage), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator at the address listed for the Plan Administrator at the beginning of this booklet. Your notice must be in writing and must include: (i) the Plan name, (ii) your name and the name of each qualified beneficiary impacted by the qualifying event, (iii) the type of qualifying event, and (iv) the date of the qualifying event. The notice to the Plan Administrator can be provided by you or any other qualified beneficiary, or any representative on behalf of you or any other qualified beneficiary.

Beginning of Coverage and Length of Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have 60 days to make an election. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's enrollment in Medicare (Part A, Part B or both), the employee's divorce or legal separation or a Covered Dependent child losing eligibility, COBRA Continuation Coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation Coverage lasts for up to 18 months. However, if the qualifying event is the employee's termination of employment or reduction in hours of employment and the qualifying event occurs within the 18-month period after the employee becomes enrolled in Medicare, the employee's Covered Dependent spouse and Covered Dependent children are entitled to COBRA Continuation Coverage for up to 36 months from the date the employee enrolled in Medicare.

Possible Extensions

There are two additional ways in which this 18-month period of COBRA Continuation Coverage can be extended:

- A. ***Disability Extension.*** If you or anyone in your family who is covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA Continuation Coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months.

You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the later of: (i) the date of the qualifying event (the employee's termination of employment or reduction in hours); (ii)

the date of the Social Security Administration determination; and (iii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. **In addition, you must notify the Plan Administrator of the Social Security Administration determination before the end of the 18-month period of COBRA Continuation Coverage.** Notice should be sent to the Plan Administrator at the address set forth at the beginning of this booklet. The notice must be in writing and must include: (a) the Plan name, (b) the name of the employee and the disabled qualified beneficiary, if different, (c) the date of the Social Security Administration's determination of disability, and (d) a copy of the Social Security Administration's determination of disability. The notice can be provided by the employee, the qualified beneficiary or any representative on behalf of the employee or the qualified beneficiary.

- B. ***Second Qualifying Event Extension.*** If your family experiences another qualifying event while receiving COBRA Continuation Coverage, your Dependent spouse and Dependent children in your family can receive additional months of COBRA Continuation Coverage, for up to a maximum of 36 months. This extension is available to your Dependent spouse and Dependent children if you die, get divorced or legally separated, or enroll in Medicare Part A and/or Part B (and your enrollment in Medicare Part A and/or Part B would have been a qualifying event if it occurred before your termination of employment or reduction in hours of employment). The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at the address set forth at the beginning of this booklet. The notice must be in writing and must include: (i) the Plan's name, (ii) the name of the employee and each qualified beneficiary impacted by the second qualifying event, (iii) the nature of the second qualifying event, and (iv) the date of the second qualifying event. The notice can be provided by the employee, the qualified beneficiary or any representative on behalf of the employee or the qualified beneficiary.

More Information About Individuals Who May Be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage is considered to be a qualified beneficiary provided that, if the Covered Employee is a qualified beneficiary, the Covered Employee has elected COBRA Continuation Coverage for himself/herself. The child's COBRA Continuation Coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA Continuation Coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the Covered Employee who is receiving benefits under the Plan pursuant to a QMCSO received by the University during the Covered Employee's period of employment with the University is entitled to the same rights to elect COBRA Continuation Coverage as a Covered Dependent child of the Covered Employee.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA Continuation Coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;

- a qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA Continuation Coverage;
- the University ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA Continuation Coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Employee or Covered Dependent not receiving COBRA Continuation Coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA Continuation Coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA Continuation Coverage, you must notify the Plan Administrator of the date of your Medicare entitlement. If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA Continuation Coverage, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your coverage under the Plan ends because of one of the qualifying events listed above. Your special enrollment options may cost less than COBRA Continuation Coverage. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you. You can learn more about your options by visiting www.healthcare.gov.

Alternatives to COBRA Continuation Coverage

When you become eligible for COBRA Continuation Coverage, you may also become eligible for other coverage options that may cost less than COBRA Continuation Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Exchange/Marketplace or you may be eligible for Medicaid. By enrolling in coverage through the Health Insurance Exchange/Marketplace or Medicaid, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about your options by visiting www.healthcare.gov.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan Participant who is not receiving COBRA Continuation Coverage. The amount of your COBRA premiums may change from time to time

during your period of COBRA Continuation Coverage and will most likely increase over time. You will be notified of COBRA premium changes.

First Payment for COBRA Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA Continuation Coverage not later than 45 days after the date of your election. (This is the date your election form is postmarked, if mailed, or the date your election form is received by the individual at the address specified for delivery of the election form, if hand-delivered.) Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, suppose your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA Continuation Coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

The prescription drug claims incurred after you lose Plan coverage will not be processed and paid until you have elected COBRA Continuation Coverage and made the first payment for it. **If you do not make your first payment for COBRA Continuation Coverage in full within 45 days after the date of your election, you will lose all COBRA Continuation Coverage rights under the Plan.**

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent month of COBRA Continuation Coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA Continuation Coverage is due on the first day of the month for that month's COBRA Continuation Coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA Continuation Coverage under the Plan will continue for that month without any break. **You will not receive periodic notices of payments due for these coverage periods, and you will not receive a bill. It is your responsibility to pay your COBRA Continuation Coverage premiums on time.**

Grace Periods for Monthly COBRA Premium Payments

Although monthly payments are due on the first day of each month of COBRA Continuation Coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. **If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA Continuation Coverage under the Plan.**

Questions

If you have questions about your COBRA Continuation Coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. If you have questions about your rights under the Patient Protection and Affordable Care Act or other laws affecting the Plan, you may contact the nearest Regional or District EBSA Office. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Health Insurance Exchange/Marketplace, you may visit www.healthcare.gov.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Under the Trade Act of 2002

Certain employees and former employees whose employment is adversely affected by international trade through increased imports or a shift in production to another country and who are eligible for federal trade adjustment assistance ("TAA") or alternative trade adjustment assistance ("ATAA") are entitled to a second opportunity to elect COBRA Continuation Coverage. This opportunity applies to the employee or former employee and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost).

COBRA Continuation Coverage elected during the second 60-day election period begins on the first day of the second election period and not on the date of the original loss of coverage.

If you are an employee or former employee and you qualify for TAA or ATAA, contact the University promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA Continuation Coverage during a special second election period.

USERRA Continuation of Coverage

If you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue Plan coverage for yourself and your Covered Dependents for up to 24 months, in accordance with the Uniformed Service Employment and Reemployment Rights Act ("USERRA"). Regardless of whether you continue health coverage during your absence, if you return to a position of employment with the University, your health coverage and that of your Covered Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your Covered Dependents in connection with this reinstatement, except as otherwise provided under USERRA. The procedures set forth above for electing COBRA Continuation Coverage apply to this election for continuation coverage. Contact the University for additional information about USERRA continuation coverage.

HIPAA PRIVACY COMPLIANCE

The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures. As required by HIPAA, the Plan has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information ("PHI").

What is PHI?

HIPAA defines PHI as information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

Restrictions

HIPAA restricts the Plan Sponsor's ability to use and disclose PHI. The Plan Sponsor shall have access to PHI from the Plan only as permitted under the Plan or as otherwise required or permitted by HIPAA.

Enrollment/Disenrollment

The Plan may disclose to the Plan Sponsor information about whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan. Enrollment and disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not considered PHI.

Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under the Plan; and (b) from which individual identifiers have been deleted. Summary Health Information is not considered PHI.

Plan Administration

The Plan may disclose PHI to the Plan Sponsor for Plan administration functions. Plan administration functions are those administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, reviewing appeals and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and do not include any employment-related actions or decisions.

With respect to any PHI disclosed to it by the Plan (other than information that is disclosed pursuant to a Participant's signed authorization), the Plan Sponsor shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

- make a Participant's PHI available to the Participant in accordance with HIPAA's right of access;
- make PHI available for amendment, and incorporate any amendments to PHI, in accordance with HIPAA's requirements;
- make available the information required to provide an accounting of disclosures, in accordance with HIPAA's requirements;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that adequate separation between the Plan and the Plan Sponsor is established.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than information disclosed pursuant to a Participant's signed authorization) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the firewall) is supported by reasonable and appropriate security measures;
- ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware, as follows: the Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI; in addition, the Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI.

Separation Between the Plan and the Plan Sponsor

The Plan Sponsor shall allow only certain authorized personnel to have access to PHI. No other employees of the Plan Sponsor shall have access to PHI. The authorized personnel shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any authorized personnel does not comply with the privacy

provisions of this section, he/she shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

Certification of the Plan Sponsor

The Plan is permitted to disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions required by HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth above.]

ADMINISTRATION OF THE PLAN

Amendment and Termination

The Plan Administrator has the right to amend the Plan at any time, without prior notice to Participants, provided that the amendment does not eliminate benefits to which a Participant has become entitled. No amendment shall (i) increase the duties and liabilities of the Plan Administrator without the Plan Administrator's written consent, or (ii) divert Plan funds or assets (if any) from the exclusive purpose of paying for the benefits provided by the Plan for or on behalf of the Participants. Anyone claiming an interest under the Plan will be bound by any such amendment.

Authority to Construe and Apply Plan Documents; Standard of Judicial Review

To the full extent permitted by law, the Plan Administrator shall have the discretionary authority to:

- construe and interpret any uncertain, ambiguous or disputed term or provision in Plan and related documents; and
- decide all questions of law and fact concerning the Plan and related documents and their application (including, but not limited to, determining questions concerning eligibility and benefits).

The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your Covered Dependents, your estate and your beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law. Any review of an exercise of this discretionary authority shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described in this section.

Additional Powers and Duties of the Plan Administrator

The Plan Administrator shall have the following powers and duties:

- to require any person to furnish such reasonable information as the University, the Plan Administrator or the Pharmacy Benefit Manager may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan, and to rely on such information;
- to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan;

- to decide on questions concerning the Plan and the eligibility of any employee or dependent to participate in the Plan, and to authorize payments from the Plan, in accordance with the provisions of the Plan;
- to manage the operation and administration of the Plan according to its terms and for the exclusive benefit of Plan Participants;
- to maintain (i) records and data necessary and desirable for the Plan's proper operation and administration, and (ii) governing documentation of the Plan for inspection by any Eligible Employee or Participant;
- to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility under the terms of the Plan; and to retain such actuaries, accountants (including employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration;
- to rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and shall be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.
- to prepare and file Plan tax returns, annual reports, financial statements, and other documents required by law or under the Plan's terms;
- to appoint a committee to assist the Plan Administrator either generally or specifically in performing its obligations.

No Enlargement of Employment Rights

Nothing contained in the Plan is to be construed as a contract of employment between the University and you, nor shall the Plan be deemed to give you the right to be retained in the employ of the University, or to limit the right of the University to employ or discharge you or to discipline you, for any reason or for no reason.

No Guarantee of Tax Consequences

Neither the Employer, the Plan Administrator, nor Plan Sponsor makes any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes.

Right to Offset Future Payments

In the event of an erroneous payment or payment amount to or on behalf of a Participant, the Plan may reduce future payments payable to or on behalf of such Participant by the amount of the error. This right to offset does not limit the Plan's right to otherwise recover an erroneous payment in any other manner.

Right to Recover Payments

If the Plan reimburses a Participant in a total amount exceeding the amount necessary to satisfy the Plan's obligation, the Plan or the University may recover the excess directly from the person to or for whom the payment was made. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other manner.

APPENDIX

OVERVIEW

Participating Network Pharmacies

The Plan provides you with access to [an extensive national pharmacy network.] The Plan has entered into contractual arrangements with various pharmacies [throughout the country] called “Participating Network Pharmacies.” These Participating Network Pharmacies generally offer Participants access to prescription drugs at discounted rates in exchange for being able to participate in the network. Generally, Participating Network Pharmacies are available to help Participants with their short-term medications. (Participants will also have access to a mail order service for long-term or maintenance medications.) Participating Network Pharmacies are not limited to CVS retail stores. You will be furnished with a list of Participating Network Pharmacies as a separate document, automatically and without charge. To find a Participating Network Pharmacy, you may also log on to www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654.

Participants may also use other pharmacies (pharmacies that are not Participating Network Pharmacies). However, the cost of prescriptions drugs from such a pharmacy may be higher.

Co-payment

A co-payment is the flat dollar amount you pay each time you receive a prescription drug that is covered under the Plan. The amount of your co-payment under the Plan is set forth on the schedule below.

Co-insurance

A co-insurance payment is the percentage you pay toward your prescription drug expenses after the deductible, if any, is satisfied. Some prescription drug expenses are paid by the Plan at [80%], which means that your co-insurance obligation is [20%] of the cost of the prescription drug, up to the out-of-pocket maximum, as described in the following section. The co-insurance payment required under the Plan is set forth on the schedule below.

Minimum/Maximum Co-Payment

If you are responsible for making a co-insurance payment and your percentage of the cost results in an amount that is **less than** the Plan’s “minimum co-payment,” you will only be required to pay the minimum co-payment amount. If you are responsible for making a co-insurance payment, and your percentage of the cost results in an amount that is **greater than** the Plan’s “maximum co-payment,” you will not be required to pay more than the maximum co-payment amount.

Total Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you or your family must pay for covered prescription drugs during the Plan Year. The amount of the out-of-pocket maximum applicable under the Plan is set forth on the schedule below. Once you reach the applicable limit under the Plan, the Plan will pay 100% of your covered prescription drug expenses for the rest of the Plan year. The out-of-pocket maximum does not include:

- the difference in cost between generic and brand name drugs;

- the difference in cost between Participating Network Provider and non-Participating Network Provider.

Coverage of Preventive Care Medications

Certain preventive care medications (specifically, evidenced-based items that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force) are required by law to be covered under the Plan. You will not be required to pay a deductible, co-payment or co-insurance payment when you obtain such preventive care medications from a Participating Network Pharmacy. Because the Plan’s coverage of these preventive care medications is based on the recommendations of the United States Preventive Services Task Force, the particular medications that are subject to coverage will change over time as the recommendations of the United States Preventive Services Task Force change.

BENEFITS - GENERALLY

Your benefits under the Plan will differ depending on the type of prescription drug you take (for example, [generic vs. preferred vs. non-preferred vs. specialty]), how you buy it (for example, from a Participating Network Provider vs. non-Participating Network Provider, or at a pharmacy vs. through the mail), and the other cost-savings measures implemented by the University.

Type of Drug

All prescription drugs that are covered under the Plan fit within one of the following categories:

- **Generic:** A non-brand name drugs that has the same active ingredients as a brand-name drug and is sold for substantially less than the brand-name drug. For a detailed list of the generic drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.
- **Preferred:** A drug that is on the list of preferred brand name drugs and requires you to pay less than you would pay for a non-preferred drug. Drugs in this category are based on a combination of factors, including safety, effectiveness and cost. For a detailed list of the preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.
- **Non-Preferred:** A drug that is not on the list of preferred brand name drugs and requires you to pay more than you would pay for a preferred drug. For a detailed list of the non-preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.
- **Specialty:** Drugs that are used in the management of chronic or genetic diseases, including injectables, infused drugs or oral medications, or drugs that otherwise require special handling. For a detailed list of the specialty drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.

The category to which a particular drug belongs may change periodically based on CVS Caremark’s formulary. These changes may occur without notice to you. When a change occurs, you may be required to pay more or less for a covered prescription drug, depending on the category to which it is assigned. Because a drug’s category may change periodically, you should call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com for the Plan’s most current information.

Retail Purchases

The Plan allows you to fill prescriptions at a retail pharmacy. You should use a retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Through a retail pharmacy, you are generally able to receive up to a 30-day supply of medication.

If you receive your prescription drug from a Participating Network Pharmacy, you should show the pharmacist your ID card at the time you submit your prescription. You will be required to pay the applicable amount identified on the schedule below at the time of purchase. The Plan will pay the remaining cost of the prescription drug if there is coverage for that prescription drug under the Plan.

If you fill your prescription at a non-Participating Network Pharmacy, or if you fail to show your ID card at the time of purchase from a Participating Network Pharmacy, you may be required to pay the entire cost of the prescription drug at the time of your purchase. The Plan will pay its share of the cost of the drug once you submit a claim form to the Plan's Pharmacy Benefit Manager. You may obtain a claim form from the Plan's Pharmacy Benefit Manager (CVS/Caremark) by calling 1-888-202-1654. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

The Plan has a retail refill restriction. You may receive only one initial 30-day (or less) supply of your prescription maintenance medication and two refills on such medication through a retail pharmacy. After that, you must utilize the Plan's mail order service, as described below, or fill a 90-day supply of your medication at a retail CVS/pharmacy (Maintenance Choice Program).

Mail Order Service and Maintenance Choice Purchases

The Plan requires you to fill certain prescriptions through its mail order service or at a retail CVS pharmacy. You should use the Plan's mail order service or a retail CVS pharmacy when filling long-term maintenance medications. Maintenance medications are used to treat chronic illnesses such as heart conditions, allergies, high blood pressure, and arthritis. Through the mail order service and at retail CVS pharmacies, you are able to receive up to a 90-day supply of your medication. You should inform your prescribing physician that you have mail order and CVS pharmacy 90-day prescription drug programs. That information will indicate to your prescribing physician that you can obtain a 90-day supply of your medication.

To obtain a prescription through the Plan's mail order service, you must complete an order form and send it to CVS/Caremark along with your prescription and your applicable payment amount. It may take up to 2-3 weeks to receive your prescription in the mail. You may later order refills on your prescription through the mail order service by calling 1-888-202-1654 or by visiting www.caremark.com. This will reduce the time it takes to receive your refill.

You may opt-out of the Mail Order Service and the CVS pharmacy 90-day supply programs by calling Customer Care at 1-888-202-1654.

Utilization Management Programs

The Plan uses tools such as co-payments, Step Therapy, Prior Authorization, and Quantity Limits to provide better prescription coverage while managing the rising costs of prescription medications. These programs are designed to maximize value. The goal is to help you choose a medication that's proven safe and effective for your condition, while getting it at the lowest possible cost. By using the most cost-effective first line medications you will not only save money with lower co-payments, but the plan saves as well; helping to ensure that the Plan can continue to provide excellent prescription coverage for you and your family.

Mandatory Generic Medications

A generic drug is identical to a brand name drug in that it is required to have the same active ingredient(s), strength, dosage, way it works, way it is taken, and the way it should be used. When a generic drug product is approved, it has met rigorous standards established by the Food and Drug Administration (FDA). There is little difference between a brand-name drug and its generic equivalent. The generic may differ from the brand-name drug in color, shape, size, or taste, but these things don't affect the way the drug works and they are looked at by the FDA. The big difference is that generics usually cost less than the brand. You are encouraged to work with your doctor to use generics, when they are right for you.

The Plan uses a mandatory generic substitution program whereby Participating Network Pharmacies and the Plan's mail order service will substitute brand name drugs with generic equivalents, when generic equivalents are available and appropriate. This program will not be applied when the prescription contains a "dispense as written" restriction or when the Participant has requested that only the brand name drug be dispensed.

If the member or the physician wishes to use a brand name drug when the FDA has approved a therapeutically equivalent generic, the member will pay the difference in the brand name and generic medication price, plus the generic co-payment. **There are no exceptions for this mandatory generic**

Step Therapy Program

A step therapy program is designed specifically for patients with certain conditions that require them to take medications regularly. It is the practice of beginning medication therapy for a medical condition with the most cost-effective drug and progressing to other more costly therapy(s) should the initial medication not provide adequate therapeutic benefit. You will first try a recognized First Line medication (Step 1) before approval of a more costly and complex therapy is approved (Step 2). If the Step 1 therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a Second Line medication. Generally, Second Line medications require the usage and failure of a First Line medication before coverage will be approved. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

CVSCareMark's Therapeutics Committee is responsible for the development and maintenance of the Step Therapy List. Because new drugs are constantly being introduced to the market, please check with CVSCareMark for the most up-to-date information.

Prior Authorization Requirement

Certain prescription drugs are subject to prior authorization from the Plan. This means that you must obtain approval through CVS Caremark before your medication will be covered under the Plan. The prior authorization criteria are developed in order to ensure safe, effective and appropriate utilization of selected drugs. Your prescribing physician will be required to confirm that you have met the required evidence-based criteria before the Plan will cover your prescription. You will be informed about any prior authorization requirement that applies to your prescription at the time of your purchase. In addition, you may determine whether a prior authorization will apply to your prescription by contacting CVS Caremark Customer Service at (888) 202-1654.

Quantity Limits

Quantity limits are used to manage the quantity of medications available to any member that may be potentially harmful, subject to abuse, is not consistent with the standard of care in today's medical practice, or other reasons. Certain lifestyle medications (such as Viagra, Cialis) are subject to quantity limits or other medications that could potentially be harmful if certain dosages are exceeded. Members may obtain prior authorization to receive such medications at the higher than normal dosage when medically necessary. The chart below lists medications subject to quantity limits. CVSCareMark is responsible for the development and maintenance of the Quantity Limit List. Because new drugs are constantly being introduced to the market, please check with CVSCareMark for the most up-to-date information.

Maintenance Choice/Retail 90 Network

You have the option of receiving long-term maintenance prescription drugs through the Plan's mail order service described above or at a local CVS retail pharmacy. This program provides you with the flexibility to decide which delivery system is most convenient to you. If you utilize a CVS retail pharmacy, you will have the opportunity to discuss your medication face-to-face with a pharmacist. You will pay the same amount for your 90-day supply of maintenance medication whether you receive it at a local CVS retail pharmacy or through the Plan's mail order service.

"Dispense as Written" Restriction

If you or your doctor chooses for you to receive a brand name drug when a generic drug is available (such as when the prescription contains a "dispense as written" restriction), you will be responsible for paying the difference between the cost of the brand name drug and the cost of the available generic drug. You will also be responsible for paying the applicable co-payment or co-insurance amount for your prescription, as outlined in the schedule below.

Specialty Guideline Management

The Plan has adopted the Specialty Guideline Management program, which evaluates the appropriateness of drug therapy for specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This program is available for all specialty conditions, and outreach is made to both the Participant and the prescriber to evaluate the therapy.

The Specialty Guideline Management program requires approval of treatment for select medicines. Under this program, there will be a review of clinical information for approval of treatment with these

medicines. Decisions are based on nationally recognized guidelines and are administered by a CVS Caremark clinical specialist.

Specialty Connect™

The Plan has adopted the CVS Caremark Specialty Connect™ program. A Participant may take advantage of this program by dropping off or having a specialty prescription sent to any CVS retail pharmacy, or the Participant's doctor may send the prescription to the Plan's specialty mail order service. A Participant may then choose to pick up specialty medications at a CVS retail pharmacy, have them shipped to the Participant's home address, or have them shipped to a location of choice. Additionally, clinical services for Participants taking specialty drugs will be offered through the CVS Caremark CareTeams. The CareTeams are staffed by specialty pharmacy clinicians with up-to-date knowledge on evidence-based protocols. CareTeams will work to help improve Participants' adherence by educating them about taking their medications correctly, reviewing proper medication storage and handling, and troubleshooting medication side effects.

Broader Vaccination Network

The Plan has elected to participate in CVS Caremark's Broader Vaccination Network program. This program offers broad access to routine vaccination services through more than 50,000 retail pharmacies, including CVS retail pharmacies. Vaccines are available when an immunizing pharmacist or MinuteClinic® practitioner is on duty, and may require a prescription. A Participant will need to provide a Plan ID card and photo ID at the pharmacy. You may visit www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654 for more information.

ADDITIONAL COVERAGE

Care Outside the United States

Prescription drugs purchased outside of the United States are generally not covered under the Plan. However, if you are outside of the United States and need to purchase prescription drugs due to an emergency, such medication will be covered [as if you had received it from a Participating Network Pharmacy.] In such circumstances, you will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a claim form to CVS Caremark for reimbursement from the Plan.

New Drugs

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, the Plan Sponsor will work with CVS Caremark to determine whether a particular new drug will be covered under the Plan and whether any coverage restrictions or limitations will apply.

EXCLUSIONS FROM COVERAGE

Certain expenses that you or your Covered Dependents incur for medications are not covered under the Plan. For a list of excluded drugs, you may log on to www.caremark.com/druglist or call the telephone number on the back of your ID card for more information.

BENEFITS AT A GLANCE

DRUG CATEGORY	RETAIL PHARMACY		MAIL ORDER OR MAINTENANCE CHOICE PROGRAM	
	Gold Plan*	Blue Plan*	Gold Plan*	Blue Plan*
Generic	\$10 co-pay	\$12 co-pay	\$25 co-pay	\$30 co-pay
Brand (preferred)	25% coinsurance up to \$70 maximum	30% coinsurance up to \$85 maximum	25% coinsurance up to \$175 maximum	30% coinsurance up to \$225 maximum
Brand (non-preferred)	35% coinsurance up to \$85 maximum	40% coinsurance up to \$125 maximum	35% coinsurance up to \$175 maximum	40% coinsurance up to \$250 maximum
Specialty	30% coinsurance up to \$125 maximum	35% coinsurance up to \$150 maximum	n/a	n/a
Total Out-of-Pocket Maximum is a Combined Maximum with Medical Insurance	Gold Plan In Network Individual \$2,500 Family \$5,000	Gold Plan Out of Network Individual \$5,000 Family \$10,000	Blue Plan In Network Individual \$4,500 Family \$9,000	Blue Plan Out of Network Individual \$9,000 Family \$18,000
Day Supply Limit		Retail Pharmacy		Mail Order
The maximum amount you can receive per prescribed order		[30]-day supply, [except that Retail 90 Program/Maintenance Choice Program allows for 90-day supply]		[90]-day supply
Refill Limit		Retail Pharmacy		Mail Order
The maximum amount you can receive per refill order <i>After the 2nd refill of a 30 day supply of maintenance medication, you must utilize the mail order service or Maintenance Choice Program at a CVS.</i>		[30]-day supply, [except that Retail 90 Program/Maintenance Choice Program allows for 90-day supply]		[90]-day supply
Use For:		Short-term medications or immediate prescription drug needs [except that Retail 90 Program/Maintenance Choice Program]		Long-term, maintenance, and injectable medications

*You either pay a percentage of the drug's cost (co-insurance), or a set co-payment amount (not both).