Section I

Farmers Automobile Insurance Association
Inactive Health and Welfare Benefit Plan
Wrap Plan Document
and
Summary Plan Description

Original Effective Date: January 1, 2016

Restatement Effective Date: January 1, 2020

Farmers Automobile Insurance Association
Inactive Health and Welfare Benefit Plan
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Farmers Automobile Insurance Association Inactive Health and Welfare Benefit Plan General Information

Name of Plan:	**Farmers Automobile Insurance Association Inactive Health and Welfare Benefit Plan**
Plan Sponsor:	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**
Plan Administrator: (Named Fiduciary)	**Farmers Automobile Insurance Association**
Plan Sponsor ID No.	**37-0268670**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 through December 31**
Plan Number:	**508**
Plan Type:	**Welfare Plan**
Original Effective Date:	**January 1, 2016**
Restatement Effective Date:	**January 1, 2020**
Third Party Administrator:	**Group Plan Solutions Benefit Administration,** **a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 855-545-7165** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Pharmacy Benefit Manager: (RX Company)	**OptumRx** **Customer Service: 877-633-4461** **Customer Service for Retirees on Medicare: 866-884-4326** **Website:** www.optumrx.com
COBRA Notice:	**Group Plan Solutions Benefit Administration,** **a Division of Pekin Insurance** **COBRA** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**

Participating Employers: **Farmers Automobile Insurance Association**
Tax ID: 37-0268670

Pekin Insurance Company
Tax ID: 37-6028411

Pekin Life Insurance Company
Tax ID: 37-0866596

Agent for Service of Process: Farmers Automobile Insurance Association
2505 Court Street
Pekin, IL 61558

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Covered Person the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Participant and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

ARTICLE I
ESTABLISHMENT OF PLAN

1.01 Effective Date

The Farmers Automobile Insurance Association Inactive Health and Welfare Benefit Plan Wrap Plan Document and Summary Plan Description ("Plan") was originally effective as of January 1, 2016 and this restatement is hereby adopted effective as of January 1, 2020.

1.02 Purpose

The purpose of the Plan is to provide specified health and welfare benefits to Eligible Persons and their Dependents. The Plan is intended to qualify under the applicable sections of the Internal Revenue Code of 1986, as amended or may be amended from time to time ("Code"), and is to be interpreted in a manner consistent with the applicable requirements of the Code. This document is intended to satisfy the applicable requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The benefits offered under this Plan may be the subject of a separate Insurance Policy, Administrative Services Agreement, benefit booklet, plan document and/or certificate of insurance. The provisions of any such Related Documents are incorporated herein by reference. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply.

1.03 Duration

The Plan is to be maintained for the exclusive benefit of Eligible Persons and the Dependents of Eligible Persons and is established with the intention of being maintained for an indefinite period of time. However, Farmers Automobile Insurance Association, in its sole discretion and in accordance with the provisions of Article XI, may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings unless a different meaning is plainly required by the context. Words and phrases not defined in this Article shall have the meaning set forth in the applicable plan document, Insurance Policy or Administrative Services Agreement, if any, and if not defined in the applicable plan document, Insurance Policy or Administrative Services Agreement, then such words and phrases shall have the meaning customarily given them by the applicable Insurer or third party administrator, as the case may be. Notwithstanding any provision to the contrary, words and phrases also defined in any applicable Related Document shall supersede this Article when used in interpreting that Related Document.

2.01 ***Administrative Services Agreement*** means the written agreement and any attachments thereto, as amended, between the Employer or the Plan and a service provider, as needed to describe services to be provided by such provider. To the extent required, such agreements are set forth in Appendix B and are hereby made a part of this Plan.

2.02 ***Affiliated Covered Entity*** means legally separate Covered Entities that are under common control or common ownership and are designated as an affiliated group of covered entities in accordance with 45 CFR §164.103. For purposes of this definition, "common control" exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity; and "common ownership" exists if an entity or entities possess an ownership or equity interest of five (5) percent or more of the other entity.

2.03 ***Affiliated Employer*** means any employer, as designated by the Employer, which is under common control with the Employer within the meaning of Code §414(b), (c), (m) and (o).

2.04 ***Benefit*** means any employee welfare benefit that is incorporated into this Plan and would be treated as an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately.

2.05 ***Benefit Plan*** means the specific terms and conditions regarding a Benefit that is provided by this Plan, including the terms and conditions of the Related Document(s), attached hereto as Appendix B, regarding such Benefit. The terms of such Benefit Plans, including but not limited to (as applicable) eligibility to participate, the amount payable, required deductibles, copayments, benefit maximums, conditions precedent to payment, limitations and exclusions, procedures for coordinating benefits payable, procedures for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in Appendix B. The Plan Sponsor may add a Benefit Plan or Related Document or delete a Benefit Plan or Related Document by amending Appendix B, without any need to otherwise amend this Plan. Amendment of Appendix B may be made by an officer or duly authorized representative of the Plan Sponsor.

2.06 ***CFR*** means the Code of Federal Regulations.

2.07 ***Claim*** means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to a Covered Person. This notification must include full details of the service received, including the Covered Person's name, age, gender, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claim Administrator may request in connection with services rendered to the Covered Person.

2.08 ***Claims Administrator*** means, with respect to any Benefit Plan, any individual(s) or entity (ies) that is (are) under a contract or agreement with the Plan Administrator to provide claim administration and related services. With respect to any insured Benefit Plan, the Insurer shall be the Claims Administrator.

2.09 ***COBRA*** means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), as amended, and the regulations issued thereunder.

2.10 ***Code*** means the Internal Revenue Code of 1986, as hereto or hereafter amended or supplemented, or as superseded by laws of similar effect, together with the regulations and rulings issued pursuant thereto. Reference to any section or subsection of the Code includes references to any comparable or successor provisions of any legislation that amends, supplements or replaces such section or subsection.

2.11 ***Covered Entity*** means: (i) a Health Plan, (ii) a Health Care Clearinghouse, or (iii) a Health Care Provider who transmits Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR §160.103. For purposes of Article VIII, a Covered Entity shall include the Health Care Components of the Plan.

2.12 ***Covered Expense*** means a charge for a service or supply allowable under the applicable Benefit Plan.

2.13 ***Covered Person*** means collectively Eligible Persons and Dependents who satisfy the requirements for coverage under the relevant Benefit Plan.

2.14 ***Credited Service*** means the total period of service as an active employee of the Employer or an Affiliated Employer recognized for purposes of determining eligibility for participation under the Plan.

2.15 ***Dependent*** means, for purposes of this Plan, any person who meets the requirements as a dependent in accordance with the terms of the relevant Benefit Plan as set forth in the applicable Related Document.

2.16 ***Disabled Employee*** means any person who met their 180 day waiting period and were considered disabled under the Farmers Automobile Insurance Association Long Term Disability Plan (LTD Plan) prior to January 1, 2014 and has been continuously disabled under the LTD Plan since that date.

2.17 ***Effective Date*** means January 1, 2016, the effective date of the Plan. The effective date of this restatement of the Plan is January 1, 2020.

2.18 ***Eligible Inactive Person*** means, for purposes of this Plan, an individual who: (a) is not eligible for Medicare based on age, (b) is covered under the FAIA Group Health Plan and (c) is (i) a Retiree; (ii) a Disabled Employee (iii) Dependent of (i) or (ii); or (iv) a Surviving Dependent.

2.19 ***Eligible Person*** means, for purposes of this Plan, an Eligible Inactive Person or an Eligible Retired Medicare Person who satisfies the eligibility requirements of the Related Document(s), attached hereto as Appendix B. Eligible Person shall not include any person who is an Employee.

2.20 ***Eligible Retired Medicare Person*** means for purposes of this Plan, an individual who: (a) is enrolled in Medicare based on age (both Part A and Part B) (b) is covered under the FAIA Group Health Plan and (c) is retired and is (i) a Retiree; (ii) a Dependent of a Retiree (iii) a Dependent of a Disabled Employee; or (iv) a Surviving Dependent.

2.21 ***Employee*** means any individual relative to whom the relationship between him and the Employer is the legal relationship of employer, and employee.

2.22 ***Employer*** means Farmers Automobile Insurance Association and any Participating Affiliate. For purposes of Article VIII, Employer shall also mean the Plan Sponsor.

2.23 ***ERISA*** means the Employee Retirement Income Security Act of 1974, Title 29 United States Code Section 1001 *et seq.*, as hereto or hereafter amended, and the regulations issued pursuant thereto. Reference to any section or subsection of ERISA includes references to any comparable or successor provisions of any legislation that amends, supplements or replaces such section or subsection.

2.24 ***FAIA Group Health Plan*** means, the Farmers Automobile Insurance Association Medical and Dental Benefit Plan (Inactive Plan).

2.25 ***Health Care*** means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR §160.103. Health Care includes, but is not limited to, the following:

(a) Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and

(b) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

2.26 ***Health Care Clearinghouse*** has the meaning set forth in 45 CFR §160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions:

(a) Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(b) Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

2.27 ***Health Care Component*** means a component or combination of components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR §164.105(a)(2)(iii)(C).

2.28 ***Health Care Operations*** means the performance of any of the activities set forth in Section 8.03(c) of the Plan.

2.29 ***Health Care Provider*** shall have the meaning set forth in 45 CFR §160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

2.30 ***Health Care Treatment*** shall have the meaning set forth in Section 8.03(a) of the Plan.

2.31 ***Health Information*** shall have the meaning set forth in 45 CFR §160.103 and includes information, whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, Health Plan, an employer, a life insurer, a school or university, or a Health Care Clearinghouse that 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.

2.32 ***Health Plan*** means an individual or group plan that provides or pays the cost of medical care, and includes a group health insurance issuer and other such plans or arrangements as set forth in 45 CFR 160.103, including the Health Care Components of the Plan.

2.33 ***HIPAA*** means the Health Insurance Portability and Accountability Act of 1996, as hereto or hereafter amended, and the regulations issued pursuant thereto, including the HIPAA Security and HIPAA Privacy Rule.

2.34 ***HIPAA Privacy Rule*** means the regulation protecting the privacy of Individually Identifiable Health Information and applies to Health Care Providers, Health Plans, and Health Care Clearinghouses.

2.35 ***Hybrid Entity*** means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR §164.105(a)(2)(iii)(C)) for purposes of fulfilling the hybrid entity requirements of HIPAA, as defined in 45 CFR §164.103. For purposes of this definition, “covered functions,” means those functions of a Covered Entity, the performance of which makes the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse.

2.36 ***Individual***, as such term is used in Article VIII, has the meaning set forth in 45 CFR §160.103 as the person who is the subject of Protected Health Information.

2.37 ***Individually Identifiable Health Information*** has the meaning set forth in 45 CFR §160.103 and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, a Health Plan, an employer, or a Health Care Clearinghouse, that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

2.38 ***Insurance Policy*** means the written agreement, as amended, between the Employer and an Insurer, which provides for a transfer of the risk associated with the provision of Benefits under one or more of the Benefit Plans from the Employer to the Insurer. Any Insurance Policy shall be effective in accordance with the terms of such policy. Such Insurance Policies are set forth in Appendix B.

2.39 ***Insurer*** means an insurance company with a signed contract with the Employer to provide coverage under one or more of the Benefit Plans.

2.40 ***Organized Health Care Arrangement*** has the meaning set forth in 45 CFR §160.103 and includes:

(a) A group health plan (within the meaning of 45 CFR §160.103) and a health insurance issuer with respect to such group health plan, but only with respect to Protected Health Information created or received by such health insurance issuer that relates to Individuals who are or who have been participants or beneficiaries in such group health plan;

(b) A group health plan and one (1) or more other group health plans each of which are maintained by the same Plan Sponsor; or

(c) The group health plans described in paragraph (b) of this definition and health insurance issuers with respect to such other group health plans, but only with respect to Protected Health Information created or received by such health insurance issuers that relates to Individuals who are or have been participants or beneficiaries in any of such group health plans.

2.41 ***Other Group Health Plan*** means a group benefit plan, other than those provided under this Plan that provides medical coverage on an insured or uninsured basis. Other Group Health Plan includes, but is not limited to, any group, blanket, or franchise insurance, group practice or prepaid coverage plans, labor-management trusteed plans, union welfare plans, employer organization plans, group automobile insurance, individual automobile insurance based on the principles of “no fault” coverage, group coverage sponsored by or provided through a school, university or other educational institution, coverage under any governmental program, and coverage required or provided by law.

2.42 ***Participant*** means an Eligible Person or Qualified Beneficiary who meets the requirements for participation set forth in Article III and, relative to a particular Benefit, the Related Documents attached hereto, and who elects to become a Participant and has not for any reason become ineligible to participate further in the Plan.

2.43 ***Participating Affiliate*** means any Affiliated Employer that adopts this Plan and makes contributions as required by the Employer.

2.44 ***Pekin Insurance Health Benefit Plan*** means Pekin Insurance Traditional Health Benefits, High Deductible Health Benefits, Dental Benefits Plans for active Employees or any other group health plan that the Employer or Participating Employer is the Plan Sponsor.

2.45 ***Plan*** means the "Farmers Automobile Insurance Association Inactive Health and Welfare Benefit Plan."

2.46 ***Plan Administrator*** means the individual(s) or corporation(s) appointed by the Employer to carry out the administration of the Plan. In the event a Plan Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Plan Administrator.

2.47 ***Plan Sponsor*** means the Employer, Farmers Automobile Insurance Association ("Farmers Automobile Insurance Association").

2.48 ***Plan Year*** means the twelve-month period from January 1st through December 31st, and the twelve-month period beginning each January 1st thereafter.

2.49 ***Policy*** means any formal set of Employer practices and/or rules that have been adopted and approved by the appropriate representatives of the Employer.

2.50 ***Privacy Notice*** means the statement communicated to Plan Participants that sets forth the uses and disclosures of Protected Health Information that may be made by the Plan under HIPAA, as more fully described in 45 CFR §164.520.

2.51 ***Privacy Official*** means the Individual appointed by the Employer, as may be required and appropriate on behalf of a Health Care Component of the Plan, who is responsible for developing, implementing and maintaining the policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Employer's Health Plans

2.52 ***Protected Health Information ("PHI")*** means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 U.S.C. 1232g), employment records held by the Employer in its role as an employer, and other records described in 20 U.S.C. 1232g(a)(4)(B)(iv).

2.53 ***Qualified Beneficiary*** means any person afforded rights of continued group health care coverage under COBRA as a result of a qualifying event.

2.54 ***Related Document*** means the applicable documents, including Insurance Policies, Administrative Services Agreements, HIPAA-related documents, benefit booklets, or

certificates of insurance, listed in Appendix B, which are hereby incorporated in the Plan by reference.

2.55 ***Required by Law*** means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental or inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits, as more fully described in 45 CFR §160.103.

2.56 ***Retiree*** means an individual who: (a) was enrolled in the Pekin Insurance Health Benefit Plan on the day before their retirement as an employee with the Employer; (b) qualifies for benefits under the terms and definitions set forth by the Farmers Automobile Insurance Association Retirement Plan as of their retirement date; and (c) was not terminated for gross misconduct.

2.57 ***Summary Health Information*** has the meaning set forth in 45 CFR §164.504 and includes information that summarizes the claims history, expenses, or types of claims by Individuals for whom the Plan Sponsor has provided benefits under the Plan, and from which the following information has been removed:

(a) Names;

(b) Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR §164.514(b)(2)(i)(B));

(c) All elements of dates (except year) directly relating to the Individual(s) involved (*e.g.*, birth date) or their medical treatment (*e.g.*, admission or discharge date) except that ages and elements may be aggregated into a single category of ages over age 89);

(d) Other identifying numbers, such as Social Security, telephone, fax, account or medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, e-mail or Internet addresses, URLs or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;

(e) Facial photographs or biometric identifiers (*e.g.*, finger prints);

(f) Any other unique identifying number, characteristic, or code; and

(g) Any information of which the Employer has knowledge that could be used alone or in combination with other information to identify an Individual.

2.58 ***Surviving Dependent*** means any person who was a covered under any Pekin Insurance Health Benefit Plan as a Dependent at the time of death of one of the following:

(a) an Employee
(b) a Retiree or
(c) a Disabled Employee prior to January 1, 2014

and the person described in (a), (b) or (c) above, had at least 9 years of service with the Employer on his/her date of death.

2.59 ***USC*** means the United States Code.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.01 Eligible Person

Unless otherwise specified in Appendix B, an individual eligible to participate in the Plan shall be an Eligible Person as defined in Section 2.19 and his or her Dependents.

3.02 Participation

(a) An Eligible Person who fails to take the necessary steps to participate in the Plan when first eligible, within the time and in the manner determined by the Plan Administrator, shall be deemed to have waived his/her rights to participation in all other Benefits provided under the Plan as set forth in the applicable Related Document, attached hereto in Appendix B, the provisions of which are incorporated by reference.

(b) A Retiree (and his/her Dependents) who fails to take the necessary steps to participate in any Benefit under the Plan as established by the Plan Administrator shall not be able to participate in a future Plan Year.

3.03 Termination of Participation

(a) Except to the extent this Plan and the applicable Related Documents provide otherwise, each Participant's eligibility to participate in this Plan and his coverage under this Plan shall terminate upon the occurrence of any of the following events:

(1) He ceases to satisfy the eligibility conditions specified within this Plan and the applicable Related Document(s);

(2) His death;

(3) Voluntarily Terminates from the Plan; or

(4) The termination of the Plan.

A Retiree (and his/her Dependents) who terminate from the Plan shall not be able to participate in a future Plan Year.

ARTICLE IV

OTHER BENEFIT COVERAGE

4.01 Benefit Limitations

Benefits provided under any Benefit Plan may be limited by benefits received by a Covered Person from other sources. Such sources may include benefits payable under Workers' Compensation, Social Security, Medicare or other government-sponsored programs. Such sources may also include benefits from other insurance policies, plans or programs, including those sponsored by a Covered Person's own employer.

4.02 Health Plan Coordination of Benefits

Absent any provision in a Related Document to the contrary, Benefits payable for Covered Expenses of a Covered Person who also is entitled to benefits from an Other Group Health Plan shall be coordinated so that the total amount payable shall not exceed the amount of the Covered Expense, as set forth in each Health Plan.

(a) When an Other Group Health Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a paid benefit.

(b) If this Plan is secondary to a managed network health program, payable Plan benefits are limited to the copayments due under the managed care network. Benefits provided under this Plan will not coordinate with benefits provided under any other managed network health program.

(c) Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements will not be considered an allowable expense.

(d) If the Other Group Health Plan does not contain a coordination of benefits provision, the Other Group Health Plan shall be primary and this Plan shall be secondary.

(e) If the Other Group Health Plan does contain a coordination of benefits provision, similar to this one, this Plan will determine its benefits using the guidelines set forth herein. If in accordance with the rules of this Article IV, this Plan is to pay benefits before an Other Group Health Plan, this Plan will pay its normal liability without regard to benefits of the Other Group Health Plan. If this Plan is to pay its benefits after an Other Group Health Plan, this Plan will pay its normal liability less any benefits paid by the other plan. The combined coverage shall not be more than this Plan would normally pay.

(f) Benefits payable under an Other Group Health Plan include such amounts as would have been payable had a claim been properly filed for them.

(g) The rules establishing the order of benefit determination are:

(1) The benefits of the plan that covers a person as an active employee shall be paid first.

(2) The benefits of a plan which covers a person as the dependent of an active employee shall be paid before those of a plan which covers the person as an inactive employee or retiree or as such person's dependent.

(3) If the claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the other parent. However, if both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined first.

(4) If the claimant is a dependent child and such child's parents are separated or divorced:

(A) The benefits of the plan that covers the claimant as a dependent child of the parent with custody shall be determined first.

(B) The plan of the spouse of the parent with custody will be determined second.

(C) The plan of the parent not having custody of the child will be determined third.

Provided however, that if a court decree assigns financial responsibility for the health care expenses of the dependent child to one of the parents, the benefits of the assigned-parent's plan will be determined first.

(5) If none of the above rules establish an order of benefit determination, the benefits of the plan that has covered the claimant for the longer period of time, will be payable first.

(h) When the rules of this Article IV operate to reduce the total amount of benefits otherwise payable to a Covered Person under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of a Health Plan.

4.03 Special Medicare Rules

Except as otherwise prohibited by federal law, any otherwise Covered Person who is also entitled to benefits under the Medicare program may elect or reject medical coverage under this Plan.

This Plan will pay benefits primary to Medicare only when required to do so by law. In all other instances, this Plan will pay secondary to Medicare.

4.04 Subrogation and Reimbursement

Except as otherwise indicated in a Related Document, the Plan shall have the option of becoming subrogated to all claims, causes of action and other rights which the Covered Person (or his estate, parent or guardian) may have against a third party or insurer, government program, or other source of coverage for monetary damages, compensation or indemnification on account of any illness or injury allegedly caused by a third party.

(a) The Plan and the Employer shall have the following rights:

(1) To pursue a Covered Person's legal claims or rights against another party, or any insurance company, when Plan benefits are paid or provided to a Covered Person and the condition, illness or injury for which the benefits were paid either were caused by the other party or are covered by other insurance.

(2) To pursue a Covered Person's legal rights against any other party or under any insurance coverage with respect to any injury, illness or condition for which this Plan has provided benefits.

(3) To be reimbursed from any damage award or insurance proceeds by the Covered Person and his legal representatives, estate and heirs for the full value of any benefits provided in relation to an injury, illness or other condition which is caused by the other party or is covered by other insurance.

(b) Subrogation applies whenever another person or insurance carrier is, or may be considered, liable for damages or pays insurance proceeds with respect to a Covered Person's injury, illness or condition, and this Plan has provided or paid benefits (or is legally required to pay) with respect to such injury, illness or condition.

By accepting coverage or benefits under the Plan, the Covered Person agrees that, to the extent of the full value of any such benefits paid or provided by the Plan, the Plan and the Employer are subrogated to all rights of the Covered Person against any third party or insurance company without application of the Common Fund doctrine, make whole doctrine, Rime's doctrine, or any other similar legal theory.

By accepting coverage or benefits under this Plan, the Covered Person also:

(1) Agrees that the Plan and the Employer may assert their subrogation rights independent of the Covered Person.

(2) Agrees and is obligated to cooperate with the Plan and its agents to pursue and protect the Plan's and the Employer's subrogation rights. Among other things, the Covered Person shall provide the Plan with any relevant information requested and shall sign and deliver any documents requested by the Plan.

(3) Agrees that the Plan's and the Employer's rights of subrogation shall be considered as a first priority claim against any other person or entity, to be paid before any claims are paid, including claims by the Covered Person for general damages.

(4) Agrees that he will not release any party from liability for the payment of medical expenses without first obtaining the written consent of the Plan.

(5) Agrees that, if he enters into litigation or settlement negotiations regarding the obligations of or claims against other parties, he will notify the Plan and will not prejudice in any way the Plan's and the Employer's subrogation rights.

(6) Agrees that the Plan and/or the Employer or their agents may take any lawful action to pursue and protect the Plan's and the Employer's subrogation rights.

(7) Agrees that the costs of legal representation of the Plan and the Employer in matters related to subrogation shall be borne solely by the Plan and the Employer, and that the costs of the Covered Person's legal representation shall be borne solely by the Covered Person, unless there is a written agreement to the contrary. That is, unless the Plan and the Employer agree otherwise in writing, the Plan's and the Employer's rights to recover the full

value of benefits paid or provided to the Covered Person shall in no way be diminished by the cost of legal representation of the Covered Person.

(c) Reimbursement applies whenever a Covered Person recovers damages or insurance proceeds by settlement, verdict or otherwise for or in relation to an injury, illness or other condition and the Plan and/or the Employer has paid or provided benefits in relation to such injury, illness or other condition.

By accepting coverage or benefits under the Plan, the Covered Person also:

(1) Agrees on behalf of himself and his legal representatives, estate and heirs, that the Plan and/or the Employer shall be reimbursed promptly from any settlement, verdict, insurance proceeds or other recovery, the full value of the benefits paid or provided by the Plan.

(2) Agrees that the Plan or the Employer, at their option, may collect amounts from the proceeds of any settlement, verdict, judgment, insurance coverage or other recovery by the Covered Person or his legal representative, regardless of whether the Covered Person has been fully compensated.

(3) Grants the Plan and the Employer a first priority lien, to the extent of the Plan's and the Employer's claim for reimbursement, against the proceeds of any such settlement, verdict, insurance proceeds or other recoveries or amounts received by or on behalf of the Covered Person or his legal representatives, estate or heirs.

(4) Assigns to the Plan and the Employer any benefits the Covered Person may have or be entitled to under any automobile policy or any other coverage, to the extent of the Plan's and the Employer's claim for reimbursement.

(5) Agrees to sign and deliver, at the request of the Plan, any documents that are needed to protect such lien or effect such assignment of benefits.

(6) Agrees to cooperate with the Plan and its agents, to provide any requested information, and to take such actions as the Plan or its agents request, all to protect the right of reimbursement of the Plan and the Employer and to assist the Plan and/or the Employer in making a full recovery of the value of the benefits paid or provided.

(7) Agrees to take no action that would prejudice the Plan's and the Employer's rights of reimbursement.

(8) Agrees that the Plan and the Employer shall be responsible only for those legal fees and expenses to which they agree in writing.

(9) Agrees to hold any proceeds of any settlement, verdict, judgment, insurance coverage or other recovery in trust for the benefit of the Plan and the Employer and that the Plan and the Employer shall be entitled to recover from the Covered Person reasonable attorney fees incurred in collecting such proceeds from the Covered Person.

ARTICLE V

CONTRIBUTIONS AND FUNDING

5.01 Contributions

As a prerequisite to Participation, each Eligible Person may be required to contribute toward the cost of the Benefits provided under a Benefit Plan. The amount of any such contribution shall be determined from time to time by the Employer.

5.02 No Obligation to Insure or Fund Benefits

The Employer shall have no obligation, but shall have the right, to insure any Benefits under the Plan or to establish any fund or trust for the payment of Benefits under this Plan except as mandated by law.

5.03 Insured Benefits

In the case of a Benefit that is insured with an Insurer, any Benefits accruing shall be paid solely by such Insurer, and the Employer shall have no responsibility for the payment of such Benefits.

5.04 Non-Insured Benefits

Payments of any non-insured Benefits under the Plan shall be made solely from the general assets of the Employer.

5.05 Payment of Plan Expenses

All expenses of the Plan shall be paid by the Plan to the extent they are not paid for by the Employer. The Employer may be reimbursed by the Plan for any expenses it may pay for on behalf of the Plan, to the maximum extent permitted by law and the Plan.

ARTICLE VI

ADMINISTRATION

6.01 Plan Administrator

The administration of the Plan shall be under the supervision of the Employer, as Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan.

6.02 General Fiduciary Responsibilities

The Plan Administrator, Employer and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and:

(a) For the exclusive purpose of providing Benefits to Participants and their beneficiaries;

(b) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

6.03 Specific Responsibilities and Authority of the Plan Administrator

Other than to the extent assigned under the terms of a Related Document, the Plan Administrator shall have such duties and powers as may be necessary to administer this Plan, including, but not by way of limitation, the following.

(a) To construe and interpret the Plan, and decide all questions of eligibility.

(b) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan.

(c) To prepare and distribute information explaining the Plan to Participants.

(d) To receive from Participants such information as shall be necessary for the proper administration of the Plan.

(e) To furnish the Participants such annual reports with respect to the administration of the Plan as are reasonable and appropriate, or as may be required by law.

(f) To appoint individuals to assist in the administration of the Plan and to engage any other agents it deems advisable, including legal and employee benefit consulting firm counsel.

(g) To purchase any insurance deemed necessary for providing Benefits under this Plan.

(h) To promulgate election and claim forms to be used by Participants.

(i) To prepare and file any reports or returns with respect to the Plan required by the Internal Revenue laws or any other laws.

(j) To recommend to the Employer such amendments in the Plan as it deems necessary or appropriate in order to enable the Plan to comply with ERISA and any other applicable legal requirements, and

(k) To take all actions not expressly enumerated herein necessary for effective administration of the Plan.

In exercising their fiduciary functions, the Plan fiduciaries have the duty and full discretionary authority to determine eligibility for benefits and to interpret and apply the terms of the Plan, including making any factual determinations. Using their discretionary authority, the Plan fiduciaries may correct defects, rectify any omission, or reconcile any inconsistency or ambiguity in the Plan. No decision by the Plan fiduciaries shall be set aside by a court, unless the party contesting the decision shall prove by clear and convincing evidence that the decision is arbitrary and capricious.

6.04 Insurer / Claims Administrator Responsibilities

(a) The Benefit Plans offered within the Plan shall be administered by the applicable Insurer and /or Claims Administrator in accordance with the terms and conditions of the applicable Related Document.

(b) The applicable Insurer and/or Claims Administrator shall be a "named fiduciary" for purposes of ERISA with respect to the portions of the Plan that are governed by the applicable Related Document and to the extent provided in such Related Document.

6.05 Delegation of Authority

The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Insurer and/or Claims Administrator) authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any Benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

6.06 Rules and Decisions

The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable, or appropriate. All such rules and decisions shall be uniformly and consistently applied to all Participants in similar circumstances. When making any decision or determination, the Plan Administrator shall be entitled to reply upon such information as may be furnished to it by a Participant, legal counsel, or the contracted insurance company or benefits administrator under the Plan.

6.07 Indemnification

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any director, officer, or employee of the Employer against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) (collectively "Loss") occasioned by any act or omission to act that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan under ERISA or any other law, unless such Loss is determined to be due to such person's negligence or willful misconduct.

6.08 Reliance on Other Information

In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the insurers or administrators of any of the Benefit Plans offered within the Plan, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

6.09 Nondiscriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

6.10 Standard of Review

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole and exclusive discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant or beneficiary is entitled to receive any benefit under the terms of this Plan, which interpretation shall be made by the Plan Administrator in its sole and exclusive discretion.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive discretion, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator in its sole discretion in accordance with Section 6.03. The Plan shall be amended retroactively to cure any such ambiguity. Neither this Section 6.10, nor any other Plan provision, may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Plan Administrator. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator 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 and shall be entitled to the maximum deference permitted by law.

ARTICLE VII

CLAIMS PROCEDURES

7.01 Claim Filing Procedures

Claims with respect to a Benefit Plan shall be submitted directly to the Claims Administrator, as designated in the applicable Benefit Plan and/or Related Document, on such forms as are prescribed by the Claims Administrator. The claimant may be required to provide such other information as the Claims Administrator may deem necessary or appropriate for determining the validity of any claim.

7.02 Payment of Claims

Upon submission of proof of a valid claim, any benefits shall be paid to the Participant or beneficiary in accordance with all relevant provisions of the applicable Benefit Plan. If the Plan Administrator (or its representative) shall determine that a Participant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits hereunder shall be payable to such Participant.

7.03 Claims Procedures for Benefits provided under a Group Health Plan

(a) How to file a Claim

In order to obtain your benefits under a group health plan, it is necessary for a Claim to be filed with the Claim Administrator for the group health plan. To file a Claim, you should consult the Related Documents concerning the group health plan.

Once the Claim Administrator receives a Claim, it will be processed and the benefit payment will usually be sent directly to the hospital or physician. A Covered Person will receive a statement telling you how much was paid. In some cases the Claim Administrator will send the payment directly to the Covered Person or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, a Covered Person will have to file his or her own Claims. This is primarily true when the Covered Person is receiving services or supplies from providers other than a hospital or physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

A. Complete a Claim Form. These are available from the Employer's Benefits Department or from the Claim Administrator's office.

B. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.

C. Mail the completed Claim Form with attachments to the Claim Administrator at the address noted in the Related Documents for the group health plan.

Claims must be filed within the required time period set forth in the Related Document for the group health plan or they will not be eligible for payment.

(b) Timing of Notification of Benefit Determinations

The Claim Administrator shall notify a claimant of the benefit determination in accordance with Subsection (1), (2) or (3) of this Section, as appropriate.

(1) Urgent Care Claims

"Urgent Care Claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

A. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

B. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as such by the Plan.

In the case of an Urgent Care Claim, the Claim Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claim Administrator shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this Subsection (1) shall be made in accordance with the provisions of this Section. The Claim Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no event later than forty-eight (48) hours after the earlier of:

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

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

(2) Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

A. Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claim Administrator shall notify the claimant, in accordance with the provisions of this Section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

B. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and the Claim Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(3) Other Claims

In the case of a claim not described in Subsections (1) or (2) above, the Claim Administrator shall notify the claimant of the Plan's benefit determination in accordance with either Subsections (A) or (B) below, as appropriate.

A. Pre-Service Claims. "Pre-Service Claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving medical care.

In the case of a Pre-Service Claim, the Claim Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claim Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15)-day period, of the circumstances requiring the

extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

In the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

The preceding paragraph shall apply only in the case of a failure that:

(i) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(ii) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

B. Post-Service Claims. "Post-Service Claim" means any claim for benefit under the Plan that is not a Pre-Service Claim or an Urgent Care Claim.

In the case of a Post-Service Claim, the Claim Administrator shall notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claim Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30)-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from

receipt of the notice within which to provide the specified information.

(4) Calculating time periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with this Section, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(c) Manner and Content of Notification of Benefit Determination

The Claim Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination, which shall include any rescission of coverage. The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(5) A description of any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;

(6) An explanation of any scientific or clinical judgment relied upon in making the adverse benefit determination in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request, if the adverse determination is based on medical necessity, experimental treatment, or similar limitation;

(7) A statement of the opportunity to request the diagnosis and treatment codes (and their meanings), which will be provided upon request;

(8) In the case of an adverse benefit determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning an Urgent Care Claim, the information described above may be provided to the claimant orally within the time frame prescribed in this Section, provided that a written or electronic notification is furnished to the claimant not later than three (3) days after the oral notification.

(d) Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant, or his duly authorized representative, may request a review upon written application to the Plan Administrator or its designee. Any such request for a review must be mailed to the Plan Administrator within one hundred eighty (180) days after receipt by the claimant of a written notification of denial of a claim or from the date the claim was made and not acted on. Send your request to the address noted in the Related Document for the group health plan.

The Plan Administrator shall provide each claimant as part of the review process:

(1) The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(2) Reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(3) Any new or additional evidence considered relied upon or generated by the Plan or at the direction of the Plan in connection with the claim, which will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date;

(4) Prior to the issuance of a final adverse benefit determination based on a new or additional rationale, that new or additional rationale, which will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date;

(5) A review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(6) A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(7) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(8) The identification of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(9) The health care professional engaged for purposes of a consultation described above shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(10) In the case of a claim involving urgent care, for an expedited review process pursuant to which:

A. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

B. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator. The hours of operation for the Claim Administrator, telephone number and address is available in the Related Documents concerning the group health plan.

(e) Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify a claimant of the Plan's benefit determination on review in accordance with Subsections (1), (2) or (3), as appropriate.

(1) Urgent Care Claims

In the case of an Urgent Care Claim, the Plan Administrator shall notify the claimant, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

(2) Pre-Service Claims

In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

(3) Post-Service Claims

In the case of a Post-Service Claim, the Plan Administrator shall notify the claimant, of the Plan's benefit determination on review within a reasonable period of time but not later than sixty (60) days after receipt by the Plan of the claimant's request for benefit determination.

(4) Calculating time periods

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with this Section, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information relevant to the claimant's claim for benefits.

(f) Manner and Content of Notification of Benefit Determination on Review

The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of a final internal adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(4) A statement of the claimant's right to bring an action under section 502(a) of ERISA;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

A document record or other information shall be considered "relevant" to a claimant's claim if such document record or other information:

A. Was relied upon in making the benefit determination;

B. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

C. Demonstrates compliance with the administrative processes and safeguards required by law in making the benefit determination; or

D. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) Authorized Representatives

A Covered Person may pursue a Claim or appeal an adverse benefit determination on his own behalf or through an authorized representative. An authorized representative may be (i) a health care professional with knowledge of the claimant's medical condition, (ii) an attorney at law representing the claimant, (iii) a spouse or relative of the claimant, or (iv) any other individual authorized to act on behalf of the claimant. The authorized representative shall provide evidence, sufficient to the Employer or Claim Administrator, that the representative is duly authorized by the claimant to act on his behalf. A written instrument signed by the claimant or, in the case of a minor, the minor's guardian

or other legally appointed representative appointing an authorized representative shall be sufficient authorization until revoked.

An individual covered under a group health plan cannot transfer or assign, in whole or in part, his benefit claim or right to appeal an adverse benefit determination to any person or entity, including to any provider. Any attempt to transfer or assign a benefit claim or right to appeal an adverse benefit determination shall be null and void.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.01 Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan, including analyzing Plan costs and the effectiveness of the Plan's administration or for such other purposes as may be permitted under 45 CFR §164.504(f)(1)(ii) and the provisions of this Article.

8.02 Disclosure of Protected Health Information to Employer

The Plan will disclose Protected Health Information to the Employer only in accordance with 45 CFR §164.504(f) and the provisions of this Article.

8.03 Use and Disclosure of Protected Health Information

Protected Health Information disclosed by the Plan to the Employer in accordance with the provisions of this Article may only be used by the Employer for the following purposes related to Health Care Treatment, payment for Health Care and Health Care Operations without the covered Individual's written authorization (that meets the requirements of 45 CFR §164.508) (hereinafter "permitted uses and disclosures"):

(a) The provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another and such other forms of treatment as may be permitted under 45 CFR §164.501.

(b) Activities undertaken by the Plan to obtain premiums or reimbursement, or to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom Health Care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts, such as, cost of a benefit, Plan maximums and co-payments as determined for an Individual's claim;

(2) Coordination of benefits;

(3) Adjudication of health benefit claims, including appeals and other payment disputes;

(4) Subrogation of health benefit claims;

(5) Establishing Eligible Person contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities and related Health Care data processing;

(8) Claims management and related Health Care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance, including stop-loss and excess of loss insurance;

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, name and address of the Health Care Provider and/or health plan);

(13) Reimbursement to the Plan; and

(14) Such other payment activities as may be permitted under 45 CFR §164.501.

(c) The activities of a Covered Entity under 45 CFR §164.501 including, but not limited to:

(1) Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

(2) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(3) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner performance, rating Health Care provider and plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning related analysis associated with managing and operating the plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

(ii) Customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;

(8) Resolution of internal grievances;

(9) The sale, transfer, merger or consolidation of all or part of the Covered Entity with another Covered Entity (within the meaning of 45 CFR §160.103), or an entity that following such activity will become a Covered Entity (within the meaning of 45 CFR §160.103), and due diligence related to such activity;

(10) Consistent with the applicable requirements of 45 CFR §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity; and

(11) Such other Health Care Operations as may be permitted under 45 CFR §164.501.

(d) On behalf of the Plan, the Employer may designate, with the concurrence of the appropriate Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of an Organized Health Care Arrangement. If the Plan participates in an Organized Health Care Arrangement, it may disclose Protected Health Information about an Individual to another Covered Entity that participates in the Organized Health Care Arrangement for any Health Care Operation activities of the Organized Health Care Arrangement.

(e) The Plan shall disclose Protected Health Information pursuant to an authorization that meets the requirements of 45 CFR §164.508.

8.04 Employer Certification and Responsibility

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose Protected Health Information to the Employer and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR §164.504(f). Additionally, the Employer agrees:

(a) To use or disclose Protected Health Information to the extent permitted in Section 8.03 of this Article, to the extent provided under HIPAA, or as otherwise Required by Law;

(b) To ensure that any and all of their agents or subcontractors to whom the Employer provide Protected Health Information received from the Plan agree to the same restrictions and conditions as are imposed upon the Employer;

(c) Not to use or disclose Protected Health Information for employment-related actions or in connection with any other benefit or employee benefit plan of the Employer;

(d) To report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the permitted uses and disclosures in Section 8.03 of this Article of which it becomes aware;

(e) To make Protected Health Information available to Individuals in accordance with 45 CFR §164.524;

(f) To make Protected Health Information available for Individual's amendment and incorporate any amendments in accordance with 45 CFR §164.526;

(g) To make the information available that will provide Individuals with an accounting of disclosures in accordance with 45 CFR §164.528;

(h) To make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services upon request for purposes of determining compliance with HIPAA;

(i) If feasible, to return or destroy all Protected Health Information received from the Plan that the Employer maintains in any form and retain no copies of such information when such Protected Health Information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer, as applicable, will limit further uses and disclosures of the Protected Health Information to those purposes that make the return or destruction of the information infeasible; and

(j) To ensure that adequate separation required by 45 CFR §164.504(f) and provided in Sections 8.05, 8.06, and 8.07 of this Article between the Plan, and the Employer, is established and maintained.

8.05 Employees With Access To Protected Health Information

In accordance with HIPAA and to the extent approved by the Privacy Official duly appointed by any Covered Entity or Health Care Component of the Plan, the Plan shall disclose Protected Health Information only to the employees or classes of employees or other persons under the Employer's control identified in Appendix A and hereinafter referred to as "Identified Persons." The Plan Sponsor may add an Identified Person or delete an Identified Person by amending Appendix A, without any need to otherwise amend this Plan. Amendment of Appendix A may be made by a duly authorized officer or representative of the Plan Sponsor.

8.06 Limitations To Protected Health Information Access and Disclosure

Access to and use of Protected Health Information by the Individuals described in Section 8.05 above shall be restricted to those Plan administration functions that the Employer performs for the Plan and/or the uses set forth in Section 8.04 of this Article. Such access or use shall be permitted only to the extent necessary for these Individuals to perform their respective duties for the Plan.

8.07 Noncompliance

Instances of noncompliance with the permitted uses and disclosures of Protected Health Information set forth in Section 8.03 of this Article by Individuals described in Section 8.05 shall be addressed in the following manner:

(a) The Plan shall establish and communicate a set of sanctions that are applicable to a wide variety of breaches of covered health policies and procedures. The range of sanctions may include:

(1) Additional/remedial privacy training;

(2) Counseling by supervisor;

(3) Letter of reprimand from supervisor;

(4) Removal from being within the firewall;

(5) Removal from current position;

(6) Suspension from current position;

(7) Termination of employment; and

(8) Other sanctions as the Privacy Official shall deem appropriate.

(b) The Plan, in consultation with the Privacy Official, shall develop a procedure for:

(1) Determining the appropriate sanction to be administered to a member of its "workforce" for a breach of a covered health policy or procedure.

(2) Determining who (e.g., the Privacy Official, etc.) has responsibility for assessing the sanction against the "workforce" member; and

(3) Determining a process for administering any sanctions.

For purposes of this subparagraph, "workforce" shall mean an employee, volunteer, trainee, or other person who performs duties under the direct control of the Covered Entity, whether or not he or she is paid by the Covered Entity.

(c) The Privacy Official, on behalf of the Plan, shall develop and implement a system for maintaining a record of each sanction administered. The record of sanctions shall conform to the record keeping and documentation standards and implementation specifications required under HIPAA. The Plan will have the option of having this record maintained by the Privacy Official or his or her designee.

8.08 Nondisclosure of Protected Health Information

A Health Insurance Issuer that provides services to the Plan is not permitted to disclose Protected Health Information to the Employer except as would be permitted by the Plan under this Article and only if a Privacy Notice is maintained and provided as required by 45 CFR §164.520(a)(2)(ii).

8.09 Notice To Participants

The Plan shall not disclose, and may not permit a Health Insurance Issuer providing services to the Plan to disclose Protected Health Information to the Employer unless a separate statement, as set forth in 45 CFR §164.520(b)(1)(iii)(C), describing the intention of the Plan to make such disclosure, is included in a Privacy Notice that is maintained and provided as required by 45 CFR §164.520.

8.10 Policies and Procedures

To the extent required by HIPAA, the Employer shall adopt on behalf of the Health Plan and/or any Health Care Component of the Plan, policies and procedures as necessary to administer the terms and conditions of this Article and the Health Plan's obligations under HIPAA. Such policies and procedures shall meet the requirements of 45 CFR §164.530(i).

8.11 Hybrid Entity Designation

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, one or more Health Care Components as part of a Hybrid Entity for purposes of complying with this Article and the HIPAA requirements. If such designation is made, the following rules shall apply:

(a) References to:

(1) The Plan or a Covered Entity in this Article shall refer to the Health Care Component of the Plan or Covered Entity;

(2) Health Plan, Health Care Provider or Health Care Clearinghouse in this Article shall refer to the Health Care Component of the Covered Entity if such Health Care Component performs the functions of a Health Plan, Health Care Provider or Health Care Clearinghouse, as applicable; and,

(3) Protected Health Information in this Article shall refer to Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan or Covered Entity.

(4) Electronic Protected Health Information shall refer to electronic Protected Health Information that is created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan or Covered Entity.

(b) The Plan shall be responsible for complying with the requirements of HIPAA, as set out in this Article, and as fully set forth in 45 CFR §164.105(a), including, but not limited to, ensuring:

(1) That the Health Care Component does not disclose Protected Health Information and electronic Protected Health Information to another component of the Plan under circumstances where HIPAA would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities;

(2) That a Health Care Component whose activities would make it a business associate does not use or disclose Protected Health Information or electronic Protected Health Information that it creates or receives from or on behalf of the Health Care Component in a way prohibited by HIPAA; and

(3) That if a person performs duties for both the Health Care Component in the capacity of an employee, volunteer, trainee or other person performing duties

under the direct control of such component and for another component of the entity in the same capacity with respect to that component, such employee, volunteer, trainee or other person performing duties under the direct control of such component must not use or disclose Protected Health Information created or received in the course of or incident to the member's work for the Health Care Component in a manner prohibited by HIPAA.

(c) The Plan shall retain documentation of the Hybrid Entity designation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR §164.530(j).

8.12 Affiliated Covered Entities

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of a single Affiliated Covered Entity for purposes of complying with this Article and HIPAA. If such designation is made, the following rules shall apply:

(a) The Affiliated Covered Entity shall ensure that Affiliated Covered Entity shall comply with the requirements of HIPAA, as set forth in this Article, and as set forth in 45 CFR §164.105.

(b) If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, the Affiliated Covered Entity shall meet the requirements of 45 CFR §164.504(g) regarding multiple covered functions.

(c) The Plan shall document, in writing or electronically, which Health Care Components of the Plan constitute the Affiliated Covered Entities and retain such documentation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR §164.530(j).

8.13 Electronic Data Security Standards

The Plan shall apply the following provisions to enable it to disclose electronic Protected Health Information to the Employer and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR §164.314(b).

(a) Except when electronic Protected Health Information is disclosed to the Employer with the safeguards set forth in (1) through (3) below, the Plan and Employer shall reasonably and appropriately safeguard electronic Protected Health Information that is created, received, maintained or transmitted to or by the Employer on behalf of the Plan.

(1) The Plan may disclose electronically Summary Health Information to the Employer if requested by the Employer for the purpose of obtaining premium bids from Health Plans, for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan in accordance with 45 CFR §504(f)(1)(ii).

(2) The Plan, or a health insurance issuer with respect to the Plan, may disclose electronically to the Employer information on whether an Individual is participating in the Plan, or is enrolled in or has dis-enrolled from a Health

Insurance Issuer offered by the Plan in accordance with 45 CFR §504(f)(1)(iii).

(3) The Plan may disclose Protected Health Information to the Employer for which it has obtained from the Individual about which the Protected Health Information concerns, a valid authorization that meets the requirements of 45 CFR §164.508.

(b) Additionally, the Employer agrees to comply with 45 CFR §164.314, including the following:

(1) The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) The Employer shall ensure that the separation requirements applicable to the Plan set out in Sections 8.05, 8.06 and 8.07 of this Article and 45 CFR §164.504(f)(2)(iii) shall be supported by reasonable and appropriate security measures.

(3) The Employer shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect the information.

(4) The Employer shall report to the Plan any successful security incident (within the meaning of 45 CFR §164.304) of which it becomes aware.

(c) The Plan and the Employer shall take any such further action as is required to comply with the electronic data security standards requirements of HIPAA.

8.14 Other Uses and Disclosures of Protected Health Information

The Plan may disclose Protected Health Information to such other entities and under such circumstances as permitted under HIPAA and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA.

ARTICLE IX

GROUP HEALTH PLAN MANDATES

9.01 Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The Plan will comply with the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 with respect to any Benefit Plan that provides health benefits. The Plan Administrator, consistent with COBRA's requirements, will notify eligible Participants and their Dependents of their right to continuation coverage and will establish reasonable procedures, consistent with COBRA's requirements, for the election of, and payment for, any continuation coverage ultimately elected. The cost of such COBRA continuation coverage shall be borne by the COBRA continuee.

9.02 Newborns' and Mothers' Health Protection Act

The Plan shall comply with the Newborns' and Mothers' Health Protection Act (NMHPA) with respect to group health coverage offered under any Benefit Plan that provides health benefits. Under federal law, mothers and newborn children are entitled to a hospital stay of at least 48 hours for normal delivery, and at least 96 hours for a Cesarean delivery.

9.03 Participant's Rights

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information about the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof.

9.04 Other Laws

The Plan shall comply with all other federal law, and such state law to the extent not preempted by ERISA, to the extent such laws are applicable to Benefits provided under this Plan.

ARTICLE X

MISCELLANEOUS

10.01 Exclusive Benefit

The Plan shall be maintained for the exclusive benefit of the Eligible Persons who participate in the Plan. No individual shall have a right to Benefits under the Plan except as specified herein and in no event shall a right to Benefits under the Plan be or become vested.

10.02 No Assignment of Benefits

A Participant's rights, interests, or Benefits under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution of levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Plan or Related Documents, and any such attempts shall be void.

However, a Covered Person may direct, in writing, that benefits payable to him be paid instead to an institution in which he is or was hospitalized, to a provider of medical services or supplies furnished or to be furnished to him, or to a person or entity that has provided or paid for, or agreed to provide or pay for, a benefit payable under the Plan.

Notwithstanding the foregoing, the Plan reserves the right to make payment directly to the Covered Person and to refuse to honor such direction and assignment. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of medical services or supplies except to the extent the Plan actually chooses to do so.

10.03 Clerical Error

Clerical error by the Employer or Plan Administrator shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

10.04 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous payment. This right to offset shall not limit the right of the Plan to recover an erroneous payment in any other manner.

10.05 Right to Recover Payments

In the event a payment is made by the Plan with respect to Covered Expenses, in an amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from one or more of the following, as the Plan Administrator, in its sole discretion, shall determine: a person to or for or with respect to whom the payments were made, an insurance company, or any other organization.

10.06 Facility of Payment

If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, death, illness or infirmity, mental incompetence or incapacity of any kind, the Plan Administrator may, in its discretion, direct the payment of such benefit:

(a) Directly to such person;

(b) To the legally appointed guardian or conservator of such person;

(c) To a relative, friend or institution for the comfort, support and maintenance of the person entitled to receive such amount, including without limitation, any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution caring for such person; or

(d) As directed by a court of competent jurisdiction.

The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any banking institution of the Plan Administrator's choice.

10.07 Lost Payee

Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward Employer contributions to the Plan. However, if a claim is made by the Participant or beneficiary, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable in accordance with the terms of the Plan. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

10.08 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

10.09 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan’s control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

10.10 No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the Employer neither ensures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to Article III will be excludable from the Participant's gross income or wages for federal, state or local tax purposes.

10.11 Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or any other laws of similar effect.

10.12 Legal Remedy

Before pursuing a legal remedy, an individual claiming benefits or seeking redress under the Plan shall first exhaust all claim, review, and appeal procedures available or required under the Plan.

10.13 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Illinois.

10.14 Writings Incorporated by Reference

The documentation, as amended, listed in and attached in Appendix B is made a part of the Plan as though fully set forth herein. This document, including the Related Documents identified in Appendix B, legally governs the operation of the Plan and shall be treated as a single employee welfare benefit plan for purposes of ERISA.

10.15 Conflicting Provisions of Related Documents

The provisions of the Plan shall be interpreted to apply in conjunction with and in addition to the provisions of the materials that are incorporated by reference in the Plan to form and constitute the Related Documents. In the event of a direct conflict between the provisions of a Related Document and the provisions of the Plan, the provisions of the Plan shall prevail. Where terms and provisions specifically applicable to an individual Related Document are not addressed in the Plan document, such terms and provisions as set forth in such Related Document will govern.

10.16 Severability

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

10.17 Captions and Headings

The caption or heading of an article, section or provision of the Plan is for convenience and reference only and shall not to be considered in interpreting the terms and conditions of the Plan.

10.18 Gender and Form

Words used in the Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would apply. Words used in the Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would apply, and vice versa.

10.19 Fiduciary Capacity

Any person, or group of persons, designated by the Employer to serve in a fiduciary capacity may share a fiduciary capacity or serve in more than one fiduciary capacity with respect to the Plan.

10.20 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and such waiver shall operate only as to the specific term, condition, or provision waived.

10.21 Reliance by and Liability of the Parties

The Employer, the Plan or Claims Administrator, and any person to whom a duty in connection with the administration, management, or operation of the Plan is delegated may rely upon any table, valuation, certificate, report, and/or opinion furnished by an actuary, accountant, legal counsel, or other specialist. An action taken or omitted in good faith based on such reliance shall be binding and conclusive on all parties, and no liability shall be incurred for such action or reliance, except as required by law. No liability shall be incurred for any other action or inaction of such parties except for willful misconduct or willful breach of duty to the Plan.

10.22 Disclaimer

None of the services provided under the Plan are warranted by the Employer and Participants shall look solely to the service provider with respect thereto. The Employer assumes no obligations other than those set forth in the Plan and shall not be liable for acts of omission or commission on the part of any Insurer, service provider, or other party.

10.23 Bonding and Insurance

To the extent required by ERISA or other applicable law with respect to Benefits subject to ERISA, every fiduciary of the Plan, and every person handling the funds of the Plan, or component hereunder, shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

10.24 Complete Statement of Plan

The Plan supersedes all prior plans governing the types of Benefits provided under the Plan. This document, including the Related Documents, contains a complete statement of the terms of the Plan. The right of any person to any benefit of a type provided under the Plan shall be determined solely in accordance with the terms of the Plan. No other evidence, whether written or oral, shall be taken into account in determining the right of any person to any benefit of a type provided under the Plan.

10.25 Quality of Health Services.

The selection by the Employer of the coverages that may be financed through the Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any health, dental, or vision care service provider, nor does the Employer assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

Each Eligible Person for whom enrollment is provided under any coverage agrees, as a condition of such enrollment, that such Eligible Person will look only to appropriately certified or licensed providers, and not to the Employer, for Benefit related services, and further that the Eligible Person releases, discharges, indemnifies, and holds harmless the Employer, the Plan Administrator, their respective employees, officers, directors, and shareholders, and all other persons associated with them, with respect to all matters relating to (a) the quality, sufficiency, and appropriateness of health, dental, prescription drug, or vision care services provided, (b) the failure by any provider to provide any service needed, or to properly obtain informed consent prior to rendering or withholding any service, regardless of the reason for such failure, and (c) professional malpractice by a service vendor or provider, or the failure of any insurance carrier to pay for any care for which the Eligible Person or other service recipient believes himself entitled to reimbursement.

ARTICLE XI

AMENDMENT OR TERMINATION OF PLAN

11.01 Right to Amend

The Employer, by formal action of the Board of Directors, reserves the right, in its sole discretion, at will and at any time and from time to time, but subject to requirements of law, to modify, add, reduce, or eliminate, in whole or in part, any or all provisions of the Plan including, but not limited to, any Benefit, benefit structure, condition for or method of payment, or rate of contribution, whether applicable to all or a category of individuals.

11.02 Right to Terminate

The Plan established with the intention of being maintained indefinitely notwithstanding, the Employer, by formal action of the Board of Directors, reserves the right, at will and at any time, but subject to requirements of law, to terminate the Plan.

11.03 Effect of Amendment or Termination

The amendment or termination of the Plan shall be effective as of the date the Employer shall determine except that no amendment or termination shall be retroactive or reduce benefits payable for Covered Expenses prior to the later of the date the amendment or termination is effective or adopted unless otherwise required or permitted by law.

APPENDIX A

IDENTIFIED PERSONS

Effective January 1, 2020, the following are identified as individuals who receive Protected Health Information for Health Care Operations:

- Vice President - Life Administration, who shall assume the responsibilities of the Privacy Official; and
- Any other Individual who is under the control of the Employer or a Participating Affiliate and who receives Protected Health Information relating to Payment or Health Care Operations of, or other matters pertaining to, the Plan in the ordinary course of business (within the meaning of 45 CFR §164.504(f)(2)(iii)) and who has been designated, in writing, by the Privacy Official.

Kimberly Remmert — 12/17/19

Signature — Date

Kimberly Remmert — VP - HR

Print Name — Title

APPENDIX B

RELATED DOCUMENTS

The Plan hereby incorporates the terms and conditions of the following plan document, Insurance Policies, Administrative Services Agreements, certificates of insurance and booklets, and HIPAA-related documents, as specified below and any superseding document thereof:

A. Farmers Automobile Insurance Association Medical and Dental Benefits Plan (Inactive Plan) Plan.

B. Farmers Automobile Insurance Association Medicare Prescription Drug Plan

Appendix B identifies the related documents incorporated in to the Plan as of January 1, 2020 or as later revised.

Kimberly Remmert — 12/17/19

Signature — Date

Kimberly Remmert — VP-HR

Print Name — Title

Section II

Farmers Automobile Insurance Association
Medical and Dental Benefit Plan
Document and Summary Plan Description

(Inactive Plan)

Original Effective Date: January 1, 2017

Restatement Effective Date: January 1, 2020

Table of Contents

ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Farmers Automobile Insurance Association (the "Sponsor") as of January 1, 2020 hereby sets forth the provisions of the Farmers Automobile Insurance Association Medical and Dental Benefit Plan (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Farmers Automobile Insurance Association, as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1 et seq. ("ERISA").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Document to be executed.

Farmers Automobile Insurance Association

By: Kimberly Remmert

Name: Kimberly Remmert

Title: VP-HR

Date: 12/17/19

INTRODUCTION AND PURPOSE AND GENERAL PLAN INFORMATION

Introduction and Purpose

Farmers Automobile Insurance Association has established the Plan for the benefit of employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward benefit coverage.

The purpose of this Plan Document 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 medical and dental benefits. The Plan Document is maintained by Farmers Automobile Insurance Association and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Farmers Automobile Insurance Association Medical and Dental Benefit Plan**
Plan Sponsor/Employer:	**Farmers Automobile Insurance Association 2505 Court Street Pekin, IL 61558 Phone: 309-346-1161**
Plan Administrator: (Named Fiduciary)	**Farmers Automobile Insurance Association 2505 Court Street Pekin, IL 61558 Phone: 309-346-1161**
Plan Sponsor ID No.	**37-0268670**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 – December 31**
Plan Number:	**508**
Plan Type:	**Welfare Plan**
Original EFFECTIVE DATE:	**January 1, 2017**
Restatement EFFECTIVE DATE:	**January 1, 2020**
Third Party Administrator:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance 2505 Court Street Pekin, IL 61558 Phone: 888-301-0747 Fax: 309-478-2912 Email: inquiry@groupplansolutions.com Website: www.groupplansolutions.com**

Case Management Prior Authorization, Precertification And Utilization Review for Medical Conditions and Mental Health and Substance Use Disorder:	**Hines & Associates, Inc. 14 N Riverside Avenue St. Charles, IL 60174**
24-hour Precertification:	**Phone: 888-641-5304 Website: www.precertcare.com**
Pharmacy Benefit Manager:	**Optum RX Customer Service: 844-265-1771 For Retirees on Medicare: 877-633-4461 Website: www.optumrx.com**
Preferred Provider Networks:	**Unity Point Health PLUS (formerly First Choice) Group Plan Solutions P.O. Box 21424 Eagan, MN 55121 Phone: 866-510-2922 HealthLink - Open Access III P.O. Box 419104 St. Louis, MO 63141 Phone: 800-624-2356 PHCS PO Box 21424 Eagan, MN 55121 Phone: 888-955-7427 HealthEOS by Multiplan PO Box 6090 Depere, WI 54115-6090 Phone: 800-279-9776 Travel Network: PHCS - Healthy Directions P.O. Box 1587 Pekin, IL 61555-1587**
COBRA Notice:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance COBRA 2505 Court Street Pekin, IL 61558 Phone: 888-301-0747 Fax: 309-478-2912 Email: inquiry@groupplansolutions.com Website: www.groupplansolutions.com**

Participating Employers:	**Farmers Automobile Insurance Association** **Tax ID: 37-0268670** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161** **Pekin Insurance Company** **Tax ID: 37-6028411** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161** **Pekin Life Insurance Company** **Tax ID: 37-0866596** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**
Agent for Service of Process:	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Participant and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

SCHEDULE OF MEDICAL BENEFITS

Effective 1/1/2020
Farmers Automobile Insurance Association Medical and Dental Benefit Plan
Inactive Plan

Calendar Year Deductible

The amount of the Covered Medical Expenses a Participant is responsible to pay each Calendar Year. The Preferred Provider and Non-Preferred Provider Calendar Year Deductibles are accumulated separately.

	Preferred Providers	Non-Preferred Providers
Individual Deductible (per Calendar Year)	$ 750	$ 1,500
Family Deductible (per Calendar Year)	$ 2,250	$ 4,500

All individual Deductible amounts will satisfy the family Deductible, but no one Participant will be required to pay more than the individual Deductible amount.

Out-of-Pocket Maximum - Medical

The maximum amount of Covered Medical Expenses (excluding prescription drug copays) a Participant must pay per Calendar Year before the Medical Benefits section of the Plan will begin to pay benefits for Covered Medical Expenses at 100% for such Calendar Year. The Preferred Provider Out-of-Pocket Maximum and Non-Preferred Provider Out-of-Pocket Maximum are accumulated separately for the calendar Year.

	Preferred Providers	Non-Preferred Providers
Individual Out of Pocket Maximum (per Calendar Year)	$ 4,000	$ 8,000
Family Out of Pocket Maximum (per Calendar Year)	$ 8,000	$16,000

Out of Pocket Maximum – Medical includes: annual medical deductible, coinsurance, office visit and emergency room copays. All individual Out-of-Pocket amounts will satisfy the family Out-of-Pocket maximum, but no one Participant will be required to pay more than the individual Out-of-Pocket amount.

Out-of-Pocket Maximum – Prescription Drug

The maximum amount of prescription drug Copays an Individual Participant must pay per Calendar Year before the Medical Benefits section of this Plan will begin to pay prescription drug card benefits at 100% for the Calendar Year is $6,350 per Individual.

Coinsurance & Benefit Maximums for Covered Medical Expenses per Participant

Preferred Provider and Non-Preferred Provider Coinsurance percentages are the percentages of Covered Medical Expenses paid by the Medical Benefits section of the Plan. Benefit Maximum is the limit on the Covered Medical Expenses that the Medical Benefits section of the Plan will pay on behalf of any Participants per Calendar Year. Expenses must be eligible under the Medical Benefits section of the Plan, Medically Necessary and the most cost-effective medically appropriate care.

<table>
<tr><th>Medical Services and Supplies</th><th>Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)</th><th>Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)</th><th>Benefit Maximum per Participant, if any</th></tr>
<tr><td>Preventative Care</td><td>100% (Deductible Waived)</td><td>Not Covered</td><td></td></tr>
<tr><td>Primary Care Physician Office Visit evaluation and management services</td><td rowspan="2">$25 Copay (Deductible Waived - 80% coinsurance applies to additional services.)</td><td>60%</td><td rowspan="2"></td></tr>
<tr><td>Virtual Care Visit with designated telemedicine provider</td><td>Not Covered</td></tr>
<tr><td>Specialist Physician Office Visit evaluation and management services</td><td>$40 Copay (Deductible Waived - 80% coinsurance applies to additional services.)</td><td>60%</td><td></td></tr>
<tr><td>Hospital Services - Inpatient
Precertification required</td><td>80%</td><td>60%</td><td></td></tr>
</table>

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Hospital Services – Outpatient **May require Case Management Prior Authorization**	80%	60%	
Serious Mental Health Conditions – Inpatient ***Precertification required***	80%	60%	
Serious Mental Health Conditions – Outpatient **Precertification/Case Management Prior Authorization recommended** – See **PRECERTICATION OF SERVICES** section	80%	60%	
Ambulatory Surgical Facility	80%	60%	
Physician & Surgeon Services	80%	60%	
Emergency Room (Access Fee waived if participant is admitted immediately following the emergency room visit) *No coverage for Non-Emergency Services at an Emergency Room*	80% after $75 Access Fee for Emergency Services	80% after $75 Access Fee for Emergency Services	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Emergency Ambulance Services (ground and air)	80%	80%	
Skilled Nursing Facility **Case Management Prior Authorization required**	80%	60%	90 days per Calendar Year maximum
Outpatient Diagnostic Tests and Laboratory Tests	80%	60%	
Outpatient Non-Emergency High Tech Diagnostic Services. MRI, MRA, CT and PET	80%	60%	
Outpatient Radiation and Chemotherapy ***Case Management Prior Authorization required***	80%	60%	
Outpatient Medical Supplies including Durable Medical Equipment ***Preapproval required***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Maternity Services – Routine Prenatal	100% Deductible Waived - 80% coinsurance applies to additional services	60%	
Maternity Services- Hospital Inpatient Confinement	80%	60%	
Inpatient Rehabilitation Services ***Precertification/Case Management Prior Authorization required***	80%	60%	
Human Organ or Tissue Transplants ***Precertification required (inpatient) & Preapproval (outpatient)***	100%, After Deductible (at Center of Excellence Transplant Facility)	Non-Center of Excellence 90% of first $100,000, After Deductible No coverage thereafter	See Covered Expenses for complete benefit description
Transplant Service Lodging and Transportation Allowance when Center of Excellence Transplant Facility is used ***Preapproval required***	100%, Deductible Waived, $200 daily maximum, $10,000 lifetime maximum	Not Covered at Non-Center of Excellence	
Substance Use Disorders – Inpatient ***Precertification required - See PRECERTIFICATION OF SERVICES section***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Substance Use Disorders - Partial Hospitalization and Outpatient Services ***Precertification/Case Management Prior Authorization recommended***– See ***PRECERTICATION OF SERVICES*** section	80%	60%	
Hospice Care ***Case Management Prior Authorization required***	80%	60%	
Home Health Care ***Case Management Prior Authorization required***	80%	60%	90 visits per Calendar Year maximum
Temporomandibular Joint Dysfunction (TMJ) services including diagnostic and surgical treatment Oral Appliances for TMJ ***Preapproval required***	80% 50% for Oral Appliances	60% 50% for Oral Appliances	TMJ benefits limited to $2,500 lifetime max allowed Oral Appliances for TMJ limited to one every 3 years, applied to the $2,500 TMJ lifetime max allowed

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Oral Appliances for Teeth Grinding ***Preapproval required***	50%	50%	Benefit Limit for Oral Appliances related to Teeth Grinding limited to one every 3 years and $2,500 Calendar Year max allowed
Oral Appliances for Sleep Apnea **Preapproval *required***	50%	50%	Benefit Limit for Oral Appliances related to Sleep Apnea limited to one every 3 years and $2,500 Calendar Year maximum allowed
Therapy – Physical & Occupational	80%	60%	20 visit for each therapy type per Calendar Year, **additional visits require Preapproval**
Speech Therapy ***Preapproval required***	80%	60%	***Preapproval required***

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Therapy – Manipulative (Chiropractic, Osteopathic & Naprapath). Spinal manipulation/adjustment	$25 Copay (After Copay, Deductible Waived - 80% coinsurance applies to additional services.)	60%	20 visits per Calendar Year maximum
Infertility Treatment ***Preapproval required***	80%	60%	3 completed oocytes retrievals per lifetime, see Covered Expenses for complete benefit description
Bariatric Surgery ***Preapproval required***	80%	60%	See Covered Expenses for complete benefit description
Cardiac Rehabilitation Services – Phase I and Phase II	80%	60%	36 treatments per 6 month period
Injectable Medications, administered in an office setting. ***Preapproval required***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Reasonable and Customary Percentile Level	95th	95th	
Retail Prescription Drugs (per drug purchased) (1 copay for 1-30 day supply, 2 copays 31-60 day supply, 3 copays 61-90 day supply.) No more than a 30 day supply allowed on Specialty drugs and opioids.	Generic Drugs: $20 Copayment Preferred Brand Drugs: $30 Copayment Non-Preferred Brand Drugs: $50 Copayment Specialty Drugs: $100 Copayment	Not Covered	
Mail Order Prescription Drugs (per drug purchased) 90 day supply No more than a 30 day supply allowed on Specialty drugs and opioids.	Generic Drugs: $60 Copayment Preferred Brand Drugs: $90 Copayment Non-Preferred Brand Drugs: $150 Copayment Specialty Drugs: $100 Copayment	Not Covered	

SCHEDULE OF DENTAL BENEFITS

Effective 1/1/2020
Farmers Automobile Insurance Association Medical and Dental Benefit Plan
Inactive Plan

Dental Expense Benefits

Maximum Benefit (per Calendar Year per Individual)	$1,500*
Individual Deductible (per Calendar Year)	$ 50
Family Deductible (per Calendar Year)	$ 150**

Preventative Dental Services – Not subject to deductible, payable at 100%

Basic Dental Services – After Deductible, payable at 80%

Major Dental Services – After Deductible, payable at 50%

Orthodontic Treatment Benefit

Orthodontic Maximum Benefit (per lifetime per Individual***)	$1,500
Orthodontic Deductible	None
Orthodontic Coinsurance	50%

* Preventative Dental Services do not apply to annual Maximum Benefit Amount.

**All individual Deductible amounts will satisfy the family Deductible, but no one Participant will be required to pay more than the individual Deductible amount.

*** Lifetime Orthodontic Maximum Benefit Amount is separate from the Calendar Year Maximum Benefit for all other Covered Dental Expenses.

Note: Waiting periods and frequency/age limits may apply

NOTE: Certain services may be covered under the Medical Benefits section of this Plan. The Medical Benefits section of this Plan would pay as primary and the Dental Benefits section of this Plan would pay as secondary.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; however they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for that information. There are also definitions located in other sections of this Plan Document.

ACCESS FEE

Means the amount You must pay each time You incur Covered Expense for Emergency Services provided in a Hospital emergency room. The amount is shown on the Schedule of Medical Benefits. This amount must be paid anytime You receive Emergency Services in a Hospital emergency room, and are not directly admitted to the Hospital as an Inpatient. This amount is in addition to any deductible and coinsurance amounts.

ADVERSE BENEFIT DETERMINATION

Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure 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 a Claimant's eligibility to participate in the Plan.

APPEAL

Means a review of an adverse benefit determination by the Third Party Administrator, as required under this Plan's claims and internal appeals procedures.

Once an authorized representative is appointed, the Third Party Administrator will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless You provide specific written direction otherwise.

APPROVED CLINICAL TRIAL

A phase I, phase II, phase III, or phase IV Clinical Trial

- Conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition or disease; and
- Is one of the following:
    - Federally funded trials;
    - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
        1. The National Institutes of Health;
        2. The Centers for Disease Control and Prevention;
        3. The Agency for Health Care Research and Quality;
        4. The Centers for Medicare & Medicaid Services;

5. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above;
6. The Department of Defense; or
7. The Department of Veterans Affairs.

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants in any of the following clauses below if the following conditions are met:
  - The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer reviews of studies and investigations used by the National Institutes of Health and assures unbiased reviews of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The Department of Veterans Affairs;
    - The Department of Defense;
    - The Department of Energy; or
  - The study or investigation is conducted under an investigational new drug application review by the Food and Drug Administration; or
  - The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-Threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted..

Qualified Individual

A Participant who meets the following conditions:

- The Participant is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to Treatment of cancer or other Life-Threatening Condition or disease.
- Either:
  - the referring health care provider has concluded that the Participant's participation in the clinical trial would be appropriate based upon the Participants meeting the conditions described in paragraph above; or
  - the Participant provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Participants meeting the conditions described above.

Routine Patient Costs

All items and services that are typically covered by the Medical Benefit section of the Plan for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:

- the investigational item, device, or service, itself;

- items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial participation requires Case Management Prior Authorization.

APPROVED TRANSPLANT SERVICES

Means services and supplies for organ transplants when provided at or arranged by a Transplant Center of Excellence. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services related to the organ transplant.

AUTHORIZED REPRESENTATIVE

Means:

- a person to whom You have given express written consent to represent You in an external review, and includes Your health care provider, or
- a person authorized by law to provide substituted consent for You, or
- Your health care provider when You are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from the Third Party Administrator. The completed form must be submitted to the Third Party Administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 855-545-7165
Email Address: healthclaimappeal@groupplansolutions.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

BENEFIT PERIOD

The 12 month period during which deductible and coinsurance amounts apply. It begins on January 1 of a year and ends on December 31 of the year.

CASE MANAGEMENT PRIOR AUTHORIZATION

Means the process of determining benefit coverage prior to service being rendered to a Participant. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the Participant. This Participant-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

CHILD, CHILDREN

Means the Eligible Inactive Individual or the Eligible Inactive Individual's Spouse's:

- natural born child;
- legally adopted child or child in the custody of the Eligible Inactive Individual or Eligible Inactive Individual's Spouse while adoption proceedings are pending with respect to that child; or

- any other child that has been declared the legal responsibility of the Eligible Inactive Individual or Eligible Inactive Individual's Spouse.

The child must be under 26 years of age.

It also means the Eligible Inactive Individual or Eligible Inactive Individual's Spouse's child who is 26 years of age or older, if the child meets the definition of Total Disability. The child must have become Totally Disabled before the child became 26 years of age.

CIVIL UNION

A legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act or any other U.S. state civil union law.

CLAIM

Means any request for a Plan benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means a Participant person who makes a request for a Plan benefit or benefits in accordance with the claim and appeals procedures. Any reference to claimant in the section titled Filing a Claim, Claim Procedures, and Appeal Procedures for Medical and Dental Benefits also refers to an authorized representative of the Participant person.

CLEAN CLAIM

Means one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or any other person or entity. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or fees under review for Regular, Reasonable & Customary, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

COINSURANCE

Means the designated percentage the Plan will pay per Participant per benefit period in excess of any applicable deductible for a Covered Medical Expense or a Covered Dental Expense. The applicable percentages are shown on the Schedule of Medical Benefits and the Schedule of

Dental Benefits. For Covered Medical Expenses, the Preferred Provider Coinsurance amount applies to Covered Medical Expenses provided by a Preferred Provider and the Non-Preferred Provider Coinsurance amount applies to covered services provided by a Non-Preferred Provider.

COMPLICATIONS OF PREGNANCY

Pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management, such as, but not limited to:

- extra-uterine pregnancy;
- severe toxemic disorders;
- severe puerperal sepsis;
- spontaneous miscarriage;
- severe hemorrhage;
- any complications of pregnancy requiring delivery by cesarean section.

Complication of pregnancy does not include:

- false labor;
- occasional spotting;
- physician prescribed rest;
- morning sickness;
- induced abortion;
- elective cesarean section;
- maternal age;
- repeat cesarean section, unless necessary because of existing medical complications.

CONCURRENT CARE CLAIM

Means a Claim where an ongoing course of treatment that has been approved will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. where an extension is requested beyond the initially approved period of time or number of treatments.

COPAY

The specific dollar amount a Participant is required to pay towards Covered Medical Expenses. Copay amounts vary based on the service and are shown on the Schedule of Medical Benefits.

COVERED CHILD(REN)

A Child who is covered for benefits under this Plan.

COVERED DENTAL EXPENSE(s)

The Medically Necessary, Regular, Reasonable & Customary charges for dental services and supplies that are incurred:

- by a Participant while this coverage is in force; and
- before this coverage ends.

In determining whether an expense is a Covered Dental Expense the Dental Benefits section of the Plan will consider:

- the definitions, provisions, limitations and exclusions in the Plan; and

A Covered Dental Expenses for the following items is incurred as defined below:

- fixed partial dentures, crowns, inlays, or onlays are incurred on the date the tooth is prepared;
- root canal therapy is incurred on the date the pulp chamber is opened; and
- prosthetic device is incurred on the date the master impression is made.

All other Covered Dental Expenses are incurred on the date the service is finished.

COVERED DEPENDENT

An Eligible Inactive Dependent of a Covered Individual or a Surviving Dependent

who is covered for benefits under this Plan.

COVERED INDIVIDUAL

An Eligible Inactive Individual who is covered for benefits under this Plan.

COVERED MEDICAL EXPENSE(s)

The Medically Necessary, Regular, Reasonable & Customary charges for medical services and supplies that are incurred:

- by a Participant while this coverage is in force;
- before this coverage ends; and
- for the treatment of an illness or injury, except for Preventive Care as outlined in MEDICAL BENEFITS Preventive Care.

In determining whether an expense is a Covered Medical Expense the Medical Benefits section of the Plan will consider:

- the definitions, provisions, limitations and exclusions in the Plan;
- clinical coverage guidelines and medical policies as posted on the public website of the Third Party Administrator;
- standardized billing procedures; and
- medical peer reviews and recommendations provided by nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

COVERED SPOUSE

A Spouse who is covered for benefits under this Plan.

CUSTODIAL CARE

Care which is primarily for the purpose of meeting personal needs. It can be provided by persons without professional skills or training. Examples are help in walking, getting in and out of bed, bathing, eating, dressing, and taking medicine. Custodial care also includes supervision of the patient for safety reasons. It also includes Durable Medical Equipment that does not treat a condition, but is used to facilitate activities of daily living, such as but not limited to hoyer lifts, electric wheelchairs, bath chairs, and raised toilet seats.

DEDUCTIBLE

The amount of Covered Medical Expense or Covered Dental Expense for services provided that must be incurred in a Calendar Year before any Covered Medical Expense or Covered Dental Expense is paid by the Plan.
It is equal to the lesser of:

- The amount specified under the Individual Deductible amount shown on the Schedule of Medical Benefits or Schedule of Dental Benefits.
- The amount needed to satisfy the Family Deductible amount shown on the Schedule of Medical Benefits or Schedule of Dental Benefits.

For new Participants who enter the Plan during the Calendar Year, his/her medical Deductible (not including prescription drug copays) and dental Deductible incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year medical and dental Deductible for the first Calendar Year they are a Participant in this Plan.

DENTAL

Any care or treatment or surgery relating to the teeth or gums, including but not limited to preventative dental care, extractions, restorations, endodontics, periodontics, prosthodontics, oral surgery for any condition which is caused by or related to a problem of the teeth, medications, or any appliances which rest upon or are attached to the teeth. For the purposes of this Plan, all care, surgery, or treatment of this type will be considered dental treatment or surgery, regardless of the origin of the condition which caused the treatment or surgery unless specifically listed as covered under the Medical Benefits section of the Plan. Dental is covered as listed in the Dental Benefits section of the Plan. The Medical Benefits section of the Plan will pay primary to the Dental Benefits section of the Plan if an expense is covered under both the Medical Benefits section and the Dental Benefit section of the Plan.

DENTAL SERVICES

Means care and treatment of the teeth and gums, or any services rendered by a dentist or dental surgeon. The Medical Benefits section of the Plan will pay primary to the Dental Benefits section of the plan if an expense is covered under both the Medical Benefits section and the Dental Benefit section of the Plan.

DENTIST

Means a person licensed to practice dentistry by the state in which he or she is practicing. He or she must be practicing within the scope of their license.

DEPENDENT

Means the Spouse and/or the Child or Children of an Eligible Inactive Individual, who are not themselves, Covered Individuals under this Plan.

DISABLED EMPLOYEE

An individual who met their 180 day waiting period and were considered disabled under the Farmers Automobile Insurance Association Long Term Disability Plan prior to January 1, 2014 and covered under a Pekin Insurance Health Benefit Plan on December 31, 2016.

DURABLE MEDICAL EQUIPMENT

Means medical equipment:

- which is Preapproved as required by the Medical Benefits section of the Plan;
- is used repeatedly;
- serves a medical purpose;
- would not be useful to a person without an injury or illness;
- is appropriate for treating an illness or injury in the home; and
- is the standard model equipment that meets the patient's needs.

The following items are not considered Durable Medical Equipment, and are not covered under the Medical Benefits section of the Plan:

- Expenses for Durable Medical Equipment that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a Physician) and certain medical devices including, but not limited to:
    - common household items including air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, heaters, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, heating pads, heat lamps, ice bags, or cold pack pumps;
    - personal hygiene equipment including tub chairs used in a tub or shower, and raised toilet seats, or supplies;
    - personal comfort items including cervical pillows, gravity lumbar reduction, TENS units, translift chairs, and transfer equipment;
    - exercise equipment of any type, swimming pools, hot tubs, whirlpools, spas or saunas;
    - any equipment which provides comfort or convenience;
    - structure or vehicle alterations, ramps, or elevators;
    - duplicate equipment;
    - similar types of items or equipment;
    - expense in excess of the cost for the standard model of equipment that is attributable to purchasing a more advanced model of equipment than what is covered under the Plan;
    - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
    - Medical equipment including blood pressure monitoring devices, unless prescribed by a Physician for preventive services and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension, PUVA lights and stethoscopes;
    - Computers or computer systems and related equipment or similar items or equipment;
    - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

EFFECTIVE DATE

Means the EFFECTIVE DATE of this Plan restatement, January 1, 2020 or the date the Participant is effective under this Plan as described in the section "ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE" if after January 1, 2020.

ELIGIBLE INACTIVE DEPENDENT

The Spouse or the Child or Children of an Eligible Inactive Individual.

ELIGIBLE INACTIVE INDIVIDUAL

Includes any person who is a (i) Retiree; (ii) Disabled Employee; or (iii) Surviving Dependent.

EMERGENCY SERVICES

Means Covered Expenses for those medical and health services provided:

- to treat a medical condition, manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part;

  or
- When a Physician instructs You to go to an emergency room or other emergency facility immediately to treat an emergency medical condition.

With respect to an emergency medical condition, a medical screening examination that is within the capability of the medical facility including ancillary services routinely available to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available, such further medical examination and treatment as is required to stabilize the patient.

It does not mean Covered Expense for services provided by a Non-Preferred Provider once a referral can be made to safely transfer the patient to the care of a Preferred Provider.

EMPLOYEE

Means a person actively employed by Farmers Automobile Insurance Company or a Participating Employer on a regular full-time basis. The person must work at least 30 hours a week.

EQUIVALENT GENERIC DRUG

Means a drug that the Pharmacy Benefit Manager has classified as safe, equivalent to, and as effective as the brand name drug that would otherwise have been prescribed.

EVALUATION AND MANAGEMENT SERVICES

Means those services properly assigned a CPT (American Medical Association Current Procedural Terminology) evaluation and management services code.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of an injury or illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug,

biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or

- is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

It also means any service, supply, or treatment that is not commonly and customarily recognized by the physician's profession and within the United States as appropriate treatment of the patient's diagnosed illness or injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed illness or injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered experimental/investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical treatment, procedure, drug or device that is not considered an Approved Clinical Trial will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.

The fact that a procedure, drug, or device is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

GROUP TYPE PLAN

Any of the following:

- Group or blanket insurance coverage;
- Prepayment plans (including Blue Cross – Blue Shield)
- Union Welfare plans;
- Plans growing out an employee-employer relationship;
- Any statutory plans;
- The medical benefits coverage in group automobile contracts, in group or individual automobile "no-fault" contracts, and in traditional "fault" type contracts;
- Uninsured or underinsured motorist coverage.

HABILITATIVE SERVICES

Means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by the Participant's treating Physician pursuant to a treatment plan to enhance a Child to function

with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a Child prior to that Child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, or early acquired disorder may include but are not limited to autism, Autism Spectrum Disorders, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

HEALTH INSURANCE COVERAGE

Means benefits consisting of medical care under any hospital or medical service plan or certificate, hospital or medical service contract, or health maintenance organization contract offered by a health insurance issuer.

HOME HEALTH CARE

Means care and treatment of a Participant under a plan of care established by the Participant's physician. The plan must be submitted to the Third Party Administrator in writing, and Case Management Prior Authorization is obtained, as required by the Plan. The plan of care must be reviewed at least every two months by the Participant's Physician.
It consists of the medically necessary services for:

- part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
- part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker;
- physical, inhalation/respiratory, occupational or speech therapy;
- nutrition counseling provided by or under the supervision of a registered dietician;
- evaluation and development of a home health plan by a R.N., physician extender or medical social worker, when approved or requested by the primary care physician;
- medical equipment, medical social services, medical supplies, oxygen and equipment for its administration, parenteral and enteral nutrition, prescription drugs and medicines administered in the vein or muscle, prosthetic devices and braces;
- home health aide services – when provided in conjunction with a Medically Necessary skilled service also received in the home.

The home health care services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or rehabilitation agency.

HOSPICE

Means an agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. The hospice agency must:

- Be certified or licensed as a hospice by the state in which they are operating;
- Operate under the direct supervision of a physician;
- Provide services 24 hours a day, seven days a week; and
- Maintain medical records on each patient.

HOSPICE CARE

Means care and treatment provided by a Hospice for a terminally ill person and the immediate family members of the person if they are covered under the Medical Benefits section of the Plan.

HOSPITAL

Means a place which:

- is legally operated for the inpatient care and treatment of ill or injured persons;
- is mainly engaged in providing medical and diagnostic services;
- has continuous 24 hour nursing services; and
- has a staff of one or more physicians available at all times except when the facility meets the definition of Residential Treatment Facility in this Plan.

It does not mean:

- a rest, nursing, or convalescent home;
- a facility or institution mainly for the treatment of alcoholics or drug addicts except when the facility meets the definition of Residential Treatment Facility in this Plan;
- a facility primarily affording custodial or educational care for persons suffering from mental diseases or disorders except when the facility meets the definition of Residential Treatment Facility in this Plan; or
- a freestanding ambulatory surgical facility that arranges for overnight stays within the facility.

ILLNESS

Means any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by injury.

It also means:

- a pregnancy or complication of pregnancy;
- a congenital defect or birth abnormality for a child.

IMMEDIATE FAMILY

Means the Participant's spouse, children, parents, brothers and sisters.

INACTIVE CLASS

Means an individual who is a:

- Retiree;
- Disabled Employee prior to January 1, 2014;
- Dependent(s) of Retirees and Disabled Employees prior to January 1, 2014; or
- Surviving Dependent(s).

INACTIVE PERSON ON AGE BASED MEDICARE

Means a Covered Individual or Covered Dependent under this Plan that is:

- entitled (based on age) to Medicare Part A and Part B; and
- retired; and
- either a (i) Retiree; (ii) Dependent of a Retiree (iii) Dependent of a Disabled Employee; or (iv) Surviving Dependent.

An **Inactive Person on Age Based Medicare** will be ineligible for the Prescription Medication Benefit under this Plan. An **Inactive Person on Age Based Medicare** will be eligible for Prescription Medication Benefits under the Farmers Automobile Insurance Association Medicare Prescription Drug Plan. An **Inactive Person on Age Based Medicare** will still be eligible for all other medical and dental benefits under this Plan except Prescription Medication Benefits.

INFERTILITY TREATMENT

Means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if Your Physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

INJURY

Means bodily injury caused by an accident.

INPATIENT

Means a confinement in a hospital that results in the hospital making a room and board charge. An overnight stay in an observation unit of a hospital or licensed ambulatory surgical facility will be considered an inpatient stay for Precertification purposes.

INTENSIVE CARE

Means a separate area in a hospital for the inpatient care of patients who are critically ill which:

- Provides constant nursing care which is not usual in other rooms and wards; and
- Has special lifesaving equipment which is immediately available at all times; and
- Has at least one R.N. on duty at all times.

MAIL ORDER PRESCRIPTION COPAY AMOUNT

Means the amount the participant must pay for each prescription order obtained through the mail service program.

MANIPULATIVE THERAPY

Means treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment including Osteopathic, Chiropractic, and Naprapathic Services regardless of the medical degree of the person providing the treatment.

MATERNITY SERVICES

Means:

- Prenatal and postnatal care, delivery, including Complications of Pregnancy.
- Maternity services include a minimum of:

- 48 hours of Inpatient care (in addition to the day of delivery) following a vaginal delivery, or
- 96 hours of Inpatient care (in addition to the day of delivery) following a cesarean section.

The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable. If the Inpatient Hospital stay is shorter, coverage includes a follow-up postpartum home visit by an approved provider competent to perform postpartum care.

For a covered pregnancy of a Participant mother under the Medical Benefits section of the Plan, expenses incurred for a well Newborn Child's initial Hospital confinement will be considered a Covered Medical Expense under the Participant mother's coverage. In the case of other insurance coverage for the mother, normal Coordination of Benefits will apply as if the charges for the well Newborn are for the mother. No benefits are provided for the well Newborn initial Hospital confinement when the mother is not covered under the Medical Benefits section of the Plan. Mother and well Newborn will be considered one Participant until discharge from the initial Hospital confinement and therefore the Mother must be Eligible for coverage for the Newborn's initial Hospital confinement to be eligible. In the case of a non-well Newborn with an Illness or Injury, all usual provisions of the Medical Benefits section of the Plan apply.

MAXIMUM ALLOWABLE AMOUNT

Means the cost of a procedure, drug, or device that would adequately accommodate treatment of a Participant's condition.

MEDICALLY NECESSARY

Means treatment that is or will be provided for the diagnosis, evaluation, and treatment of an illness or injury and that is:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's illness or injury;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided to the patient, and which cannot be omitted consistent with recognized professional standards of care; for a hospitalization, it means that safe and adequate care could not be obtained in a less comprehensive setting or level of care;
- Cost-effective compared to alternative interventions, including no intervention;
- Not experimental/investigational; The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to the definition in this Plan;
- Not primarily for the convenience of the patient, the patient's family, or the provider.

The fact that a provider may prescribe, order, recommend, or approve any care or treatment does not, of itself, make any care or treatment Medically Necessary or a Covered Medical Expense and does not guarantee payment.

MEDICARE

Means Title XVIII of the Social Security Act as amended.

MEDICAID

Means Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act as amended.

MINOR

Means a person who is under the legal age of competence.

MORBID OBESITY

Means:

(1) A body mass index of at least thirty-five (35) kilograms per meter squared, with co morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

(2) A body mass index of at least forty (40) kilograms per meter squared without co morbidity.

For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

NAPRAPATH

Means a provider of Naprapathic Services duly licensed to legally perform such services.

NAPRAPATHIC SERVICES

Means treatment by a Naprapth, within the scope of the applicable license, including manipulation of connective tissues and adjoining structures and by dietary measures to facilitate the body's recuperative and regenerative process.

NEVER EVENT

Means any occurrence on a United States list of inexcusable outcomes in a health care setting compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."

NON-PREFERRED PROVIDER

Means a medical provider who has not entered into a written agreement to provide services to the Plan Participants in the Medical Benefits section of the Plan at a negotiated rate.

NON-PREFERRED PROVIDER COINSURANCE

Means the amount of Covered Medical Expense that a Participant must pay for services provided by a Non-Preferred Provider in a Calendar Year, after the Medical Benefits section of the Plan has paid the Non-Preferred Coinsurance amount. Non-Preferred Coinsurance share does not include:

- any Deductible amounts;
- any Copay amounts;
- any Access Fee;
- any amount the Participant had to pay under the prescription medication benefit;
- any penalty for noncompliance with plan requirements;
- any Transplant Amount;
- any Preferred Provider coinsurance;
- any non-covered services.

The Non-Preferred Coinsurance share amount is shown on the Schedule of Medical Benefits.

NON-PREFERRED PROVIDER DEDUCTIBLE

Means the amount of Covered Medical Expense for services provided by a Non-Preferred Provider that must be incurred in a Calendar Year by a Participant before any Covered Medical Expense is paid by the Medical Benefits section of the Plan. It is equal to the lesser of:

- the amount specified under the Non-Preferred Provider Individual Deductible amount shown on the Schedule of Medical Benefits;
- the amount needed to satisfy the Non-Preferred Provider Family Deductible amount shown on the Schedule of Medical Benefits.

Preferred Provider Deductible, Coinsurance, Copay and Access Fees, Non-Preferred Provider Coinsurance and Access Fee amounts will not be used to satisfy the Non-Preferred Deductible Amount.

For new Participants who enter the Plan during the Calendar Year, his/her medical Non-Preferred Provider Deductible (not including prescription drug copays) incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year medical Non-Preferred Provider Deductible for the first Calendar Year they are a Participant in this Plan.

NON-PREFERRED PROVIDER FAMILY DEDUCTIBLE

Means the amount of deductible a covered family must pay in a Calendar Year for services provided by Non-Preferred Providers. This amount is shown on the Schedule of Medical Benefits. The Non-Preferred Provider Family Deductible may be satisfied by combining all amounts applied to Non-Preferred Provider Individual Deductibles for the Covered Individual and the Covered Dependents for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual Non-Preferred Deductible. However, only Covered Medical Expense that is incurred in a Calendar Year and applied to that same Calendar Year's Non-Preferred Individual Deductible can be used to satisfy the Non-Preferred Family Deductible.

NON-PREFERRED PROVIDER INDIVIDUAL DEDUCTIBLE

Means the maximum amount of deductible that an individual participant must pay in a Calendar Year for services provided by Non-Preferred Providers.

For new Participants who enter the Plan during the Calendar Year, his/her medical Non-Preferred Provider Deductible (not including prescription drug copays) incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year medical Non-Preferred Provider Deductible for the first Calendar Year they are a Participant in this Plan.

NON-PREFERRED PROVIDER OUT-OF-POCKET MAXIMUM

Means any share of a Covered Medical Expense the Participant is required to pay for Non-Preferred Provider Covered Medical Expenses. This maximum includes any Non-Preferred Provider Deductible and Non-Preferred Provider Coinsurance amounts applied to covered services and Non-Preferred Provider Access Fees. No one Participant will be required to satisfy more than the applicable Individual Non-Preferred Provider Deductible. Non-covered services and benefit reductions are not included in this Maximum.

OUT-OF-POCKET MAXIMUM

Means the maximum amount of Covered Medical Expenses the Participant will incur in a Calendar Year. The Out-of-Pocket Maximum includes applicable Copays, Deductibles, Coinsurance share and Access Fees. The Out-of-Pocket Maximums are shown on the

Schedule of Medical Benefits for Preferred Providers and Non-Preferred Providers. There are separate Out-of-Pocket Maximums for Medical and Prescription Drugs. The Out-of-Pocket Maximum shown in this Plan's Schedule of Medical Benefits does not include any amount You pay in a Calendar Year for Covered Expenses under the FAIA Medicare Prescription Drug Plan. After the applicable Out-of-Pocket Maximum is reached, the Medical Benefits Section of the Plan will pay the remainder of the Covered Expenses incurred by a Participant during the rest of the year for that type of Provider.

For new Participants who enter the Plan during the Calendar Year, Deductible and Coinsurance for medical expenses incurred under the Pekin Insurance Health Benefit Plan, Access Fees, and Office Visit Copays (but not Prescription Drug Copays), during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year Out-of-Pocket Maximum for the Out-of-Pocket Maximum - Medical for the first Calendar Year he/she is a Participant in this Plan.

OUT-OF-POCKET MAXIMUM - MEDICAL

Means the maximum amount of Covered Medical Expenses (not including Prescription Copays) the Participant will incur in a Calendar Year. The Out-of-Pocket Maximum - Medical is shown on the Schedule of Medical Benefits. The Out-of-Pocket Maximum - Medical includes applicable Office Visit Copays, Deductibles, Coinsurance share and Access Fees. The Out-of-Pocket Maximums are shown on the Schedule of Medical Benefits for Preferred Providers and Non-Preferred Providers. After the applicable Out-of-Pocket Maximum is reached, the Medical Benefits Section of the Plan will pay the remainder of the Covered Expenses incurred by a Participant during the rest of the year for that type of Provider.

The maximum amount of Covered Expenses You will pay in a Calendar Year. The Out-of-Pocket Maximum for this Plan is shown in the Schedule of Medical Benefits. After the Out-of-Pocket Maximum is reached, the Plan will pay the remainder of the Covered Expenses incurred by a Participant under this Plan during the rest of that Calendar Year at 100%. The Out-of-Pocket Maximum shown in this Plan's Schedule of Medical Benefits does not include any amount You pay in a Calendar Year for covered expenses under the FAIA Medicare Prescription Drug Plan or Access Fees.

For new Participants who enter the Plan during the Calendar Year, Office Visit Copays (not Prescription Drug Copays or Access Fees), Deductible and Coinsurance share incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year Out-of-Pocket Maximum for the Out-of-Pocket Maximum - Medical for the first Calendar Year he/she is a Participant in this Plan.

OUT-OF-POCKET MAXIMUM - PRESCRIPTION COPAYS

The maximum amount of Covered Expenses You will pay in a Calendar Year for Prescription Copays under this Plan. The Out-of-Pocket Maximum for Prescription Copays for this Plan is shown in the Schedule of Medical Benefits. The Out-of-Pocket Maximum – Prescription Copays does not include any amount You pay in a Calendar Year for covered expenses under the FAIA Medicare Prescription Drug Plan. After the Out-of-Pocket Maximum is reached, the Plan will pay the remainder of the Prescription Drug copays incurred by a Participant under this Plan during the rest of that Calendar Year at 100%.

For new Participants who enter the Plan during the Calendar Year, Prescription Copays incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will **not** be carried forward to this Plan.

ORAL SURGERY

Means only for the following services:

- surgical removal of complete boney impacted teeth;
- excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- treatment of fractures of facial bone;
- external incision and drainage of cellulitis;
- incision of accessory sinuses, salivary glands or ducts;
- reduction of dislocation of, or excision of, the temporomandibular joints caused by Temporomandibular Joint Dysfunction and Related Disorders (TMJ) when Case Management Prior Authorization is obtained.

Anesthesia (general) and Hospital or ambulatory surgical facility services related to covered Dental services if:

- a Covered Child is age 6 or under;
- a Participant has a chronic disability; or
- based on determination by a licensed dentist and the Participant‘s treating Physician, the Participant has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary Dental treatment or surgery if not rendered in a Hospital or ambulatory surgical facility.

The Medical Benefits section of the Plan will pay primary to the Dental Benefits section of the Plan if an expense is covered under both the Medical Benefits section and the Dental Benefits section of the Plan.

PARTICIPANT

Means any Eligible Inactive Individual or Eligible Inactive Dependent who is covered for benefits under this Plan.

PARTICIPATING PHARMACY

Means any pharmacy which is enrolled as a participant in the Pharmacy Benefit Manager’s (RX Company) prescription drug program.

PEKIN INSURANCE HEALTH BENEFIT PLAN

Means Pekin Insurance Health Benefit Plan including the Traditional Health Benefits, High Deductible Health Benefit and Dental Benefit Plans for active Employees or any other group health plan that the Employer or Participating Employers are the Plan Sponsor.

PERIOD OF COVERAGE

Means the Plan Year, with the following exceptions: (a) for Covered Individuals and Covered Dependents who first become Participants, it shall mean the portion of the Plan Year following the date participation commences; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates. A different Period of Coverage (e.g., a calendar month) may be established by the Administrator and communicated to Participants.

PHYSICIAN

Means a practitioner of the healing arts, licensed by the state the practitioner practices in. The practitioner must be performing only those services the practitioner is licensed to perform.

PREAPPROVAL

Means a review by the Plan to determine the benefit coverage of Medically Necessary services. The Plan will provide benefits for the covered service if approved by the Plan prior to receiving the services.

PRECERTIFICATION

Means the process required to obtain prior approval for Inpatient Hospital admissions and other select Hospital services.

PREFERRED PROVIDER

Means a medical provider who has entered into a written agreement to provide services to the Plan Participants in the Medical Benefit section of the Plan at a negotiated rate. The General Plan Information section indicates the name of the Preferred Provider Networks. The Plan recommends that You verify that the provider You are using or considering is currently a Preferred Provider.

In addition, covered services obtained from a Non-Preferred Provider, pathologist, anesthesiologist, radiologist, or emergency room Physician (other Physicians providing one source services to Preferred Provider Hospital/Facility are also included) shall be considered to be provided by a Preferred Provider if the services are rendered as part of treatment rendered at a Preferred Provider Hospital.

It also means a provider who is a member of the Preferred Provider travel network if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary Preferred Provider Network. It also means a provider who is a member of the Preferred Provider travel network if the treatment is for an eligible Dependent who is living outside of the primary PPO 's service area and is receiving services outside of the primary Preferred Provider network service area. The General Plan Information section indicates the name of the travel network in addition to other Preferred Provider Networks. Please refer to Your ID card for correct network identification. The travel network may also be found on Your ID card.

It also means a provider accessed under the qualification outlined in Benefit for Covered Expense Provided by a Non-Preferred Provider or Benefit for Covered Expense for Emergency Services Provided in a Hospital Emergency Room. However, rates for reimbursement will be at the Regular, Reasonable & Customary rate due to lack of a negotiated Preferred Provider.

It also means a Non-Preferred Provider if the nearest Preferred Provider is more than 50 miles from the Participant's residence. Consideration of covering services of a Non-Preferred Provider as Preferred must be approved. However, rates for reimbursement will be at the Regular, Reasonable & Customary rate due to lack of a negotiated Preferred Provider direct contract.

PREFERRED PROVIDER COINSURANCE

Means the amount of Covered Medical Expense that a participant must pay for services provided by a Preferred Provider in a Calendar Year, after the Medical Benefits section of the Plan has paid the coinsurance amount. Preferred Provider Coinsurance does not include:

- any Deductible amounts
- any Copay amounts

- any amount the participant had to pay under the prescription medication benefit
- any penalty for noncompliance with Plan requirements
- any Transplant amount
- any Non-Preferred Coinsurance
- any non-covered services

PREFERRED PROVIDER DEDUCTIBLE

Means the amount of Covered Medical Expense for services provided by a Preferred Provider that must be incurred in a Calendar Year by a Participant before any Covered Medical Expense is paid by the Medical Benefits section of the Plan. It is equal to the lesser of:

- the amount specified under the Preferred Provider Individual Deductible amount shown on the Schedule of Medical Benefits;
- the amount needed to satisfy the Preferred Provider Family Deductible amount shown on the Schedule of Medical Benefits.

Non-Preferred Provider Deductible and Preferred Provider or Non-Preferred Provider Coinsurance amounts will not be used to satisfy the Preferred Provider Deductible amount.

PREFERRED PROVIDER FAMILY DEDUCTIBLE

Means the maximum amount of deductible a covered family must pay for Covered Medical Expense in a Calendar Year for services provided by Preferred Providers. This amount is shown on the Schedule of Medical Benefits. The Preferred Provider Family Deductible may be satisfied by combining all amounts applied to Preferred Provider Individual Deductibles for covered Participants for the Calendar Year. No one Participant will be required to satisfy more than the applicable Preferred Provider Individual Deductible. However, only Covered Medical Expense that is incurred in a Calendar Year and applied to that same Calendar Year's Preferred Provider Individual Deductible can be used to satisfy the Preferred Provider Family Deductible.

PREFERRED PROVIDER INDIVIDUAL DEDUCTIBLE

Means the maximum amount of deductible that an individual participant must pay for Covered Medical Expense in a Calendar Year for services provided by Preferred Providers.

PREFERRED PROVIDER OUT-OF-POCKET MAXIMUM

Means any share of a Covered Medical Expense the Participant is required to pay for Preferred Provider Covered Medical Expenses. This Maximum includes any Preferred Provider Deductible, Preferred Provider Coinsurance, Preferred Provider Access Fees, and office visit Copay amounts applied to covered services. Non-covered services and benefit reductions are not included in this Maximum.

No one Participant will be required to satisfy more than the applicable Individual Preferred Provider Deductible.

Non-Preferred Provider Deductible, Prescription Copay and Access Fee amounts will not be used to satisfy the Preferred Provider deductible amount. All Prescription Copays apply towards the Out-of-Pocket Maximum – Prescription Drugs.

For new Participants who enter the Plan during the Calendar Year, Access Fees, Office Visit Copays (not Prescription Drug Copays), Deductible and Coinsurance share incurred under the Pekin Insurance Health Benefit Plan during that same Calendar Year will be carried forward to this Plan and credited to the Participant's Calendar Year Preferred Provider Out-of-Pocket

Maximum for the Out-of-Pocket Maximum - Medical for the first Calendar Year he/she is a Participant in this Plan.

PRESCRIPTION COPAY

Means the amount the Participant must pay for each prescription order obtained at a retail pharmacy. It is shown on the Schedule of Medical Benefits.

PROOF OF LOSS

Consists of:

- a properly completed claim form; and
- any other information the Plan needs to process the Claim.

REGULAR, REASONABLE & CUSTOMARY

Means the lesser of:

- the actual charge;
- what the provider will accept for the same service or supply in the absence of insurance;
- the amount the provider has agreed to charge under a Preferred Provider agreement with the Plan;
- the amount the provider has agreed to accept under the terms of a negotiated agreement with the Plan;
- an amount determined by the Plan by comparing charges made by other medical professionals and/or facilities with similar credentials, for similar services and supplies, adjusted to the geographic locale, and based upon the Regular, Reasonable & Customary percentile level deemed appropriate by the Plan;
- an amount based on the level and/or method of reimbursement used by the Centers of Medicare and Medicaid Services for the same services or supplies; or
- an amount based on accepted industry standard or a commercially available database using factors such as, but not limited to the:
    - complexity or severity of the treatment;
    - level of skill and experience required for the treatment;
    - cost and quality data;
    - comparable fees and costs for the treatment;
    - reimbursement amounts paid by Centers for Medicare and Medicaid Services for the same services or supplies;
    - generally accepted billing practices; and/or
    - industry standard cost, reimbursement, and utilization data.

Regular, Reasonable & Customary for certain surgical charges will be determined as follows:

- for multiple surgical procedures performed at the same operative session, the Plan will allow up to 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
- for charges by an assistant surgeon, the Plan will allow up to 20% of the amount allowed for the primary surgical procedure when an assistant is deemed Medically Necessary.

The Plan Administrator reserves the right to take into consideration all of the above means of determining the Regular, Reasonable & Customary rate and in some instances an allowable amount may not be the lesser of.

RESIDENTIAL TREATMENT CENTER

Means a facility, licensed as such under applicable law, whose primary function is offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with mental health conditions, serious mental health conditions and/or Substance Use Disorders.

It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

RETIREE

Means an individual who: (a) was enrolled in a Pekin Insurance Health Benefit Plan on the day before the Employee's retirement from the Employer as an Employee; (b) qualifies for retiree health care benefits under terms and definitions set forth by the Farmers Automobile Insurance Association Retirement Plan as of their retirement date; and (c) was not terminated for gross misconduct.

SCHEDULE OF DENTAL BENEFITS

Means a list which states those benefits that the Plan Administrator has decided to provide to participants under the Dental Benefits section of the Plan.

SCHEDULE OF MEDICAL BENEFITS

Means a list which states those benefits that the Plan Administrator has decided to provide to participants under the Medical Benefits section of the Plan.

SKILLED NURSING FACILITY

Means a legally operated institution or a part of an institution for the treatment of inpatients. Treatment must be under the supervision of a Physician. The facility must provide 24 hour nursing service under the supervision of a R.N. It must maintain daily medical records of each patient. This definition does not include:

- a rest home or home for the elderly;
- an institution, nor a unit of an institution, used for custodial or educational care;
- an institution, nor a unit of an institution, used for the treatment of alcoholics, drug addicts, or the mentally ill.

SPACE MANAGEMENT

Means the installation of fixed or removable appliances designed to maintain space by keeping adjacent and opposing teeth from moving, when teeth are prematurely lost or extracted.

SPOUSE

Means a party to a legal marriage or civil union.

STABILIZE

Means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

SUBSTANCE USE DISORDER

Means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- substance use disorders;
- substance dependence disorders;
- substance induced disorders; and
- alcoholism.

SURVIVING DEPENDENT

Means any person who was a covered under any Pekin Insurance Health Benefit Plan as a Dependent at the time of death of one of the following classes of participants:

(a) an Employee
(b) a Retiree or
(c) a Disabled Employee prior to January 1, 2014

and the person described in (a), (b) or (c) above, had at least 9 years of service on his/her date of death.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TERMINALLY ILL PERSON

Means a person who has been diagnosed by a physician as having a life expectancy of six months or less.

TOTAL DISABILITY

Mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may require, in its sole discretion.

TRANSPLANT CENTER OF EXCELLENCE

Means a facility which has entered into an agreement through a national organ transplant network to render approved transplant services to the Medical Benefits section of the Plan's Participants. The Transplant Center of Excellence facility may or may not be located within the Participant's geographic area. A list of Transplant Center of Excellence facilities upon request will be made available to the participants.

URGENT CARE

Means medical care for an Illness or Injury serious enough that a reasonable person would seek care right away, but not so severe as to require Hospital emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

URGENT CARE CENTER

Means a licensed facility that provides Urgent Care.

YOU, YOUR

Means a Plan Participant.

ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility and Effective Date for Individual Coverage

All Eligible Inactive Individuals who are enrolled in the Medical Benefits section of a Pekin Insurance Health Benefit Plan on their last day as an Employee (or date they qualify as a Surviving Dependent or Disabled Employee) are eligible to enroll in the Medical Benefits section of this Plan. All Eligible Inactive Individuals who are enrolled in the Dental Benefits section of the Pekin Insurance Health Benefit Plan for active Employees on their last day as an Employee (or date they qualify as a Surviving Dependent or Disabled Employee) are eligible to enroll in the Dental Benefits section of this Plan.

For coverage under this Plan to become effective all Eligible Inactive Individuals who meet the eligibility requirements above must follow the enrollment procedures required by the Employer for the Medical Benefits section and/or the Dental Benefits section of the Plan within 30 days of their eligibility date for this Plan. If the Eligible Inactive Individual completes the enrollment procedures on a timely basis the coverage under the Plan's Medical Benefits section and/or Dental Benefits section will become effective on the date they became eligible for this Plan.

Eligible Inactive Individuals, upon loss of coverage under a Pekin Insurance Health Benefit Plan for active Employees, can choose between COBRA continuation coverage under the Pekin Insurance Health Benefit Plan for active employees they lost coverage under or enrolling in this Plan. If You or a Dependent who is eligible for this Plan elects COBRA within the 60 day COBRA election period, neither You or any family member will be eligible for this Plan.

If a Covered Individual terminates from the Plan, they are not eligible to reenroll in the Plan.

All Medicare eligible Participants are required to enroll in Medicare Parts A and B.

Eligibility and Effective Date for Dependent Coverage

An Eligible Inactive Individual's Dependents shall only be eligible to be covered as a Dependent under this Plan if the Dependent was covered under the Eligible Inactive Individual's coverage under any Pekin Insurance Health Benefit Plan on the Eligible Inactive Individual's last day as an Employee (or date they qualify as a Surviving Dependent or Disabled Employee). An Eligible Inactive Individual's Dependents shall only be eligible to be covered as a Dependent under the Medical Benefits section of this Plan if the Dependent was a covered under the Medical Benefits section of the Pekin Insurance Health Benefit Plan on their last day as an Employee (or date they qualify as a Surviving Dependent or Disabled Employee). An Eligible Inactive Individual's Dependents shall only be eligible to be covered as a Dependent under the Dental Benefits section of this Plan if the Dependent was a covered under the Dental Benefits section of the Pekin Insurance Health Benefit Plan for active Employees on their last day as an Employee (or date they qualify as a Surviving Dependent or Disabled Employee). In all cases, the Plan Sponsor's determination of eligibility shall be conclusive.

Eligible Inactive Dependents coverage will be effective under the Medical Benefits section and/or the Dental Benefits section as applicable on the date the Eligible Inactive Individual becomes covered under the Medical Benefits section and/or the Dental Benefits section of this Plan.

A person cannot be covered as both a Dependent and an Eligible Inactive Individual under the Plan. A Dependent Child cannot be covered as a Dependent of more than one Participant.

If two Employees or Eligible Inactive Individuals (married/civil union) are covered under this Plan or the Pekin Insurance Health Benefit Plan and the Employee or Eligible Inactive Individual who is covering the Dependent Child(ren) terminates coverage, the Dependent coverage may be continued by the other Employee or Eligible Inactive Individuals as long as coverage is

continuous under the applicable benefit section (Medical or Dental) of this Plan or the Pekin Insurance Health Benefit Plan.

If a Covered Individual has a Spouse/Civil Union Partner that is covered under the Pekin Insurance Health Benefit Plan as an active Employee and the active Employee terminates coverage under the Pekin Insurance Plan, the Spouse may be added to this Plan as a Covered Dependent by the other Covered Individual as long as coverage is continuous under the applicable benefit section (Medical or Dental) of this Plan or the Pekin Insurance Health Benefit Plan.

If a Covered Dependent terminates from the Plan they are not eligible to reenroll in the Plan.

No new Spouses or other Dependents will be eligible to be added to the Plan after Your retirement date or January 1, 2017, whichever is later, subject to the Transition Rule below.

All Medicare eligible Participants are required to enroll in Medicare Parts A and B.

Transition Rule:

Any Eligible Inactive Individuals and Eligible Inactive Dependents who are covered as a Retiree, Disabled Employee, or Surviving Dependent or as a Dependent of a Retiree, Disabled Employee, or Surviving Dependent on December 31, 2016 will automatically be enrolled under the associated Medical Benefit section and/or Dental Benefit section of this Plan.

Any Retiree who retires between January 1, 2017 and January 1, 2018 will have a one-time special enrollment opportunity on their retirement date to add a Dependent to the Medical Benefits section or Dental Benefits section of this Plan, the Dependent coverage will be effective the first day of the Retiree's retirement even if the Dependent was not covered under a Pekin Insurance Health Benefit Plan on the Retiree's last day as an Employee as required under the rules as stated in the Eligibility and Effective Date for Dependent Coverage section of this Plan. The Retiree must be covered under a Pekin Insurance Health Benefit Plan on their last day as an Employee to be able to add a Dependent to this Plan on their retirement date.

SPECIAL ENROLLMENT and OPEN ENROLLMENT PERIODS

Eligible Inactive Individuals are not eligible for special enrollment due to the loss of other coverage.

Similarly, Covered Individuals or Eligible Inactive Individuals who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent and no Dependents that were not Covered Dependent on the Pekin Insurance Health Benefit Plan on the day prior to the Eligible Inactive Individual's retirement date can be covered under this Plan.

There is no open enrollment under this Plan.

Rehiring a Covered Individual

A Covered Individual who is rehired by the Employer will be terminated from this Plan and may become eligible for a Pekin Insurance Health Benefit Plan for active Employees. You will be treated as a new hire.

TERMINATION OF COVERAGE

Termination Dates of Covered Individual Coverage

The coverage of any Covered Individual under the Medical Benefits section and Dental Benefits section of this Plan will end on the earliest of the following dates:

- The date this entire Plan terminates or with respect to a specific benefit, the date the

specific benefit is terminated;
- The date the Covered Individual requests coverage be terminated, as long as the request is made on or before the date requested ;
- The last day of the period for which the Covered Individual has made a contribution, if the Covered Individual fails to make a required contribution for coverage when it is due;
- The date the Covered Individual ceases to be eligible for coverage under the Plan;
- Immediately after a Covered Individual or a Covered Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information;
- The date of the Covered Individual's death.

If a Covered Individual terminates from the Plan they are not eligible to reenroll in the Plan.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Covered Individual who are covered under this Plan will end on the earliest of the following dates:

- The date this entire Plan terminates or with respect to a specific benefit, the date the specific benefit is terminated;
- The date coverage for Dependents and\or Surviving Dependents is discontinued under this Plan;
- The date coverage terminates under this Plan for the Covered Individual upon whom the Dependent depends for eligibility unless he/she qualifies as a Surviving Dependent;
- The period for which the Covered Individual has made a contribution, if the Covered Individual fails to make a required contribution for Dependent coverage when it is due;
- The date the Covered Individual requests coverage for a Dependent be terminated, as long as the request is made on or before the date requested;
- The date a Surviving Dependent is eligible for coverage under another group health plan or is covered by another group health plan;
- The date a Surviving Dependent enters into a Marriage or Civil Union.
- If the Surviving Dependent was receiving benefits as a Child, the date the Surviving Dependent np longer meets this Plan definition of a Child;
- The date such person ceases to be a Dependent as defined in this Plan, except as may be provided for in other areas of this section;
- In the case of a Child age 26 or older, for whom coverage is being continued due to Total Disability, the earliest of:
    - the date of cessation of such Total Disability;
    - the date proof of the uninterrupted continuance of Total Disability is not provided, including failure to submit to any requested examination; or
- the date the Child is no longer dependent on the Covered Individual for support;
- Immediately after a Covered Individual or a Covered Individual's Covered Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information; or
- The date of the Covered Dependent's death.

If a Covered Dependent or Covered Spouse terminates from the Plan he/she is not eligible to reenroll in the Plan.

MEDICAL BENEFIT

Amount of Benefit for Covered Expense

Preventative Care

The Plan will pay 100% of the Regular, Reasonable & Customary charge for Covered Expense incurred for preventive services, but only when provided by a Preferred Provider unless there is no Preferred Provider that can perform the services. Non-Preferred Provider must be Preapproved to qualify for Preferred Provider coverage. The deductible will not apply to this benefit.

Non-Preferred Provider laboratory tests and professional pathology laboratory services ordered by a Preferred Provider at a covered preventative care visit will be covered and treated as Non-Preferred Provider regular medical services and be covered subject to the applicable deductible and coinsurance as shown on the Schedule of Medical Benefits.

Preventive Services means:

- Items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force including those regarding breast cancer screening, mammography, and prevention, other than those issued on or around November 2009;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the person receiving the immunization;
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents;
- Preventive care and screenings for women as provided for by the Health Resources and Services Administration;
- It includes:
    - Colorectal cancer examination and screening as recommended by the American Cancer Society;
    - Shingles vaccine for Participants 50 years of age or older;
    - Human papilloma virus vaccines;
    - Screening mammography and clinical breast exams;
    - Pap test for cervical cancer;
    - Digital rectal examination and a prostate-specific antigen test;
    - CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination for Participants having a family history of one or more first-degree relatives with ovarian cancer, or with clusters of women relatives with breast cancer, or a family history of nonpolyposis colorectal cancer, or a positive BRCA1 or BRCA2 mutation test;
    - Blood Profile;
    - Urinalysis;
    - CBC;
    - EKG;
    - Chest X-Ray;

- TSH (thyroid);
- Lipid Profile;
- Hematocrit;
- Any other preventative care as outlined on the Schedule of Benefits.

It does not mean similar services when prescribed to monitor or diagnose a Participant who is having current symptoms or who has been diagnosed with an illness.

Benefit for Covered Expense Provided by a Preferred Provider

The Plan will pay according to the Schedule of Medical Benefits for the Covered Expense for evaluation and management services provided by a Preferred Provider.

After the applicable office visit Copay, the plan will pay 100% of Covered Expenses for the office visit charge made by a Preferred Provider for treatment of an illness or injury. The office visit Copay amounts are shown on the Schedule of Medical Benefits. It applies to each office visit charge by a Preferred Provider.

If, during an office visit, a Preferred Provider performs and bills for x-ray or laboratory tests, the Plan will waive the Preferred Provider Deductible amount, and pay the Covered Expense for those x-ray or laboratory tests at the applicable Preferred Provider Coinsurance percentage. The Preferred Provider Coinsurance percentage amounts are shown on the Schedule of Medical Benefits.

Except as stated above, payment of any benefit for services by a Preferred Provider will be considered Covered Expenses for services by a Preferred Provider and must equal the applicable Preferred Provider Deductible during a Calendar Year. After meeting the Calendar Year Preferred Provider Deductible the Plan will pay benefits for Covered Expenses provided by the Preferred Provider at the applicable Preferred Provider Coinsurance percentage as outlined on the Schedule of Medical Benefits. If the amount of Covered Expense paid by the Participant for Preferred Provider Deductible and Preferred Provider Coinsurance, Copays and Access Fees during a Calendar Year equals the Preferred Provider Out-of-Pocket Maximum, the Plan will pay the Covered Expenses for those services at 100% for the remainder of the Plan Year subject to any limitations outlined in the Plan or Schedule of Medical Benefits.

Benefit for Covered Expense for Emergency Services

When You incur Covered Expense for Emergency Services provided in a hospital emergency room, You must pay an emergency room Access Fee (refer to Schedule of Medical Benefits). This amount must be paid anytime You receive Emergency Services in a hospital emergency room, and are not directly admitted to the hospital as an inpatient. This amount is in addition to any deductibles and coinsurance share amounts. If You are directly admitted to the hospital as an inpatient following an emergency room visit, the emergency room Access Fee will not apply.

Emergency Services provided by a Preferred Provider or a Non-Preferred Provider will be considered to be services from a Preferred Provider and will be paid as outlined above in the section titled “Benefit for Covered Expense Provided by a Preferred Provider.”

If the Emergency Services were provided by Non-Preferred Providers, once it has been established the Participant is stabilized and a safe transfer to a Preferred Provider can be made and the Participant chooses to continue to receive care from Non-Preferred Providers, benefits for Covered Expense from Non-Preferred Providers will be paid as outlined below in the section titled “Benefit for Covered Expense Provided by a Non-Preferred Provider.”

Benefit for Covered Expense Provided by a Non-Preferred Provider

Before the Plan pays any benefits for services by a Non-Preferred Provider, Covered Expenses equal to the Non-Preferred Provider Deductible must be incurred in a Calendar Year. The Plan will then pay benefits for Covered Expenses provided by the Non-Preferred Provider that are in excess of the Non-Preferred Provider Deductible for the remainder of the Calendar Year. These benefits will be paid at the Non-Preferred Provider Coinsurance percentage shown on the Schedule of Medical Benefits. If the amount of Covered Expenses the participant pays for Non-Preferred Provider Deductible and Coinsurance and Non-Preferred Provider Access Fees during a Calendar Year equals the Non-Preferred Provider Out-of-Pocket Maximum, the plan will then pay Covered Expenses for these services at 100% for the remainder of the Calendar Year.

If there is no Preferred Provider of the required specialty, the Plan will consider Covered Expenses by the Non-Preferred Provider to be considered as if services were provided by a Preferred Provider. Use of a Non-Preferred Provider due to convenience, physician preference or patient/family preference does not qualify for extension of Preferred Provider coverage. All Covered Expenses from other providers resulting from use of a Non-Preferred Provider under this provision will be considered Non-Preferred Provider unless there are no Preferred Providers available for use by the Non-Preferred Provider. Consideration of covering Non-Preferred Provider services as Preferred Provider must be Preapproved as required by the Plan.

Use of Non-Preferred Providers

When You use a Non-Preferred Provider:

- The amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and
- You may be expected to pay a larger portion of the bill, even after the Plan has paid the percentage of eligible expense provided under the Plan.

Benefits Payable for Covered Expense

Covered Expense means the medically necessary, Regular, Reasonable & Customary charges for medical services and supplies that are incurred:

- By a Participant while this Plan is in force;
- Before coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a Covered Expense under this Plan, the Plan may take into consideration:

- The definitions, provisions, limitations, and exclusions in the Plan, including the Schedule of Benefits, attachments and amendments;

- Any clinical coverage guidelines or medical coverage policies as posted on the Third Party Administrator's website;
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations that review the medical effectiveness of health care services and technology;
- If proper Preapproval, Case Management Prior Authorization or Precertification has occurred as outlined in the Plan or Schedule of Benefits.
- By a Hospital for:
    - Semiprivate room and board;
    - Care in the Intensive Care Unit;
    - Hospital services and supplies which are to be used while in the hospital;
    - Emergency Services in a hospital emergency room;
    - Outpatient medical care and treatment.
- For outpatient surgery performed in a licensed ambulatory surgical facility;
- By a physician for:
    - Office visits;
    - Hospital care;
    - Surgical services, including postoperative care following inpatient or outpatient surgery; for multiple surgical procedures performed during the same operative session, Covered Expense will include 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
    - Services of an assistant surgeon when medically necessary to perform the surgery, but no more than 20% of the primary provider's allowable fee;
    - Injections and medication that must be consumed at the physician's office when Preapproval is obtained, as required by this Plan and outlined in the Schedule of Benefits except for items excluded under Medical Benefit Limitations & Exclusions;
    - An additional surgical opinion following recommendation for elective surgery limited to one consultation and related diagnostic services by a physician (if You request, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first arranged consultation);
    - Oral Surgery, as defined herein, including anesthesia and related charges;
    - Dental Services rendered by a Dentist or physician which are required as a result of accidental injury to the jaws, teeth, mouth, or face;
    - Professional pathology laboratory services which are required to physically analyze a specimen and make a diagnosis, including laboratory tests which do not require the physician to make a personal interpretation as in the case of automated clinical pathology tests;
    - Designated telemedicine provider Virtual Care visits.
- For other services and supplies for:
    - Medically Necessary local ground ambulance transportation to the nearest Preferred Provider Hospital able to provide the care;
    - Medically Necessary air ambulance transportation to the nearest Preferred Provider Hospital able to provide the care;
    - Anesthesia and its administration;

- X-rays;
- High tech diagnostics services such as MRI, MRA, CT, and PET scanning procedures;
- Radiation therapy, Case Management Prior Authorization is required;
- Chemotherapy, or similar treatment, provided in the office, hospital, or the home, but the Covered Expense for chemotherapy provided through a hospital or physician's office will not exceed the Regular, Reasonable & Customary fees for home chemotherapy when Case Management Prior Authorization is obtained as required by the Plan;
- Wigs or hair prosthesis (Limited to $100 per Participant per lifetime), when required due to hair loss resulting from chemotherapy and/or radiation therapy;
- Laboratory tests;
- Blood, blood plasma, and its administration;
- Ostomy supplies when Preapproval is obtained as required by the Plan;
- Allergens dispensed by a physician;
- Durable Medical Equipment for the purchase or rental when Preapproval is obtained as required by the Plan;
- Outpatient diabetes self–management training, education and medical nutrition therapy if these services are rendered by a physician, or duly certified, registered or licensed health care professional with expertise in diabetes management;
- Insulin Pumps when Preapproval is obtained as required by the Plan;
- Initial purchase of artificial eyes and larynx when Preapproval is obtained as required by the Plan;
- Crutches;
- Orthopedic braces when Preapproval is obtained, as required by the Plan except for items excluded under Medical Benefit Limitations & Exclusions;
- Custom foot orthotics when Preapproval is obtained as required by the Plan except for items excluded under Medical Benefit Limitations & Exclusions up to a maximum allowable of $200 per Calendar Year;
- The standard prosthetic limb that meets Your needs as determined by the Plan; Initial purchase, fitting and adjusting of the limb; repair, refitting and/or replacement of a prosthetic limb as long as it has been properly maintained and not subjected to abuse or misuse, and when not covered by product warranty when Preapproval is obtained as required by the Plan;
- The purchase of one pair of the following while covered:
  - One pair of orthopedic shoes;
  - One support stocking for each leg;
  - One article of similar apparel- type item;

- For Home Health Care visits when Case Management Prior Authorization is obtained as required by the Plan, not to exceed:
  - The number of visits shown on the Schedule of Benefits during one Calendar Year; and
  - The cost for such care in an inpatient facility;
- For care in a licensed Skilled Nursing Facility when Case Management Prior Authorization is obtained as required by the Plan, but not for longer than the number of days shown on the Schedule of Benefits during one Calendar Year;

- For Hospice Care when Case Management Prior Authorization is obtained, as required by the Plan;
- For expense incurred for outpatient physical therapy, outpatient occupational therapy and only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time when Preapproval is obtained, as shown on the Schedule of Benefits and as required by the Plan;
- For expense incurred for outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness will be considered Covered Expense when Preapproval is obtained, as shown on the Schedule of Benefits and as required by the Plan;
- For expense incurred for inpatient stay in an inpatient rehabilitation facility, but only when the patient is able to participate in intensive therapy and treatment of at least 3 hours per day, and there is documented measureable improvement occurring as a result of the therapy, treatment, and stay when Precertification is obtained, as required by the Plan;
- For expense incurred for visits for Phase I and Phase II outpatient cardiac rehabilitation services if a Participant has a history of any of the following: acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, heart valve surgery, heart transplantation, stable angina pectoris, compensated heart failure or trans myocardial revascularization, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. Benefits are limited to the number of visits shown on the Schedule of Benefits during a six month period and must be performed at a Preferred Provider;
- For expense incurred for visits for outpatient pulmonary rehabilitation, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time;
- For expenses incurred for manipulative therapy (Osteopathic, Chiropractic, Naprapathic Services) See Schedule of Benefits;
- Injections for contraceptive purposes, including Depo-Provera and Norplant;
- Contraceptive devices which require a written prescription before dispensing;
- Elective sterilization surgery;
- Medically Necessary expense incurred for Maternity Services;
- Medically Necessary expense incurred for a well or ill newborn, but only if Dependent coverage has been added for the newborn within 30 days following the newborn's birth;
- Medically Necessary expense incurred for the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and Substance Use Disorder, including:
    - Medically Necessary individual outpatient mental health or rehabilitation care visits to qualified physicians, licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services, Precertification is recommended by the Plan (Provider office visits do not require precertification);
    - Medically Necessary inpatient mental health or rehabilitation care at an inpatient facility, Residential Treatment Center or Hospital when Precertification is obtained, as required by the Plan;
    - Partial Hospitalization, Precertification is recommended by the Plan;
    - Intensive Outpatient Treatment (day treatment), Precertification is recommended by the Plan;
    - Opiate replacement therapy and psychotherapy, Precertification is recommended by the Plan;

  - Nursing services provided in the home, Precertification is recommended by the Plan;
  - Detoxification (sub-acute/non-medical);
  - Diagnosis, detoxification and treatment of the medical complications of the use of or addiction to alcohol or drugs on either an inpatient basis, Precertification is required, or outpatient basis, Precertification is recommended by the Plan;
- For Approved Clinical Trials Covered Expenses includes routine patient costs incurred by a Qualified Individual who participates in an Approved Clinical Trial. A Qualified Individual who wishes to participate in an Approved Clinical Trial must obtain Case Management Prior Authorization and use a Preferred Provider if a Preferred Provider is participating in the trial and the Preferred Provider accepts the Qualified Individual as a participant in the trial. However, if the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by a Non-Preferred Provider or there is no Preferred Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then routine patient costs will be covered as if provided by a Preferred Provider and subject to Regular, Reasonable & Customary when Case Management Prior Authorization is obtained, as required by the Plan;
- The treatment of injuries to whole natural teeth. The treatment must be performed during the first 12 months after the date of injury;
- Treatment of congenital defects and birth abnormalities, including cleft palate or cleft lip, for a child;
- Hearing examinations, but only to test or treat hearing loss related to illness or injury;
- Bone anchored Hearing aids, osseointegrated auditory implants, when Preapproval is obtained, as required by the Plan;
- Examination and testing of sexual criminal assault victim (services covered with no cost share);
- Diagnosis and Treatment of Autism Spectrum Disorder(s) including the following care when prescribed, provided or ordered for an Participant diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:
  - Psychiatric care, including diagnostic services;
  - Psychological assessments and treatments;

  Preapproval is recommended by the Plan;
- Habilitative services for Participants under age 19 years of age with a congenital, genetic, or early acquired disorder if all of the following conditions are met:
  - A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder;
  - Treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, optometrist, licensed nutritionist, clinical social worker, or Psychologist upon the referral of a Physician; and
  - Treatment must be Medically Necessary and therapeutic and not Experimental/Investigational;

  Preapproval is recommended by the Plan;
- Non-experimental, Medically Necessary surgical treatment of Morbid Obesity when bariatric surgery is performed for the treatment of Morbid Obesity. Bariatric surgery

is Medically Necessary for Morbid Obesity when ALL of the following medical criteria are met:

- Completion of a comprehensive multidisciplinary bariatric evaluation proximate to surgery which would include:
  - Physical exam with surgical history with discussion of the specific procedure to be performed; and
  - Clinically appropriate lab data with diagnostics; and
  - Nutritional consultation with counseling/education, which includes a reduced calorie diet program supervised by a dietician or nutritionist; and
  - Mental health evaluation and clearance;

  A physician's summary letter is not sufficient documentation. Documentation must include medical records documenting compliance with the physician's plan of care and the patient's progress throughout the course of treatment including medical documentation supporting body mass index (BMI) and comorbidities;
- The Participant is over the age of 21 or if the Participant is under 21 and
  - Two (2) authorized physicians determine that the surgery is necessary to:
    - Save the life of the Participant; or
    - Restore the Participant's ability to maintain a major life activity; and
    - Each physician must document in the Participant's medical record the reason for the physician's determination;

Bariatric surgery requires Preapproval. See the Third Party Administrator website to obtain a list of covered bariatric surgeries and current clinical coverage guidelines or medical coverage policies;

- Genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:
  - the insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.);
  - the outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational;
- Inpatient treatment following a covered mastectomy for the length of time determined to be appropriate by the attending physician;
- A Physician office visit or in-home nurse visit within 48 hours of discharge from the hospital following a covered mastectomy;
- One breast prosthesis per breast or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance; replacement breast prosthesis once every two years;
- Three post-mastectomy surgical bras every six months, limited to the standard model;
- For treatment of physical complications of a mastectomy, including lymphedema;
- Breast reduction surgery when performed in conjunction with reconstructive surgery following a mastectomy;
- Breast reduction surgery that is preapproved and where the Plan determines it to be Medically Necessary:
  - Medical Necessity at minimum will require ALL of the following to be met:

- Patient is over the age of 18;
- At least 2 of the areas listed below are documented as directly attributed to macromasia and have affected daily activities for at least 1 year:
    - Headaches
    - Pain in neck
    - Pain in shoulders
    - Pain in upper back
    - Pain, ulceration and grooving of the shoulder caused by bra straps
    - Severe soft tissue infection from overlying breast tissue;
- Minimum of a 3 months trial of conservative treatments such as:
    - Use of muscle relaxants and/or analgesic/NSAIDs
    - Physical therapy, Chiropractic care and/or exercising
    - Use of proper bra support such as wide strap bars
    - Medically supervised weight loss program
    - Medical evaluation of spinal pain;
- Physical exam documenting breast hypertrophy;

Proposed surgery that removes less than 1 kg may require additional supporting documentation for Medical Necessity to be considered;

- Obstructive sleep apnea diagnosis treatments including custom made oral and dental splints and appliances for the treatment of documented obstructive sleep apnea. See Schedule of Benefits, CPAP or similar machines and oral and dental splints and appliances require Preapproval. Sleep studies require Case Management Prior Authorization;
- Temporomandibular Joint Dysfunction (TMJ) including custom made oral and dental splints and appliances for the treatment of documented TMJ. Benefits are limited to the amount shown on the Schedule of Benefits. Oral and dental splints and appliances require Preapproval;
- Oral and dental splints and appliances for teeth grinding. Benefits are limited to the amount shown on the Schedule of Benefits. Oral and dental splints and appliances require Preapproval;
- Infertility Treatment
    - Initial diagnosis of Infertility and/or Infertility Treatment when Preapproval is obtained as required by the Plan;
    - Diagnostic testing including but not limited to In-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection;

Benefits for treatments that include oocyte retrievals will be provided only when You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate Infertility Treatments; however, this requirement will be waived if You or Your partner has a medical condition that makes such treatment useless.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to You. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals and the subsequent procedure to transfer the oocytes or sperm that are eligible for coverage under this Plan in Your lifetime is three. Following the third completed oocyte retrieval and transfer, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to You. Thereafter, You will have no benefits for Infertility Treatment.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

- Medically Necessary expense incurred for an organ or bone marrow transplant, but only when performed at a facility designated as a Transplant Center of Excellence facility, and Preapproval is obtained, as required by the Plan.
  Transplant Benefits including Preapproved organ transplants according to the following schedule:
  - Transplant Center of Excellence Facility
    - 100% of Approved Transplant Services after the Preferred Provider Deductible has been met;
    - Organ Procurement and acquisition covered in full;
    - Travel/Lodging Benefit outlined below.
  - Non - Transplant Center of Excellence Facility
    - 90% of the Covered Expense in excess of the Non-Preferred Provider deductible for hospital charges, physician charges, tissue typing and other ancillary services related to the organ transplant. Once the Participant has paid 10% of $100,000 of Covered Expense for the transplant services listed above, then there is no coverage thereafter under the Plan for the transplant;
    - No coverage for organ procurement and acquisition;
    - No coverage for transportation and lodging.
  - Travel/Lodging Benefit for Transplants performed at Center of Excellence Facility.
    - When a covered organ transplant is performed at a Transplant Center of Excellence facility, the Plan will provide:
      - Transportation for the Participant patient and one member of the Participant patient's immediate family to accompany the Participant patient to and from the Transplant Center of Excellence; and
      - Lodging at or near the Transplant Center of Excellence for the family member who accompanied the Participant patient, while the Participant is confined at the Transplant Center of Excellence.

    The Plan will authorize the transportation and lodging at no cost to the Participant patient, except that the daily maximum benefit the Plan will pay for food and lodging for the family member who accompanied the Participant is $200 with a total maximum of $10,000. The Plan Administrator must be provided with itemized bills for all transportation, food and lodging expenses.

PRESCRIPTION BENEFIT

The prescription benefit under this Plan provides benefits for Covered Expense incurred for drugs which require a written prescription, and which are dispensed by a licensed pharmacist. The program also provides benefits for expense for insulin, syringes for administration of insulin and glucagon emergency kits, when prescribed by a Physician and dispensed by a licensed pharmacist.

This prescription drug card benefit is administered by the prescription drug card company, hereafter referred to as the Pharmacy Benefit Manager.

Amount of Benefit

The Participant must pay a drug Copay amount each time a prescription is ordered. The amount of the Copay will vary by the type of medication purchased, and the place of purchase.

Allowable Covered Prescription Expense

A prescription drug order is a request for each separate prescription drug and/or each authorized refill, if ordered by a Physician.

Expense incurred for a prescription drug order for the following items will be considered allowable covered prescription expense:

- Injectable and non-injectable legend drug;
- Insulin and epipens on prescription;
- Disposable insulin needles/syringes;
- Test strips for glucose monitors;
- Lancets for diabetic blood monitoring and other supplies for testing and monitoring diabetes;
- Glucagon emergency kits;
- Tretinoin, all dosage forms (Retin-A), when Medically Necessary;
- ADD/ADHD medications when Medically Necessary (PBM prior authorization may be required);
- Oral contraceptives and female contraceptive devices;
- Medications ordered in conjunction with a covered Infertility Treatment plan as defined in Amount of Benefit for Covered Expense, Infertility;
- Evidenced-based preventative oral medications that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (at no Cost-Share);
- Erectile dysfunction medications but limited to 6 pills per month;
- Any medication containing nicotine or other smoking deterrent medications as required by law;
- Compound medications if at least one ingredient is a legend drug;
- Any other oral drug which, under the applicable state laws, may be only dispensed upon a written prescription of a Physician or other lawful prescriber.

How to File a Claim

To file a prescription claim at a retail pharmacy, a Participant should present the prescription

drug card to the participating pharmacy. The pharmacist will use the information on Your card to electronically file a claim with the Pharmacy Benefit Manager.

To file a claim under the Mail Service Program, a Participant must submit the original prescription and the necessary forms to the Pharmacy Benefit Manager Mail Service Program. The necessary forms and instruction brochures can be obtained from the Third Party Administrator website, www.groupplansolutions.com or by calling the Third Party Administrator.

Prescriptions Purchased at a Retail Pharmacy

Up to a 90 day supply of prescription medication can be obtained from a retail pharmacy. Specialty drugs and opioids may not be purchased in quantities larger than a 30 day supply. You must pay the applicable Retail Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Medical Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Expense at 100%. The retail Copay tiers are outlined in the Schedule of Medical Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The “generic prescription Copay amount” must be paid anytime You purchase a generic medication;
- The “preferred brand prescription Copay amount” must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The “brand prescription Copay amount” must be paid anytime You purchase a brand medication that is not on the “preferred brand medication list” and for which an equivalent generic drug is not available;
- The “specialty prescription Copay amount” must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list.

When purchasing a qualified medication, You must pay the applicable Retail Prescription Copay according to the schedule below:

- 1 copayment for a 1 - 30 day supply;
- 2 copayments for a 31 - 60 day supply;
- 3 copayments for a 61 - 90 day supply.

The Plan will not allow more than the price the Plan has negotiated with the Pharmacy Benefit Manager for a prescription, less the prescription Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

Prescriptions Purchased From the Mail Service Program

Up to a 90 day supply of medication can be obtained from mail service program. Specialty drugs and opioids may not be purchased in quantities larger than a 30 day supply. You must pay the applicable Mail Order Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Medical Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Expense at 100%. The Copay will vary based on if the drug is Generic, Brand, Preferred Brand or Specialty. The mail order

Copay tiers are outlined in the Schedule of Medical Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The “generic mail order prescription Copay amount” must be paid anytime You purchase a generic medication;
- The “preferred brand mail order prescription Copay amount” must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The “brand prescription mail order Copay amount” must be paid anytime You purchase a brand medication that is not on the “preferred brand medication list” and for which an equivalent generic drug is not available;
- The “specialty mail order prescription Copay amount” must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list

The Plan will not pay more than the price the Plan has negotiated with the Pharmacy Benefit Manager, less the mail order Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

Prescription Drug Card Limitations and Exclusions

A prescription drug order does not include and no benefit will be payable for the following, regardless of the reason for which prescribed:

- The amount of expense for a medication that is in excess of the amount agreed upon between the Pharmacy Benefit Manager and the Plan Administrator;
- The difference between the cost of a Brand name drug and an equivalent generic drug, if the generic drug has been designated an equivalent generic drug by the Pharmacy Benefit Manager;
- For duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (a prescription (other than opioids) purchased at retail pharmacy cannot be refilled until the patient has used 75% of the medication as prescribed; a prescription (other than opioids) purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed; a prescription for opioids purchased at retail pharmacy cannot be refilled until the patient has used 80% of the medication as prescribed; or a prescription for opioids purchased at mail order cannot be refilled until the patient has used 80% of the medication as prescribed);
- Prescriptions not purchased from a Preferred Provider (in-network) pharmacy as determined by the Pharmacy Benefit Manager;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Drugs dispensed by a physician;
- Fluoride supplements;

- Hematinics;
- Immunization agents, refer to Amount of Benefit for Covered Expense; Preventative Care;
- Biological sera, refer to Amount of Benefit for Covered Expense;
- Blood or blood plasma;
- Minerals;
- Minoxidil (Rogaine) or other similar medications for the treatment of alopecia;
- Anorexiants (any drugs used for purposes of weight control);
- Non-legend drugs, other than insulin;
- Vitamins, singly or in combination, except for legend prenatal vitamins and folic acid;
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed under Allowable Covered Prescription Expense;
- Charges for the administration or injection of any drug;
- Prescriptions which an eligible person is entitled to receive without charge under any Worker's Compensation law;
- Drugs labeled "Caution-limited by federal laws to investigational use", or experimental/investigational drugs, even though a charge is made to the individual Except as outlined in Amount of Benefit for Covered Expense, Clinical Trials;
- Any charge for a prescription drug when the drug does not meet the step therapy requirements of the Pharmacy Benefit Manager;
- Any charge for more than a 90 day supply of a prescription drug at a retail pharmacy;
- Any charge for more than a 90 day supply of a prescription drug at the mail order pharmacy;
- Any charge for a prescription drug dosage that exceeds the Pharmacy Benefit Manager's optimum dosage limits;
- For prescriptions refilled in excess of the number ordered by the physician;
- For prescriptions refilled after one year from the physician's original order;
- For prescriptions to replace lost or damaged prescriptions;
- For prescriptions for the treatment of Infertility or in vitro fertilization except as outlined in Amount of Benefit for Covered Expense, Infertility;
- Drugs used primarily for cosmetic purposes, regardless of intended use;
- Any charge for a prescription drug that does not meet preauthorization requirements established by the Pharmacy Benefit Manager. The Plan can allow a one-month fill for a prescription drug that a Participant has been taking continuously in the past;
- Convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container;
- Drugs abused or otherwise misused by a Participant;
- Most prescription and non-prescription nutritional and dietary supplements are not Covered Expenses under this benefit.

MEDICAL BENEFIT LIMITATIONS & EXCLUSIONS

The following exclusions apply to the Medical Benefit section of this plan.

The Medical Benefit section of this plan does not cover loss caused by:

- Claims arising out of, caused by or contributed to war declared or undeclared, civil war, hostilities or invasion;
- Service in the armed forces;
- Complications arising from excluded treatment;
- Commission of a felony or illegal activities. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

This Plan does not pay any benefit for expense for:

- Services that aren't medically necessary;
- Services for which no benefit is defined or described in this Plan;
- Incidental appendectomies;
- Treatment of educational, training problems, or learning disorders, marital counseling, or social counseling, except as outlined in the Amount of Benefit for Covered Expense;
- Services provided by an employee of a school district, or a person contracted to provide services for a school district, or services available through a school system;
- Any experimental/investigational service, supply, or treatment;
- The use of any services or facilities of a federal, Veteran's administration, state, county or municipal hospital, except where the Plan or the Participant are legally required to pay the expenses;
- Treatment of an injury or illness caused by or resulting from an illness or injury of the Participant, if the illness or injury is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability laws, occupational disease law, or any similar law of a state or federal government, or other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the Participant made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim, but the Participant is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under this Plan until the Participant certifies the Participant no longer intends to pursue coverage through th2e worker's compensation type coverage;
- Bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription;
- Hearing aids except as outlined in Amount of Benefit for Covered Expense;
- Contact lenses, Eye glasses, Eye examinations for the correction of vision or fitting of glasses or contact lenses; Vision therapy or orthoptics treatment (eye exercises);
- Any dental treatment, dentures, dental surgery, or extractions, except as outlined in Amount of Benefit for Covered Expense;
- Any orthodontic procedure or appliance except as outlined in Amount of Benefit for Covered Expense;
- Any service or supply not recommended or approved by a licensed medical practitioner;

- Any treatment or surgery that results in the improvement of appearance, except for that which is the result of breast reconstruction following a mastectomy or when determined Medically Necessary, or treatment of congenital defects and birth abnormalities, including cleft lip or cleft palate repair, or which is the result of an injury. The treatment must be performed during the first 12 months after the date of injury;
- Services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under the section titled “Preventive Care”;
- Immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under the section titled “Preventive Care”;
- Abortions, except where the mother’s life is threatened;
- Amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy;
- Reversal of sterilization procedures;
- Nonmedical services and supplies;
- Durable Medical Equipment unless the purchase or rental of the equipment has been Preapproved as required by the Plan.
- Any service or supply that the Participant is not legally required to pay for, including any forgiveness of Deductible, Coinsurance, Copay, or Access Fee by a provider or any write off of an outstanding balance by a provider;
- Any surgery for the correction of a refractive error;
- Treatment received in an emergency room of a hospital except when Emergency Services are being rendered;
- The replacement of a piece of Durable Medical Equipment or a prosthesis unless Preapproved as required by the Plan;
- Custodial care;
- Services furnished by the Covered Employee or a member of the Covered Employee’s or the Covered Employee’s Spouse’s immediate family, or by a person who regularly lives in the Covered Employee’s home;
- Any medical treatment, weight reduction program, membership dues, or clinic fees for the treatment of obesity or morbid obesity, except where required by law or allowed for under the Amount of Benefit for Covered Expense;
- Any surgical procedure to remove excess tissue caused by weight loss;
- Nutritional supplements;
- Treatment related to the restoration of fertility or promotion of conception including in vitro fertilization except as outlined in Amount of Benefit for Covered Expense;
- Animal to human organ transplants;
- Replacement of human organs by artificial or mechanical devices;
- Treatment of caffeine, gambling, computer or similar addictions;
- Services provided by a midwife, except where specifically licensed by the state to practice midwifery;
- By a registered nurse (RN) for private duty professional nursing services;
- Sclerotherapy for varicose veins;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities;
- Medical or surgical treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, expect for direct treatment of acute traumatic injury or cancer except as provided in the Amount of Benefit for Covered Expense;
- Wigs or hair prosthesis; except as provided in the Amount of Benefit for Covered Expense;

- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered when Preapproval has been obtained as required by the Plan;
- Shoe inserts;
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs;
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy services if an expectation for practical improvement in the level of functioning within a reasonable period of time does not exist. Any charge for therapy where the same equipment could be utilized at a health club or gym;
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy when the service being provided is supervised exercise, or when the service being provided does not require a license to be performed;
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure treatment;
- Ambulance usage when another type of transportation or another level of ambulance service could have been used without endangering the patient's health;
- Any charge that does not meet the definition of Regular, Reasonable & Customary for an otherwise Covered Expense;
- Any charge for a service that exceeds the maximum allowable amount;
- Care required while incarcerated in a federal, state or local penal institution or while in custody of federal, state, or local law enforcement authorities, unless otherwise required by law or regulation;
- Court ordered testing or care unless medically necessary or unless otherwise required by law or regulation;
- Surrogate parenting;
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy or when Medically Necessary;
- Treatment performed outside the United States, except when an emergency;
- Removal of breast implants that were implanted solely for cosmetic reasons;
- Growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Participant's condition;
- Removal and/or replacement of a defective or recalled implant or device, or expense incurred as a result of medical malpractice;
- Expense that exceeds any maximum allowable amount;
- Self-injected prescription medications, except as may be provided under the Prescription Medication Benefit;
- Any oral medication intended to be self-administered except as may be provided under the Prescription Medication Benefit;
- Over the counter medications except as may be provided under the Prescription Medication Benefit;
- Expenses for complications arising from an expense not covered by the Plan;
- Injuries associated with or resulting from act of chewing except as outlined in Amount of Benefit for Covered Expense;

- Maxillary or mandibular tooth implants (osseointegration);
- Certain disorders related to early childhood, such as academic underachievement disorder;
- Communication disorders, such as stuttering and stammering;
- Sexual identification or gender disorders;
- Sexual transformation procedures, treatments, or studies;
- Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from You will be covered if You choose to use a surrogate;
- Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term;
- Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance;
- Non-medical costs of an egg or sperm donor;
- Travel costs for travel within 100 miles of Your home or travel costs not Medically Necessary or required by the Claim Administrator;
- Infertility Treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists;
- Infertility Treatment rendered to Your Dependents under age 18;
- A Never Event;
- Any treatment that does not meet the clinical coverage guidelines or medical coverage policies as posted on the Third Party Administrator's website;
- Third Party Recovery, Subrogation, and/or Reimbursement of an Injury or Sickness not payable by virtue of the Plan's third party recovery, subrogation, and/or reimbursement provisions.

PRECERTIFICATION OF SERVICES

This Plan includes a utilization review program. The purpose of this program is to:

- Promote the efficient utilization of quality health care services;
- Assure the patient and payer that health care benefits are used for quality, medically necessary services;
- Assure that all services are provided in the most cost effective, appropriate setting; and
- Minimize the risk of retrospective payment denials.

Services Requiring Precertification by Utilization Review

You must call the applicable Precertification number if:

- You are being admitted as an inpatient to a Hospital or Residential Treatment Center, including overnight observation or inpatient Physical Therapy, Speech Therapy, or Occupational Therapy;
- You are being admitted as an inpatient to a hospital for Childbirth/Delivery and Your inpatient stay exceeds:
    - 48 hours following a vaginal delivery (not including the day of delivery); or
    - 96 hours following a cesarean birth (not including the day of delivery).

Services Recommended for Precertification by Utilization Review

It is recommended that You call the Precertification number if You are going to receive any of the following medically necessary services for the treatment of mental health and Substance Use Disorders:

- Day treatment, intensive outpatient services, partial hospitalization services:
- Opiate replacement therapy and psychotherapy and nursing services provided in the home;
- Care for the diagnosis and treatment of Autism Spectrum Disorder(s).

Provider office visits do not require Precertification.

Non-Emergency Hospitalization and Inpatient Treatment

You must call the applicable Precertification number listed in the General Plan Information section at least 3 business days before You are scheduled for a non-emergency inpatient admission to a Hospital, Residential Treatment Center or other facility, inpatient surgery, or inpatient physical, speech or occupational therapy.

Medical Emergency

You must call the applicable Precertification number listed in the General Plan Information section of this Plan within 2 business days (or as soon as reasonably possible if Your condition prevents You from calling within that time frame) after Your emergency inpatient admission.

Making the Call

You can make the phone call, or You can have a relative or Your Physician make the phone call. You are responsible for making sure that someone calls the applicable Precertification, Case Management Prior Authorization or Preapproval number, for either a Medical Condition or a Mental Health and Substance Use Disorder condition, on a timely basis. These numbers can be found in the General Plan Information section of the Plan.

When the call is made, the following information should be available:

- the patient's name, date of birth, sex, and the member number and plan name;
- the proposed (or actual) date and reason for admission, surgery, treatment or scanning procedure;
- the name and phone number for the Hospital, Residential Treatment Center and ordering physician.

Precertification Process

When a call is made to the Medical Condition or Mental Health and Substance Use Disorder Conditions Precertification telephone numbers found in the General Plan Information section, the caller will be given a Precertification number. A review determination will be made to verify Medical Necessity and appropriateness only.

The Precertification process does not confirm that a provider is a Preferred Provider. It does not guarantee benefits for a service. If a Participant wants to know if a service approved by Precertification will be covered under the plan, or if a provider is a Preferred Provider, they must call the phone number for Group Plan Solutions found in the General Plan Information section of the Plan.

Medical Necessity and Appropriateness

No benefit will be payable for any hospitalization or Medical Condition or Mental Health and Substance Use Disorder Conditions treatment listed above if it is not approved as Medically Necessary and appropriate by the reviewer.

Right to Appeal

You or Your physician may, at any time, initiate a request for reevaluation or extension of a reviewer's decision by calling the applicable Precertification or Case Management Prior Authorization number. You may also file an appeal with the Third Party Administrator.

Failure to Precertify

If the Participant fails to Precertify any service requiring Precertification, the Participant will be responsible for a penalty equal to the first $500 of the total Covered Expense for services received but in no event will the penalty exceed 50% of the total charges. The Precertification penalty does not apply to Participants that Medicare pays primary including ESRD. The Participant will also be responsible for any non-covered, medically unnecessary expenses resulting from the non-certified stay.

It is the responsibility of the Participant to ensure Precertification has been obtained.

CASE MANAGEMENT PRIOR AUTHORIZATION / PREAPPROVAL

The Plan requires that certain services have Preapproval or Case Management Prior Authorization. Before obtaining these services, You must receive Preapproval or Case Management Prior Authorization from the Plan. The phone numbers to call are listed in the General Information section.

Services requiring Preapproval are:

- Injectable medications (except for insulin and its administration) administered in a physician's office;
- Insulin Pumps;
- Customized orthotics including foot orthotics, purchase, refitting, or replacement of orthotics;
- Prosthetic devices; including but not limited to artificial eyes, limbs, larynx;
- Durable Medical Equipment;
- Cranial Molding Helmets;
- Ostomy supplies;
- CPAP or similar machines; oxygen equipment;
- Most covered medical supplies;
- Outpatient Speech therapy;
- Outpatient Occupational therapy visits in excess of 20 visits per Calendar Year;
- Outpatient Physical therapy visits in excess of 20 visits per Calendar Year;
- Genetic Testing;
- Infertility Treatment;
- Bariatric Surgery;
- Habilitative Services;
- Organ Transplants;
- Bone anchored hearing aids;
- Oral or dental splints and appliances.

Services requiring Case Management Prior Authorization are:

- Home Health Care;
- Infusions whether taken at home or administered in a physician's office;
- Hospice Care;
- Clinical Trials;
- Skilled Nursing stays;
- Radiation Therapy;
- Chemotherapy;
- Sleep Studies;
- Dialysis.

Not all services above may be covered under the Plan. Refer to the Schedule of Benefits, Amount of Benefit for Covered Expense section and Medical Benefit Limitations & Exclusions section.

If a Participant is faced with a serious illness or long-term health concern, the Plan utilizes case management service to provide assistance to manage the person's healthcare benefits more effectively.

Upon the advice of a case management professional, the Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of care for the patient.

DENTAL BENEFITS

The Plan's payment of Dental Benefits is subject to all definitions, provisions, limitations, and exclusions contained in this Plan. Dental Benefits will be payable only for Covered Dental Expenses. Benefit payments for a Participant in a Calendar Year will not exceed the Maximum Benefit Amount shown in the Schedule of Dental Benefits and described in the Dental Limitations & Exclusions provision. Basic and Major Dental Services will not be paid until the Calendar Year Deductible has been met.

AMOUNT OF BENEFIT FOR COVERED DENTAL EXPENSES

The following services will be considered Covered Dental Expenses:

Preventative Dental Services

The Plan will pay 100% of Covered Dental Expense for Preventive Dental Services.

The following are considered to be Covered Dental Expense for Preventative Dental Services:

- Office visits and examinations
  - Up to 2 periodic oral exams for each Participant in a Calendar Year;
  - Emergency treatment to relieve dental pain or other non-routine, unscheduled visits, but only if no other service, except X-rays, is rendered during the visit.
- X-rays
  - Up to 4 bitewing X-ray films in a Calendar Year;
  - One set of full mouth X-rays, including bitewings, or Panoramic film - maxilla and mandible, but only one set per Participant in any 3 Calendar Years;
  - Other intraoral periapical or occlusal films – single films;
  - Extraoral superior or inferior maxillary film;
  - Panoramic film, maxilla and mandible, but only one per Participant in any 3 Calendar Years.
- Dental prophylaxis and fluoride treatments
  - Up to 2 routine prophylaxis per Participant in a Calendar Year;
  - Up to 2 fluoride treatments in a Calendar Year, but only for Participants under the age of 19.
- Topical application of a sealant on an unrestored permanent molar, but only for a Participant less than 16 years of age, and limited to one treatment per tooth in any 36 consecutive months.
- Space Management for a Participant under the age of 16 and limited to initial appliance only (includes all adjustments within 6 months after installation)
  - Fixed, unilateral, band or stainless steel crown type;
  - Removable, bilateral type.
- Fixed and removable appliances to inhibit thumb sucking
  - Only for an Participant under the age of 14;
  - Limited to the initial appliance only (includes all adjustments in the first 6 months after installation).

Basic Dental Services

The Plan will pay 80% of Covered Dental Expense for Basic Dental Services after the Calendar Year Deductible has been met.

The following are considered to be Covered Dental Expense for Basic Dental Services:

- Office visits and examinations for diagnostic consultation with a dentist other than the one providing treatment
    - Limited to one consultation for each dental specialty in any Calendar Year;
    - Only if no other service is rendered during the visit.
- Tests and laboratory examinations
    - Bacteriologic cultures;
    - Caries susceptibility tests;
    - Biopsy and examination of soft oral tissue;
    - Pulp vitality tests;
    - Diagnostic casts.
- Restorative services
    - Amalgam, silicate, or resin-based composite fillings;
    - Stainless steel crowns;
    - Resin crowns, without metal;
    - Pin retention, in addition to restoration;
    - Recementation of inlays, onlays, crowns or bridges.
- Endodontic services – excludes final restoration
    - Pulp capping;
    - Vital pulpotomy;
    - Endodontic therapy of nerve-dead teeth (includes treatment plan, clinical procedures, and follow-up care);
    - Apexification/recalcification;
    - Apicoectomy, as separate procedure or in conjunction with other endodontic procedures;
    - Retrograde filling;
    - Root amputation.
- Periodontic services
    - Gingivectomy or gingivoplasty;
    - Gingival flap procedure including root planning;
    - Sub-gingival curettage and root planning;
    - Mucogingival surgery;
    - Bone replacement graft;
    - Guided tissue regeneration;
    - Osseous surgery, including flap entry and closure;
    - Osseous grafts, including flap entry, closure and donor sites;
    - Provision splitting;
    - Pedicle or free soft tissue grafts, including donor sites;
    - Occlusal adjustment, when done in conjunction with periodontal surgery;
    - Periodontal scaling and root planning.
- Oral surgery
    - Extractions (includes local anesthesia, suturing if needed, and routine postoperative care);
    - Root Recovery;
    - Oral antral fistula closure;

- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
- Surgical access or surgical exposure of an unerupted tooth to aid eruption;
- Mobilization of erupted or malpositioned tooth to aid eruption;
- Biopsy of oral tissue;
- Surgical repositioning of teeth;
- Alveoloplasty;
- Stomatoplasty;
- Vestibuloplasty;
- Osteoplasty-Removal of:
  - Lateral exostis;
  - Torus palatiunus;
  - Torus mandibularis.
- Removal of cyst or tumor;
- Incision and drainage of abscess;
- Frenectomy;
- Sialolithotomy for removal of salivary calculus;
- Excision of hyperplastic tissue;
- Primary closure of a sinus perforation;
- Suture of soft tissue injury;
- Closure of salivary fistula;
- Dilation of salivary duct;
- Partial ostectomy/sequestrectomy for osteomyelitis or superficial bone abscess;
- Maxillary sinusotomy for removal of tooth fragment or foreign body;
- Surgical excision of soft tissue lesions;
- Surgical excision of intra-osseous lesions;
- Surgical reduction of osseous tuberosity;

- Prosthodontic services
  - Adjustments to existing dentures;
  - Repair complete or partial broken denture;
  - Add tooth to existing denture;
  - Denture rebase or reline if more than 6 months following the placement of the denture;
  - Tissue conditioning if more than 6 months following the placement of the denture;
  - Recement bridge;
  - Repair bridge;
  - Repair crowns;
  - Recement inlay;
  - Add clasp to existing partial denture;
  - Post removal.
- Other services
  - General anesthesia in conjunction with surgical procedures;
  - Antibiotic drug injection;
  - Sedative filling.

Major Dental Services

The Plan will pay 50% of Covered Dental Expense for Major Dental Services after the Calendar Year Deductible has been met.

The following are considered to be Covered Dental Expense for Major Dental Services:

- Restorative services
    - Inlays;
    - Onlays;
    - Crowns and posts:
        - Resin with metal;
        - Porcelain or porcelain with metal;
        - Full cast metal (other than stainless steel);
        - 3/4 cast metal (other than stainless steel);
        - Cast post and core, in addition to crown;
        - Core build-up including any pins;
        - Steel post and composite or amalgam core, in addition to crown;
        - Cast dowel pin;
        - Crown buildup with Pin retention.
- Prosthodontic services
    - Fixed bridge;
    - Bridge abutments;
    - Bridge Pontics;
    - Fixed partial denture;
    - Fixed partial denture retainers;
    - Fixed partial denture pontics;
    - Stress breakers;
    - Dentures (allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation):
        - Complete dentures, upper or lower;
        - Partial dentures.
- Implant services
    - Surgical placement of implant body; endosteal implant;
    - Abutment placement or substitution: endosteal implant;
    - Surgical placement: eposteal implant;
    - Surgical placement: transosteal implant.
- Implant supported prosthetic
- Other implant services
    - General anesthesia in conjunction with surgical procedures;
    - Repair implant supported prosthesis;
    - Repair implant abutment;
    - Implant removal.

Orthodontic Benefit

The Plan will pay for Covered Dental Expenses for Orthodontic Treatment for a Participant for the correction of one or more of the following dental conditions:

- Overbite or overjet of at least four millimeters;
- Maxillary and mandibular arches in either protrusive or retrusive relation of one cusp;
- Crossbite;
- An arch length discrepancy of more than four millimeters in either the upper or lower arch.

Amount of Benefit for Orthodontics

Covered Dental Expense for Orthodontic Treatment will be paid at 50%. The Maximum Benefit Amount that the Plan will pay for covered Orthodontic Treatment is shown on the Schedule of Dental Benefits. The Plan will not pay more than the Maximum Benefit Amount for any one Participant during the entire time he or she is covered under this Plan.

Payment of Benefit for Orthodontics

The Plan's payment of benefit will be made in equal quarterly installments. They will be made over a period of time equal to the estimated length of time of treatment, not to exceed two years. The first installment will be payable on the date the orthodontic appliances are first installed. Payments are then payable at the end of every three months and every three months thereafter.

Orthodontic Exclusions

The same exclusions listed in the Limitations & Exclusions provision apply to this Orthodontic Benefit provision. Additionally, no benefits will be payable under the Orthodontic Benefit for:

- A Participant, if the appliances were first installed prior to the Participant's Effective Date under this Plan. However, if the appliances were installed while the Participant has been continuously covered under the former plan and this Plan since the appliances were installed, then this exclusion will not apply. The Plan will reduce the Maximum Benefit paid by the amount th6at was paid under the former plan for Orthodontic Treatment for that Participant.

If this Coverage Replaces Another Dental Plan

If the Dental Benefits under this Plan are replacing another dental plan sponsored by the Employer, the Dental Benefits under this Plan will pay for Covered Dental Expense to replace teeth that were lost or to complete dental work that was started before the Effective Date if:

- The Participant was covered under the former dental plan and has been continuously covered under the Dental Benefits Section of this Plan since the day they became inactive or the Plan's effective date whichever is earlier; and
- The former dental plan provided benefit for the expense.

The Plan will pay the lessor of:

- What the former Plan would have paid; or
- What this Plan would otherwise pay.

The Plan will deduct any dental benefits paid by the former plan from the dental benefit payment from this Plan. Dental benefits paid by the former plan will be used to calculate the Annual limit for the first year the Participant is in this Plan and to calculate the Lifetime Maximums on the Dental Schedule of Benefits will use benefit payments.

Predetermination of Dental Benefits

If the dental treatment to be performed is expected to exceed $200.00, the expense should be submitted to the Plan for review before the treatment is performed. The Plan will then estimate the Plan's benefit in advance. This will allow both the Participant and the Dentist to have, in advance, an estimate of what will be covered.

DENTAL LIMITATIONS & EXCLUSIONS

Dental Limitations

Benefit payments for a Participant in a Calendar Year will not exceed the Maximum Calendar Year Benefit Amount shown on the Schedule of Dental Benefits. The maximum benefit payable for the Orthodontic Benefit is as described in the Orthodontic Benefit provision. The Maximum Calendar Year Benefit Amount and the maximum benefit for the Orthodontic Benefit are accumulated separately.

Many dental conditions can properly be treated in more than one way. In determining the benefit, the Plan will use the Regular, Reasonable & Customary Fees for the least expensive procedure that produces a professionally acceptable result.

Dental Exclusions

This plan does not cover loss caused by:

- Claims arising out of, caused by or contributed to war declared or undeclared, civil war, hostilities or invasion;
- Service in the armed forces;
- Complications arising from excluded treatment;
- Commission of a felony or illegal activities.

Benefits will not be paid for:

- Any treatment of an Injury or Illness caused by or resulting from an Injury or that is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability law, occupational disease law, or any similar law of a state government, federal government, or any other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the Participant made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim but the Participant is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under this Plan until the Participant certifies the Participant no longer intends to pursue coverage through the worker's compensation type coverage;
- Any service furnished by the Participant or member of the Participant's or the Participant's Spouse's Immediate Family Member, or person who regularly lives in the Participant's home;
- Replacement of lost or stolen appliances;
- Any duplicate prosthetic device or dental appliance;
- Replacement of a damaged appliance, unless damaged while in the Participant's mouth in an Injury which occurred while covered under this Plan;
- Any treatment for damage caused by abrasion or attrition;
- Dietary or nutritional counseling;
- Education or training in personal oral hygiene or dental plaque control;
- Services or supplies which do not meet the accepted standards of dental practice;
- Treatment which is experimental/investigational in nature;
- Any drugs or medicines, except for injections of antibiotics and application of desensitizing medicines by the attending dentist;
- Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide, when charged by dentist on a separate basis from the procedure for which they are used;

- General anesthesia unless Medically Necessary and administered in connection with oral or dental surgery;
- Any services furnished for cosmetic reasons, including but not limited to facings on crowns or pontics on any teeth behind the second bicuspid;
- The replacement of a complete or partial denture within 5 years of the date of the last placement, unless replacement is required because of an Injury or additional extractions are required and the denture cannot be made useable;
- The replacement of any crown, inlay or onlay restoration, or fixed partial denture unless replacement is required because of an Injury;
- Services rendered before the Effective Date or after the Termination Date;
- Services to replace one or more teeth that were lost or services to complete dental work that was started before the Participant's Effective Date, except as provided for under the "If This Plan Replaces Another Plan" provision;
- Any services to replace one or more teeth that were lost before the Effective date, except as provided for under the "If This Plan Replaces Another Plan" provision;
- Any service or supply that is not listed as a Covered Dental Expense.

FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES FOR MEDICAL AND DENTAL BENEFITS

The procedures outlined below must be followed by Participants to obtain payment of medical or dental benefits under this Plan.

CLAIMS

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan Administrator, at their expense, has the right to examine the Covered Individual/Participant when and as often as they may reasonably require while a claim is pending or during any period in which benefits are being paid. In the case of death, the Plan Administrator has the right to have an autopsy performed.

LEGAL ACTIONS

No suit at law or in equity may be brought to recover under the plan:

- any earlier than 60 days after written Proof of Loss has been sent to the Plan as required by the terms of the Plan; or
- any later than three years after the time such proof must be sent.

A call from a Provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all**

Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Participant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.
The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

ASSIGNMENT OF BENEFITS

You may assign the benefits provided by the plan. The Plan is not bound by any assignment unless it is received in written form. The Plan is not responsible for the validity of any assignment. An assignment may limit the interest of the Covered Individual/Participant.

Unless otherwise specified by You, any assignment will take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by the Plan prior to receipt of the written notice of assignment.

PAYMENT OF CLAIMS

Clean Claims will be paid promptly upon receipt of due written Proof of Loss. All claims payable under the terms of the plan shall be paid within 30 days following receipt by the Third Party Administrator of due Proof of Loss.

All accident and health benefits are payable to the Covered Individual, or if You have assigned the benefits, to the assignee. However, The Plan reserves the right to pay benefits directly to the Hospital or other provider of medical services. These payments will satisfy the Plan's responsibility to the extent of the payments.

If any benefit remains payable after the death of the Insured or while he/she is not competent to give a valid release, the Plan may pay a benefit up to $1,000.00 to any relative of his/hers who the Plan decides is justly entitled to it. Any payment made to his/her relatives in good faith will fully release the Plan of responsibility to the extent of the payment.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical

service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

    - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service claims must be filed with the Third Party Administrator within 12 months of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days from receipt by the Participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:

    - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

    - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is

needed as soon as possible, but not later than 72 hours after receipt of the claim.

- The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
  - The Plan's receipt of the specified information; or
  - The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

- Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

  - Notification to Participant 30 days
  - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15- day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

An "Adverse Benefit Determination" means

1. a determination made by the Plan Administrator that based upon the information provided, a request for a benefit does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made for the benefit; or

2. a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

A "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan Administrator at the completion of the internal review/appeal process.

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar

criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

If You Need Assistance

If You have any questions about the claims procedures or the review procedure, call the Third Party Administrator at 1-888-301-0747 or contact:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

If You need assistance with the internal claims and appeals or the external review processes that are described below, You may contact the health insurance consumer assistance office or ombudsman. For questions about appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Requirements for Appeal of Adverse Benefit Determinations

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Covered Individual/Participant;
- The Covered Individual/Participant's member ID# and date of birth;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available

is to contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

If the Plan Administrator or other appropriate named fiduciary of the Plan's decision is to continue to deny or partially deny Your claim or You do not receive timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The Federal external review process does <u>not</u> apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:
   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of

such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph B.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

COORDINATION WITH MEDICARE AND MEDICAID

MEDICARE

When Medicare is primary payer, the Plan will coordinate the Plan benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a Participant is eligible for Medicare as primary payer, but does not enroll or apply for both Part A and Part B on time, the Plan will estimate what Medicare would have paid if the Participant had made timely application.

The Plan Administrator will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a covered expense is incurred.

MEDICAID

Payment for Expenses Incurred with respect to a Participant will be made in accordance with any assignment of rights made by or on behalf of such Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred by a Participant, the fact that the Participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such Expenses Incurred.

COORDINATION OF BENEFITS

When the Plan is the secondary plan, the plan will determine the Regular, Reasonable & Customary Charge. After the primary plan pays, the Plan will either pay what is left of the Regular, Reasonable & Customary Charge or the regular benefit, whichever is less. The Plan will not pay more than the Regular, Reasonable & Customary Charge amount. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

If an expense is eligible under both this Medical Benefits section of the Plan and a Dental Benefits section of the Plan, the Medical Benefits section of the Plan will pay primary.

RULES FOR ORDER OF PAYMENT

The primary plan is:

- The plan which does not coordinate its benefits with any other plan.
- The plan which covers the person as an employee or student, rather than as a dependent. However, if a person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, for example a retired employee.
- The plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their Plan, then the plan which covers the father as an employee will be primary, rather than the plan which covers the mother as an employee.

- The plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until the Plan has been informed of the terms of the court decree. Any benefits paid prior to the Plans knowledge of the terms of the court decree will be subject to the other sections of this provision.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, then the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- The plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.
- The plan which covers the person as an employee, or the dependent of an employee, rather than the plan which covers the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
- If none of the above rules apply, then the plan which has covered the Participant the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage under the Plan.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, the Plan can make payment directly to them to satisfy the intent of this provision. Any payment made by the Plan for this reason will fully discharge the Plan Administrator of any liability under this plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under certain circumstances, You have the right to temporarily extend Your health or dental coverage under this plan under a federal continuation provision called COBRA. COBRA continuation coverage is a continuation of health or dental coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, Your Spouse and Your Covered Dependent Children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.

The health or dental coverage that will be extended is the same coverage that is provided to Covered Individuals.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

WHEN YOU BECOME A QUALIFIED BENEFICIARY

If You are a Covered Individual, You will become a qualified beneficiary if You lose Your coverage under this plan because of one of the following qualifying events:

You can continue Your insurance for 36 months, if:

- You have lost coverage or had Your coverage substantially reduced within one year before or after the date Your Employer began proceedings in a Ch. 11 bankruptcy proceeding; and
- You retired after the Ch. 11 bankruptcy proceeding;

You can continue Your insurance for Your lifetime, if:

- You have lost coverage or had his/her insurance substantially reduced within one year before or after his/her employer began proceedings in a Ch. 11 bankruptcy case; and
- You are a retiree who retired before the Ch. 11 bankruptcy proceeding;

If You are the Covered Spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under this plan because any of the following qualifying events happens:

You can continue Your insurance for 36 months, if:

- You become divorced or legally separated from Your Spouse

You can continue Your insurance for Your lifetime, if:

- You are a widow or widower of a retiree who died before the bankruptcy proceeding.

A Covered Child will become a qualified beneficiary if the Covered Child loses coverage under this plan because any of the following qualifying events happens:

You can continue Your insurance for 36 months, if:

- The parents at least one of which is a Covered Individual become divorced or legally separated
- The Child no longer meets the definition of a Child under this plan
- The Child is a Covered Dependent of a retiree who died after a Ch. 11 bankruptcy proceeding.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan Administrator, or the Plans designated representative, will notify You of Your right to continue coverage under COBRA once the Plan has been notified that a qualifying event has occurred.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

You must notify the Plan Administrator, or the Plan's designated representative, in writing of the qualifying event within 60 days after the event occurs. If the Plan Administrator, or the Plan's designated representative, is not notified within this time frame, COBRA continuation cannot be offered.

THE PLAN ADMINISTRATORS NOTIFICATION RESPONSIBILITIES

Once the Plan Administrators, or the Plans designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation on behalf of their Children.

COBRA ELECTION PERIOD

You or Your Covered Dependents have the responsibility to notify the Plan, or the Plan Administrator's designated representative, of Your desire to continue coverage within sixty days

from the later of the date of notification or loss of coverage. Upon acceptance, You or Your Covered Dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a Participant decides to continue this coverage, the first premium payment is due 45 days following the date the Participant returns the election form. Coverage is provided only when the full premium for the applicable period is received. The Participant must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Plan, or the Plan Administrators designated representative. Coverage is not in force for any period for which premium is not paid.

If You or a Covered Dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, You should contact the Plan, or the Plan Administrator's designated representative, immediately.

LENGTH OF CONTINUATION

For a Covered Spouse or Covered Child, when the qualifying event is the death of the Covered Individual, Covered Individual, Your divorce or legal separation, or a Child's losing eligibility as a Child, COBRA continuation coverage lasts for up to a total of 36 months. For a Covered Spouse or Covered Child, a substantial elimination of coverage within one year before or after the commencement of the bankruptcy proceeding COBRA continuation coverage lasts for up to a total of 36 months after the Covered Individual's death.

For a Covered Individual, when the qualifying event is a substantial elimination of coverage within one year before or after the commencement of the bankruptcy proceeding COBRA continuation coverage ends on his or her death.

PERSONS WHO CANNOT CONTINUE

A Participant cannot continue this coverage under the COBRA continuation provision if at the time of the Participant's termination, the Participant is a nonresident alien with no earned income from sources within the United States, or is the Covered Dependent of such person.

COBRA TERMINATION

Although COBRA continuation coverage has a maximum time frame, You may voluntarily terminate coverage at any time by notifying the Plan, or the Plan Administrator designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group medical or dental plan for any employee
- The date the Participant is covered by another group medical or dental plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the Participant becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.

A Participant's continuation under this Plan will terminate anytime this Plan is terminated.

GENERAL PROVISIONS

RIGHT TO RECOVERY

If the Plan made a payment in error, the Plan can recover the Plan's payment from another plan, the Participant, or anyone else to whom the Plan has made payment.

PHYSICAL EXAMINATIONS

The Plan Administrator reserves the right to have a Physician of the Plan's choosing examine any Participant whose condition, illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, illness, or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

PAYMENT OF BENEFITS

All benefits under this Plan are payable to the Covered Individual whose illness or injury, or whose Covered Dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a Covered Individual and in the absence of written evidence to this Plan of the qualification of a guardian for the Covered Individual's estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Covered Individual.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a Proof of Loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or Dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as

reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD codes or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;
- Pursuant to a misstatement contained in a Proof of Loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- Pursuant to a claim for which benefits are recoverable under any plan or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of the Participant's Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Conditions

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), Plan participant's attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against

any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's compensation or other liability insurance company; or
- Any other source including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by the Participant's recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of

causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Plan Participant is a Trustee over Plan Assets

1. Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that the Plan Participant is required to:

    a) Notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b) Instruct the Plan Participant's attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which the Participant exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

a) The responsible party, its insurer, or any other source on behalf of that party;
b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker's compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
    c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
    f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage;
    h) To instruct Plan Participant(s)' attorney to ensure that the Plan and/or its authorized representative are included as a payee on any settlement draft;
    i) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft;

j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved;

2. If the Plan Participant(s) and/or the Plan Participant(s)' attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Participant and/or Plan Participant(s)' attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and minor's estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with the plan provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator have maximum legal discretionary authority to:

- Construe and interpret the terms and provisions of the Plan;
- To make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental/Investigational);
- To decide disputes which may arise relative to a Participant's rights; and
- To decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a participant's rights and/or availability of benefits;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a Third Party Administrator to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;

- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Other Provisions

Notwithstanding anything else in the Plan to the contrary, the maximum cost sharing imposed under the Plan shall not exceed the maximum set forth in 42 U.S.C. §300gg-6(b).

Notwithstanding anything in the Plan to the contrary, the Plan shall not discriminate against providers in violation of 42 U.S.C. §300gg-5.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information about the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Medical or Dental Plan Coverage

Continue medical or dental care coverage for Yourself, Your Covered Spouse or Your Covered Children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your Employer, Your union (if any), or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a State or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Employee Benefits Security Administration.

HIPAA PRIVACY

Right to Receive and Release Information

The Third Party Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Third Party Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan

Administrator or Third Party Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Third Party Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(j) If feasible, return or destroy all protected health information 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

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under this health plan.

Please keep this information with Your other group health plan documents. If You have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please call Group Plan Solutions at 888-301-0747.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group health plans from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth:

- Following a normal vaginal delivery to less than 48 hours; and
- Following a cesarean section, to less than 96 hours.

The Plan may not require that a provider obtain authorization from the Plan for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, the Plan may not:

- Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
- Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
- Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage require a mother to give birth in a hospital;
- Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and copay. For further details, refer to Your Summary Plan Description.

Section III

Farmers Automobile Insurance Association
Medicare Prescription Drug Plan Document
and
Summary Plan Description

Original Effective Date: January 1, 2016

Restatement Effective Date: January 1, 2020

Evidence of Coverage

Your Medicare Prescription Drug Coverage as a Member of the Farmers Automobile Insurance Association (FAIA) Medicare Prescription Drug Plan (PDP), administered by OptumRx®

This Plan Document and Summary Plan Description, effective January 1, 2020, provides details about your Medicare prescription drug coverage from January 1, 2020 – December 31, 2020 and how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

For help or information, please contact OptumRx Member Services.

Toll-Free: 1-866-884-4326
TTY: 711
Hours of operation: 24 hours a day, 7 days a week
Website: optumrx.com

This plan is offered by Farmers Automobile Insurance Association (FAIA), referred to throughout the *Evidence of Coverage* as "we," "us," or "our." The FAIA Medicare Prescription Drug Plan is referred to as "plan" or "our plan."

Optum Insurance of Ohio, Inc. is a Medicare-approved Part D sponsor and administers this plan through its pharmacy benefit manager, OptumRx, on behalf of your employer, union, or trustees of a fund. If you need this information in another language or alternate format (braille, large-print, audio), please contact OptumRx at the number listed on the back of your member ID card.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2020.

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document explains how to use your Medicare prescription drug coverage through our plan, explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

If you are a new member, it is important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of the FAIA Medicare Prescription Drug Plan.

If you are confused or concerned, or just have a question, contact OptumRx. OptumRx contact information is on page 1 of this document.

Section 1.2 Legal information about the *Evidence of Coverage*

It is part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how the FAIA Medicare Prescription Drug Plan covers your care. Other parts of this contract include the Drug List (Formulary) and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in our plan between January 1, 2020 and December 31, 2020.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits for our plan after December 31, 2020. We can also choose to stop offering the plan, or offer it in a different service area.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for coverage in our plan as long as you:

- Live in our geographic service area. (Section 2.3 below describes our service area.)
- Are entitled to Medicare Part A and enrolled in Medicare Part B. **(You must have both Part A and Part B.)**
- Continue to pay your Part B premium.
- Are a United States citizen or lawfully present in the United States.
- Meet your plan's eligibility requirements.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- **Medicare Part A** generally covers services furnished by providers, such as hospitals, skilled nursing facilities, or home health agencies.
- **Medicare Part B** is for most other medical services, such as physician's services, other outpatient services, and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the service area for the FAIA Medicare Prescription Drug Plan

Although Medicare is a federal program, our plan is available only to individuals who live in our service area. To remain a member of our plan, you must keep living in this service area. Our service area includes the United States, the District of Columbia, Puerto Rico, and Guam.

Please note: You need a physical address on file to be enrolled in our plan.

If you plan to move out of the service area, contact OptumRx. OptumRx contact information is on page 1 of this document. When you move, you may have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

You must be a U.S. citizen to be a member of a Medicare plan. If you become incarcerated, or you are no longer lawfully present in the service area, you are considered outside the service area, which means you are no longer eligible for coverage and may be disenrolled.

It is also important that you call the Social Security Administration if you move or change your mailing address.

SECTION 3 What other materials will you get from us?

Section 3.1 Your member identification (ID) card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use our ID card for prescription drugs you get at network pharmacies. If you do not present your card at the pharmacy, you may be responsible for the full cost of the prescription drug and may or may not be reimbursed by the plan. If you are at the pharmacy and do not have your card, you can show them your Medicare (red, white, and blue) card, or call OptumRx to verify coverage.

Please carry your card with you at all times, and remember to show your card when you get covered drugs. If your ID card is damaged, lost, or stolen, call OptumRx right away, and we will send you a new card. OptumRx contact information is on page 1 of this document. You may also print a temporary card from the member portal website at **optumrx.com**.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 Your guide to pharmacies in our network

What are network pharmacies?

Network pharmacies are those that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies. You should only use an out-of-network pharmacy in emergency situations. If you use an out-of-network pharmacy, you may pay more for your prescriptions.

To find a list of our network pharmacies, you can visit our website at **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab). You can also call OptumRx if you need assistance, or to request that a copy of the listing be mailed to you. Our contact information is on page 1 of this document.

Section 3.3 The plan's Drug List (Formulary)

The plan has a list of covered drugs (Formulary). We call it the Drug List. It tells which Part D prescription drugs are covered by the FAIA Medicare Prescription Drug Plan. The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. The Drug List also indicates if there are any rules that restrict coverage for your drugs.

To request a copy of the Abridged Formulary (Drug List) be mailed to you or for a complete listing of all drugs covered, contact OptumRx. OptumRx contact information is on the first page of this document.

You can also visit us online at **optumrx.com** and use the "Drug Information" tool (found under the "Member Tools" tab).

Section 3.4 The Explanation of Benefits (EOB): Amount of payments made for your prescription drugs

When you use your prescription drug benefits, we will keep track of payments for your prescription drugs.

The *Explanation of Benefits* explains the total amount you, or others on your behalf, have spent on your prescription drugs, as well as the total amount we have paid for each of your prescription drugs during the month. Chapter 4 (What you pay for your Part D prescription drugs) provides more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

Your EOB is available in the online claim portal at www.groupplansolutions.com. Click on Member, then Claim Inquiry, then Health Claim (WEBeci). After you log into the portal, go to the menu on the left hand side of the screen and click on Accumulations. Scroll down to see your Prescription Drugs totals.

SECTION 4 Your monthly premium for the FAIA Medicare Prescription Drug Plan

Section 4.1 How much is your plan premium?

As a member of our plan, you may pay a monthly plan premium. Please contact your former employer, union, or fund to find out more information about what you may pay for your monthly plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>less</u>.

There are programs to help people with limited resources pay for their drugs. Chapter 2 explains more about these programs. If you qualify for one of these programs, enrolling in the program might reduce your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this *Evidence of Coverage* may not apply to you**. You will receive a separate notification that explains your drug coverage. If you are already enrolled and getting help from one of these programs and do **not** receive this notification, call OptumRx and ask for your "LIS Rider," the *Evidence of Coverage* rider for people who get Extra Help paying for prescription drugs. OptumRx contact information is on page 1 of this document.

In some situations, your plan premium could be <u>more</u>.

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible, or because they had a continuous period of 63 days or more when they did not have creditable coverage. "Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. For these members, the plan's monthly premium may be higher. It will be the monthly plan premium plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in prescription drug coverage, or how many months you were without drug coverage after you became eligible. You can find more information about the late enrollment penalty in Chapter 4.

Please note: If you have a late enrollment penalty, it may be part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Many members are required to pay other Medicare premiums.

Some people pay an extra amount for Part D because of their yearly income. This is called an Income-Related Monthly Adjustment Amount (also known as IRMAA). If your income is greater than $87,000 for an individual (or married individuals filing separately), or greater than $174,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- If you are required to pay the extra amount and do not pay it, you will be disenrolled from the plan by the Centers for Medicare & Medicaid Services and lose prescription drug coverage.

- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, refer to Chapter 4. You can also visit medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week. Or you may call Social Security at 1-800-772-1213, TTY 1-800-325-0778.

SECTION 5 Please keep your member records up-to-date

Section 5.1 How to help make sure we have accurate information about you

The pharmacists in the plan's network need to have correct information about you. **These network providers use your member record to know what drugs are covered for you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your address or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling OptumRx. OptumRx contact information is on page 1 of this document.

Remember to report any changes to your personal information to the Social Security Administration.

Read over the information we send you about any other insurance coverage you have.

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That is because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage we know about. Please read over this information carefully. If it is correct, you do not need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call OptumRx. OptumRx contact information is on page 1 of this document.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD).
    - If you are under 65 and disabled, and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or is part of a multiple-employer plan in which at least one employer has more than 100 employees.
    - If you are over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or is part of a multiple-employer plan in which at least one employer has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first or you need to update your other insurance information, call OptumRx. OptumRx contact information is on page 1 of this document. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 FAIA Medicare Prescription Drug Plan contacts
(how to contact us, including how to reach OptumRx)

How to contact OptumRx and other important departments

For assistance with claims, billing, or ID card questions, call OptumRx. You may also visit our website at **optumrx.com**. We are available to assist you 24 hours a day, 7 days a week.

Contact	Phone	TTY*	Fax	Mailing Address
OptumRx Member Services	866-884-4326	711	1-866-235-3171	OptumRx Attn: Member Services PO Box 3410 Lisle, IL 60532
Prior Authorization & Clinical Coverage Decisions	866-884-4326	711	1-844-403-1028	OptumRx Prior Authorization Department PO Box 25183 Santa Ana, CA 92799
Prior Authorization & Clinical Appeals	800-626-0072	711	1-877-239-4565	OptumRx Prior Authorization Department c/o Appeals Coordinator PO Box 25184 Santa Ana, CA 92799
Comments, Complaints & Grievances	866-884-4326	711	1-866-235-3171	OptumRx Attn: Part D Grievances PO Box 3410 Lisle, IL 60532
Manual Claims Submission & Payment Requests	866-884-4326	711	n/a	OptumRx Attn: Manual Claims PO Box 29044 Hot Springs, AR 71903
Manual Claims Appeals	800-626-0072	711	n/a	OptumRx Attn: Manual Claims Appeals PO Box 29022 Hot Springs, AR 71903

* This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.

SECTION 2 Medicare

(how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 or older, some people under 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Prescription Drug Plans, including OptumRx.

Medicare	
CALL	1-800- MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	medicare.gov This is the official government website for Medicare. It provides up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also find Medicare contacts in your state by selecting “Helpful Phone Numbers and Websites.” If you do not have a computer, your local library or senior center may be able to help you visit this website using its computer. You can also call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program

(free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to provide free local health insurance counseling to people with Medicare. For a listing of all SHIP programs, refer to the appendix at the end of this document.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization

(paid for by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) for each state.

QIOs have a group of doctors and other healthcare professionals who are paid by the federal government. They check on and help improve the quality of care for people with Medicare. QIOs are independent organizations and are not connected with our plan. For a listing of all QIO programs, refer to the appendix at the end of this document.

You should contact your QIO if you have a complaint about the quality of care you have received. For example, you can contact your QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount, but your income went down because of a life-changing event, you can call Social Security to ask for reconsideration. You can also call them with questions about the amount.

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 a.m.–7:00 p.m. ET, Monday–Friday You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m.–7:00 p.m. ET, Monday–Friday
WEBSITE	ssa.gov

SECTION 6 Medicaid

(a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited income and resources. Some people with Medicare are also eligible for Medicaid. For a listing of all Medicaid programs, refer to the appendix at the end of this document.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- Qualified Individual (QI): Helps pay Part B premiums.
- Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If

you qualify, you can get help paying for your Medicare drug plan's monthly premium and prescription copayments. This Extra Help also counts toward your out-of-pocket costs. People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and do not need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security to apply for the program. (See Section 5 of this chapter for contact information.) You may also be able to apply at your state Medical Assistance or Medicaid office. (See the appendix at the end of this document for contact information.) After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide financial help for prescription drugs for those with limited income and medically needy seniors and individuals with disabilities. For a listing of State Pharmaceutical Assistance Programs, please refer to the appendix at the end of this document.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. **Note:** To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEBSITE	rrb.gov

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get prescription drug benefits through an employer/union or retiree group **other than the FAIA**, call that employer/union benefits administrator if you have any questions. You can ask about their employer/retiree health or drug benefits, premiums, or enrollment period.

Important Note: Your (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enroll in a Medicare Part D program. Call that employer/union benefits administrator to find out whether the benefits will change or be terminated if you or your spouse enroll in a Part D plan.

Chapter 3. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs.

This chapter explains rules for using your coverage for Part D drugs. The next chapter explains what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- **Medicare Part A** covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- **Medicare Part B** also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

To find out more about this coverage, see your *Medicare & You* handbook.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You must use a network pharmacy to fill your prescriptions. (For more information, see Section 2, *Fill your prescriptions at a network pharmacy or through the plan's home delivery service.*)
- Your drug must be on the plan's Drug List (Formulary). (See Section 3, *Your drugs need to be on the plan's Drug List*.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. A network pharmacy is a pharmacy that has agreed to provide your covered prescription drugs. The term *covered drugs* means all Part D prescription drugs that are covered by the plan.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a doctor or, if applicable/allowed, to have your prescription transferred to your new network pharmacy.

Our network includes pharmacies that offer standard cost sharing, as well as pharmacies that offer preferred cost sharing. You may go to either our preferred network pharmacy or other network pharmacies to receive your covered prescription drugs. Your cost sharing may be less at preferred pharmacies. Refer to Chapter 4 for more information about cost-sharing amounts.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can choose whichever method is easiest for you:

- Use your *Pharmacy Directory*.
- Visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab).
- Call OptumRx. OptumRx contact information is on page 1 of this document.

What if the pharmacy you have been using leaves the network?
You will receive notification, and you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can use your *Pharmacy Directory*, get help from OptumRx, or visit **optumrx.com**.

What if you need a Specialty pharmacy?

Sometimes, prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, contact OptumRx.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives have access to these Specialty pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the Food and Drug Administration to certain locations or drugs that require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should rarely happen.)

To locate a specialty pharmacy, call OptumRx. OptumRx contact information is on page 1 of this document.

Section 2.3 Using the plan's home delivery services

For certain kinds of drugs, you can use the plan's network home delivery services. Generally, the drugs provided through mail order are drugs you take on a regular basis for a chronic or long-term medical condition. To request order forms and information about filling your

prescriptions by mail, call OptumRx or visit our website at **optumrx.com**. If you use a home delivery pharmacy not in the plan's network, you will be responsible for the full cost of the drug. Usually, prescriptions filled through the home delivery pharmacy will arrive within 7 to 10 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You also have 3 different options to request expedited (fast) delivery of your home delivery prescription using 2nd-day air or overnight shipping (at an additional cost):

- **Online Refills** – Visit **optumrx.com** to submit your order online and choose a shipping method.
- **OptumRx Member Services** – Use the phone numbers on the first page of this document to request an alternate shipping method.
- **Mail in the Prescription Order Form** – If you mail in a hard copy of your prescription, you can request expedited (fast) delivery by either writing your delivery method on the prescription itself, on the order form, or on a separate sheet of paper included with your form.

Note: When ordering online or sending in a form, we will notify you when your order is being processed. If you do not receive notification, or if you have any questions regarding your prescription order, please call OptumRx using the phone numbers on the first page of this document.

New prescriptions the pharmacy receives directly from your doctor's office
The pharmacy will automatically fill and deliver new prescriptions it receives from healthcare providers, without checking with you first if you used home delivery services with this plan in the 12 months.

If you no longer want the pharmacy to automatically fill and ship a new prescription, contact OptumRx as soon as possible. OptumRx contact information is on page 1 of this document. If you receive a prescription automatically by mail that you do not want, you can request a refund.

If you have never used home delivery or if you do not want (or decide to stop) automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a healthcare provider to determine if you want the medication filled and shipped. This will give you the opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy to let them know what to do with the new prescription and to prevent any delays in shipping. If the pharmacy is unable to contact you, the prescription will be canceled.

Automatic refills on home delivery prescriptions

You have the option to sign up for an automatic refill program, and you can choose which medications get enrolled into the program. Your medications are eligible for the program after the first fill. In other words, once you are close to running out of your medication, you can initiate a refill and enroll in the program at any time by calling the pharmacy or going online at optumrx.com. Once your medication is enrolled, we will start to process your next refill automatically when our records show you are close to running out of your drug. The pharmacy will automatically contact you twice within a 30-day period prior to shipping each refill. We will use your preferred method of contact to confirm your order before shipping. This will give you

the opportunity to cancel or delay scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to sign up for or use our automatic refill program, you will need to order a refill of your medication at least 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Note: If you are in a skilled nursing facility or a hospice program, your medications are not eligible for the automatic refill program. In addition, any drugs limited to a 30-day supply cannot be enrolled in the automatic refill program, and are not available through home delivery.

To opt out of the automatic refill program, members, prescribers and/or an authorized representative should contact OptumRx as soon as possible. OptumRx contact information is on the first page of this document.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers a way to get a long-term supply of "maintenance" drugs. Maintenance drugs are drugs you take on a regular basis for a chronic or long-term medical condition.

For certain kinds of drugs, such as maintenance medications, you can use the plan's network home delivery (mail-order) services. Our plan's home delivery service allows you to order up to a 90-day supply. (See Section 2.3 for more information about using our home delivery services.)

Section 2.5 When can you use an out-of-network pharmacy?

Your prescription might be covered in certain situations.

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Below are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance. The prescription is for a drug that is out-of-stock at an accessible network retail or mail-service pharmacy (including high-cost and unique drugs).
- You are evacuated or otherwise displaced from your home because of a federal disaster or other public health emergency declaration.

In these situations, **check first with OptumRx** to see if there is a network pharmacy nearby. If we pay for drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to a network pharmacy. If you go to an out-of-network pharmacy for any of the reasons listed above, the plan will cover up to a one-month supply of drugs.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy when you fill your prescription, you may have to pay a higher amount or the full cost rather than paying your normal share of the cost. You can ask us to reimburse you for our share of the cost. (Chapter 5 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List shows which Part D drugs are covered

The plan has a Drug List (Formulary).

The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

The drugs on the Drug List are only those covered under this Medicare Part D plan. (Earlier in this chapter, Section 1.1 explains Part D drugs.)

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Supported by certain reference books (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand-name and generic drugs. A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs. Generally, the brand-name drug will no longer be covered.

Section 3.2 There are 4 cost-sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Drug Tier	Helpful Tips
Tier 1	Most generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 generally include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.

Tier 3	Drugs listed under Tier 3 generally have higher copayments than preferred brand-name drugs <and may include some specialty or high-cost drugs*>.
Tier 4	Specialty or high-cost drugs listed under Tier 4 cost $670 or more for up to a 30-day maximum supply.

To find out which cost-sharing tier your drug is in, refer to your plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (What you pay for your Part D prescription drugs).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have 3 ways to find out:

- Visit **optumrx.com**.
- Check the most recent Drug List we sent you in the mail.

  Please note: The Drug List we sent includes information for covered drugs most commonly used by our members; however, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact OptumRx to find out if we cover it.
- Call OptumRx to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. OptumRx contact information is on the first page of this document.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective way. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor or other prescriber to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective way. The following information describes the types of restrictions we use for certain drugs.

Using generic drugs whenever you can

A generic drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies may provide you the generic version.** If your doctor has told us the medical reason that the generic drug will not

work for you, we may cover the brand-name drug. Your share of the cost may be greater for the brand-name drug than for the generic drug.

Getting plan approval in advance (prior authorization)

For certain drugs, you or your doctor (or other prescriber) need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization.** Sometimes, plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes, the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first (step therapy)

This requirement encourages you to try one or more specific drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit the amount of the drug that you can have, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call OptumRx or visit **optumrx.com**. OptumRx contact information is on page 1 of this document.

IMPORTANT: OptumRx has added the restriction of a 30-day maximum supply limit on opioid drugs at both retail and home delivery pharmacies. Our pharmacies will no longer dispense opioid prescriptions for more than a 30-day supply at one time. OptumRx is making this change to help reduce the risks associated with taking opioid drugs. If you currently have a prescription written for more than a 30-day supply, it is important that you reach out to your prescriber to request a new prescription in order to avoid missing a refill of your medication.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact OptumRx to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage determination process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7 for information about asking for exceptions.)

Please note: Sometimes, a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your healthcare provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

SECTION 5 What if one of your drugs is not covered in the way you would like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you would like it to be covered.

It is possible there is a prescription drug you are currently taking, or one you and your doctor think you should be taking, that is not on our formulary, or it may be on our formulary with restrictions. For example:

What if the drug you want to take is not covered by the plan? For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.

What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first—to see if it will work—before the drug you want to take will be covered for you. There might also be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.

What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be? The plan puts each covered drug into one of 5 different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way you would like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, you have several options:

- You may be able to get a temporary supply of the drug until you and your doctor decide it is okay to change to another drug or while you file an exception. Only members in certain situations can get a temporary supply.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply.

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is **no longer on the plan's Drug List**.

     – or –
   - The drug you have been taking is **now restricted in some way**. (Section 4 in this chapter explains restrictions.)
2. **You must be in one of the situations described below:**
   - **For those members who were in the plan last year:**

     We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for **up to a 30-day supply** (less if your prescription is written for fewer days). The prescription must be filled at a network pharmacy.
   - **For those members who are new to the plan and are <u>not</u> in a long-term care facility:**

     We will cover a temporary supply of your drug **during the first 90 days of your enrollment** in the plan. This temporary supply will be for **up to a 30-day supply** (less if your prescription is written for fewer days). The prescription must be filled at a network pharmacy.
   - **For those who are new members and <u>are</u> residents in a long-term care facility:**

     We will cover a temporary supply of your drug **during the first 90 days of your enrollment in the plan**. The first supply will be for **up to a 31-day supply** (less if your prescription is written for fewer days). If needed, we will cover additional refills during your first 90 days in the plan.
   - **For those who have been members of the plan for more than 90 days, are residents of a long-term care facility, and need a supply right away:**

     We will cover **up to a 31-day supply** one time (less if your prescription is written for fewer days). This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call OptumRx. OptumRx contact information is on page 1 of this document.

During the time you are using a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. If not, you and your doctor (or other prescriber) can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug.

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call OptumRx to ask for a list of

covered drugs that treat the same medical condition. This list can help your doctor or other prescriber find a covered drug that might work for you.

You can file an exception.

You and your doctor or other prescriber can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other prescriber says you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule. Please note that not all exception requests may be approved.

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 explains what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1); however, there may be changes to the Drug List during the year. For example, the plan might:

- **Add or remove drugs from the Drug List** - New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective by the Food and Drug Administration.
- **Move a drug to a lower cost-sharing tier**
- **Remove a restriction on coverage for a drug** - For more information about restrictions to coverage, see Section 4 in this chapter.
- **Replace a brand-name drug with a generic drug**

Please note: We must get approval from Medicare for any negative changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is suddenly recalled because it has been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your doctor will also know about this change and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it

If any of these changes happen for a drug you are taking, the change will not affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably will not see any increase in your payments or any added restriction to your use of the drug. On January 1 of the next year, however, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- **If a brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.

    – or –
  - You and your doctor (or other prescriber) can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (What to do if you have a problem or complaint).
- Again, **if a drug is suddenly recalled** because it has been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your doctor or other prescriber will also know about this change and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

This section describes what kinds of prescription drugs are not covered.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover "off-label use." This is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Sometimes "off-label use" is allowed. Coverage is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products (except prenatal vitamins) and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Furthermore, these categories of drugs are not covered by Medicare drug plans either but the FAIA Medicare Prescription Drug Plan will cover the following after you pay the copay category that would normally apply if you were not covered by Medicare Part D:

- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject but limited to 6 pills per month.

In addition, **if you receive "Extra Help" from Medicare** to pay for your prescriptions, the Extra Help will not pay for drugs not normally covered. (Refer to your formulary or call OptumRx for more information.) Your state Medicaid program *may* cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 8 Show your member identification (ID) card when you fill a prescription

Section 8.1 Show your ID card

To fill your prescription, show your plan member ID card at the network pharmacy you choose. When you show your ID card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you do not have your ID card with you?

If you do not have your ID card with you when you fill your prescription, ask the pharmacy to call OptumRx to get the necessary information. OptumRx contact information is on page 1 of this document. If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. (See Chapter 5 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you are in a hospital or a skilled nursing facility covered by the plan?

If you are admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. Chapter 8 (Ending your coverage in the plan) explains how you can leave our plan and join a different Medicare plan.

Section 9.2 What if you are a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

If you need more information about a particular pharmacy within a long-term care facility, please visit **optumrx.com**, check your *Pharmacy Directory*, or contact OptumRx. OptumRx contact information is on page 1 of this document.

What if you are a resident in a long-term care facility and become a new member of the plan?

If you are a new member and a resident of a long-term care facility, and you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your enrollment. The first fill will be for up to a 31-day supply (less if your prescription is written for fewer days). If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is *not* on our Drug List, or if the plan has any restriction on the drug's coverage, we will cover up to a 31-day supply one time (less if your prescription is written for fewer days).

During the time you are using a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. In this case, you and your doctor (or other prescriber) can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered (Chapter 7 provides more information about how you can ask for an exception).

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in our Medicare Prescription Drug Plan does not affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan cannot cover it.

If your plan covers Medicare Part B drugs, some drugs may be covered through the FAIA Medicare Prescription Drug Plan, but drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill us or Medicare Part B for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year, your Medigap insurance company should send you a notice by November 15 that indicates if your prescription drug coverage is "creditable," and the choices you have for drug coverage. If the coverage from the Medigap policy is creditable, it means that it has drug coverage that meets Medicare's minimum standard drug coverage. The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you did not get this notice, or if you cannot find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you are also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your spouse's employer or retiree group, other than with FAIA? If so, please contact that group's benefits administrator. They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be **secondary** to your employer or retiree group coverage. That means your coverage through your current employer will pay first.

Special note about creditable coverage

Your previous employer or retiree group should send you a notice that explains if your prescription drug coverage for the next calendar year is "creditable," and the choices you have for drug coverage. If the coverage from the group plan is creditable, it means that it meets Medicare's minimum standard coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you did not get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving unrelated drugs that should be covered by our plan, ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before filling your prescription.

In the event you withdraw your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your withdrawal or discharge. (See the previous parts of this section that tell about the rules for getting drug coverage under Part D.) Chapter 4 (What you pay for your Part D prescription drugs) provides more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug-use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.
We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems, such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amount of opioid pain medications

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your

opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake, you disagree with our determination that you are at risk for prescription drug abuse, or you disagree with the limitation, you and your prescriber have the right to ask us for an appeal. (See Chapter 7 for information about how to ask for an appeal.)

The DMP may not apply to you if you have certain medical conditions, such as cancer, if you are receiving hospice care, or if you live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) Program to help members manage their medications

Our Medication Therapy Management (MTM) Program helps our members with special situations. For example, some members have several complex medical conditions, may need to take many drugs at the same time, or could have very high drug costs.

This program is free to members and helps make sure our members are using the drugs that work best to treat their medical conditions. It also helps us identify possible medication errors.

Your pharmacist or other healthcare professional will provide you with a comprehensive review of all your medications. Talk with them about how best to take your medications, your medication costs, and any concerns or questions you have about your prescription or over-the-counter medications. You will receive a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, as well as space for you to take notes or write down any follow-up questions. You will also get a personal medication list that includes all medications you are taking and why you take them.

It is a good idea to have your medication review before your yearly "wellness" visit so you can talk to your doctor about your action plan and medication list. Take your action plan and medication list with you to your visit, or anytime you talk with your doctors, pharmacists, or other healthcare providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

We will automatically enroll you in the program and send you information if you meet the criteria. If you decide not to participate, please notify us, and we will withdraw your participation in the program.

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use **drug** in this chapter to mean a Part D prescription drug. As explained in Chapter 3, some drugs are covered under Original Medicare or are excluded by law.

To understand the payment information we provide in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Below is a list of materials that explain these basics:

- **The plan's Drug List (Formulary)**
  - The Drug List shows which drugs are covered for you.
  - It also shows which cost-sharing tier the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call OptumRx. OptumRx contact information is on page 1 of this document. You can also find the Drug List on **optumrx.com**.
- **Chapter 3 of this document -** Chapter 3 provides details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. It also explains which types of prescription drugs are **not** covered by our plan.
- **The plan's *Pharmacy Directory* -** In most situations, you must use a network pharmacy to get your covered drugs. The *Pharmacy Directory* includes a list of pharmacies in the plan's network.
  - See Chapter 3 for details, or visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the four drug payment stages?

As shown in the table below, there are four "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind that you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 **Yearly Deductible**	**This plan does NOT have a Deductible. This stage does not apply to you.**
Stage 2 **Initial Coverage**	During this stage, the plan pays its share of the cost and you pay your share of the cost of your drugs. Your share of the cost is in the table below. You stay in this stage until your year-to-date Part D out-of-pocket costs (your payments) reach a total of $6,350. Medicare sets this total and the rules for counting costs toward this amount. Most members do not reach the Catastrophic Coverage Stage because your enhanced benefits include a plan-specific out-of-pocket maximum of $$6,350. Once you reach your enhanced plan out-of-pocket maximum of $6,350, the plan will pay **all** of your drug costs for the remainder of the year.
Stage 3 **Coverage Gap**	**This plan does NOT have a Coverage Gap. This stage does not apply to you.**
Stage 4 **Catastrophic Coverage**	Generally, this stage will not apply to you based on your benefit design because your plan has a plan-specific out-of-pocket maximum. If you **do** reach the calendar year maximum out-of-pocket Part D limit (including manufacturer discounts) of $6,350, before your plan-specific maximum of $6,350, you enter the Catastrophic Stage, and your share of the cost for a covered drug will a copayment, through the remainder of the year (not to exceed the standard copayment amount during the Initial Coverage Stage). Once you have paid your plan-specific out-of-pocket maximum of $6,350, the plan will pay all of the costs for your drugs.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the Explanation of Benefits

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next (when applicable). In particular, there are two types of costs we keep track of:

- How much you have paid - This is called your **out-of-pocket** cost.
- Your **total drug costs** - This is the amount you pay out-of-pocket or others pay on your behalf, plus the amount paid by the plan.

Your EOB is available in the online claim portal at www.groupplansolutions.com. Click on Member, then Claim Inquiry, then Health Claim (WEBeci). After you log into the portal, go to the menu on the left hand side of the screen and click on Accumulations. Scroll down to see your Prescription Drugs totals.

Section 3.2 Help us keep our information about your drug payments up-to-date

To keep track of your drug costs and payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your member ID card when you get a prescription filled.** To make sure we know about prescriptions you are filling and what you are paying, show your plan ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you can send us copies of receipts for drugs you have purchased. If you are billed for a covered drug, you can ask our plan to pay our share of
- the cost. (For instructions on how to do this, go to Chapter 5 of this document.)

Below are types of situations where you may want to send us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price
- When you make a copayment for a drug that is provided under a drug manufacturer patient assistance program
- Any time you purchase a covered drug at an out-of-network pharmacy, or other times you pay full price for a covered drug under special circumstances

Send us information about payments others have made for you. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help you qualify for catastrophic coverage sooner. For example, payments made by a State Pharmaceutical Assistance Program (SPAP), an AIDS Drug Assistance Program (ADAP), the Indian Health Service, and most charities, count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

Check the written report we send you. If you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report or you have any questions, call OptumRx. OptumRx contact information is on page 1 of this document. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no Deductible for the FAIA Medicare Prescription Drug Plan

Section 4.1 You do not pay a Deductible for your Part D drugs

There is no Deductible for this plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

You begin in the Initial Coverage Stage when you fill your first prescription of the year. During this phase, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 4 cost-sharing tiers.

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

Drug Tier	Helpful Tips
Tier 1	Most generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 generally include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.
Tier 3	Drugs listed under Tier 3 includes non-preferred brand-name drugs and generally have higher copayments than preferred brand-name drugs <and may include some specialty or high-cost drugs*>.
Tier 4	Specialty or high-cost drugs listed under Tier 4 with up to a 30-day maximum supply.

To find out which cost-sharing tier your drug is in, refer to your plan's Drug List (Formulary).

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from a network pharmacy or a home delivery pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3. You may also visit **optumrx.com** and refer to the "Pharmacy Locator" tool (found under the "Member Tools" tab).

Section 5.2 A table that shows your costs for a 30-day, 60-day and 90-day supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be:

- **A copayment** - This means you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of copayment depends on which tier your drug is in.

Your share of the cost when you get Covered Part D prescription drug

	Retail Network Pharmacy **1-30-day supply**	**Retail Network Pharmacy** **31-60-day supply**	**Retail Network Pharmacy/Home Delivery** **61-90-day supply**
Cost-Sharing Tier 1 (Generic drugs)	$20	$40	$60
Cost-Sharing Tier 2 (Preferred Brand drugs)	$30	$60	$90
Cost-Sharing Tier 3 (Non-Preferred Brand drugs)	$50	$100	$150
Cost-Sharing Tier 4 (High-Cost drugs *)	$100	Not Covered	Not Covered
* High-Cost drugs are those that cost $670 or more for up to a 30-day maximum supply.			

Section 5.3 You stay in the Initial Coverage Stage until your Part D out-of-pocket costs reach $6,350 for the calendar year

Once you reach your plan out-of-pocket maximum of $6,350, the plan pays **all** of the costs of your drugs for the remainder of the year.
The *Explanation of Benefits* we provide helps you keep track of how much you and the plan have spent for your drugs during the year. This EOB provides payment details about prescriptions you have filled during the previous month.

If you **do** reach the maximum out-of-pocket Part D limit of $6,350 for the year, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage where your plan pays 100% of covered expense for your prescription drugs for the remainder of the year.

Section 5.4 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply for certain drugs

Typically, you pay a copay to cover a full month's supply of a covered drug; however, your doctor can prescribe less than a month's supply of a drug. There may be times when you want to ask your doctor to prescribe less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply **for certain drugs**.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (percentage of total cost) or a copayment (flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. Because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive. For example:
    - If the copay for your drug for a full month's supply (a 30-day supply) is $30, this means the amount you pay per day for your drug is $1. If you receive a 7-day supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.
    - You should not have to pay more per day just because you begin with less than a month's supply. From the example above, if you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7-day supply runs out, and you receive a second prescription for the rest of the month (or 23 days more of the drug), you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30 – the same as your copay would be for a full month's supply.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply (depending on the drug dispensed).

SECTION 6 There is no Coverage Gap Stage for FAIA Medicare Prescription Drug Plan

Section 6.1 You do not have a Coverage Gap Stage for your Part D drugs

There is no Coverage Gap for this Plan. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. (See Section 7 for information about your coverage in

the Catastrophic Coverage Stage where your plan pays 100% of covered expense for your prescription drugs for the remainder of the year.

When your Part D out-of-pocket costs reach $6,350, the Plan will pay **all** of the cost of your drugs for the remainder of the year

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When your Part D out-of-pocket costs reach $6,350, you leave the Initial Coverage Stage and move on to the Coverage Gap Stage where your plan pays 100% of covered expense for your prescription drugs for the remainder of the year.

Below are Medicare's rules we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, you **<u>can include</u>** the payments listed below (as long as they are for covered Part D drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this document):

- The amount you pay for drugs when you are in the Initial Coverage:
- Any payments you made during this calendar year as a member of a different Medicare Prescription Drug Plan before you joined our plan

It matters who pays.

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS Drug Assistance Programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included, but the amount the plan pays for your generic drugs is *not* included.

Moving on to the Catastrophic Coverage Stage

Once you (or those paying on your behalf) spend a total of $6,350 for Part D out-of-pocket costs during the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage where your plan pays 100% of covered expense for your prescription drugs for the remainder of the year.

These payments <u>are not included</u> in your out-of-pocket costs.

When you add up your out-of-pocket costs, you **<u>cannot include</u>** any of these types of payments for prescription drugs:

- The amount you may pay for your monthly premium

- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap
- Payments for your drugs that are made by group health plans including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments you make for drug or other medical expenses under the FAIA Group Health Plan for Inactive Employees.

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call OptumRx to let us know. OptumRx contact information is on page 1 of this document.

Important note: This plan has a plan-specific out-of-pocket maximum, which differs from the Medicare Part D limit. Medicare sets rules, as stated above, about what can and cannot be included toward the Part D limit. Our plan sets different rules as to what does and does not count toward out-of-pocket costs to reach the plan-specific out-of-pocket maximum of $6,350. Refer to your *Explanation of Benefits* to determine which costs have been applied to your maximum out-of-pocket limit.

How can you keep track of your out-of-pocket total?

We will help you. The *Explanation of Benefits* we provide includes the current amount of your out-of-pocket costs. Your EOBs will let you know when you reach a total of $6,350 in out-of-pocket costs for the year and move on to the Catastrophic Coverage Stage. If you **do** reach the Catastrophic Coverage Stage, the plan will pay 100% of the cost for your drugs.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your Part D out-of-pocket costs reach $6,350 for the calendar year. Once you are in the Catastrophic Coverage Stage, you stay in this

payment stage until the end of the calendar year. If you **do** reach the Catastrophic Coverage Stage, the plan will pay 100% of the cost for your drugs.

SECTION 8 What you pay for a vaccination depends on how and where you get it

Section 8.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage for a number of vaccines. There are two parts to our coverage of vaccinations:

- Cost of the vaccine medication itself - The vaccine is a prescription medication.
- Cost of giving you the vaccination shot - This is sometimes called the “administration” of the vaccine.

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

- The type of vaccine (what you are being vaccinated for)
  - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s Drug List.
- Where you get the vaccine medication
- Who gives you the vaccination shot

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes, when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot.

Situation 1

You buy the vaccine at the pharmacy and get your vaccination shot at the network pharmacy. Whether or not you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and administration of the vaccine.

Situation 2

You get the vaccination at your doctor’s office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this document (Asking the plan to pay its share of the costs for covered drugs).
- You will be reimbursed the amount you paid minus your normal coinsurance or copayment for the vaccine (including administration) and any difference between the amounts the doctor charges and what we normally pay. (If you receive Extra Help, we will reimburse you for this difference.)

Situation 3

You buy the vaccine at your pharmacy and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this document.
- You will be reimbursed the amount charged by the doctor minus the amount for administering the vaccine and any difference between the amounts the doctor charges and what we normally pay. (If you receive Extra Help, we will reimburse you for this difference.)

Section 8.2 You may want to call OptumRx before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call OptumRx first whenever you are planning to get a vaccination. OptumRx contact information is on page 1 of this document.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D late enrollment penalty?

Section 9.1 What is the Part D late enrollment penalty?

You may pay a financial penalty (additional monthly amount) if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or if you experienced a continuous period of 63 days or more when you did not have creditable prescription drug coverage. ("Creditable prescription drug coverage" is drug coverage that meets Medicare's minimum standard coverage.)

The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible, or how many full months, after a continuous 63 days, you went without drug coverage. Also, you will have to pay the additional amount as long as you have Medicare prescription drug coverage, and this amount may be adjusted each year.

The additional penalty amount is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in our plan, we let you know the amount of the penalty.

If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will **not** pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage for 63 or more days. If you no longer receive Extra Help, you will be responsible for paying the late enrollment penalty amount.

Section 9.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- Count the number of full months that you delayed enrolling in a Medicare drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Medicare determines the amount of the average monthly premium for Medicare Prescription Drug Plans in the nation from the previous year. For 2019, this average premium amount was $33.19. This amount may change for 2020.
- To get your monthly penalty, multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.19, which equals $4.64. This rounds to $5.00. This amount would be added to the monthly premium for someone with a late enrollment penalty.

There are three important things to note about this monthly late enrollment penalty:

- First, the penalty may change each year because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you do not have coverage after your initial enrollment period for aging into Medicare.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, you may not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this **creditable drug coverage**.
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your

human resources department to find out if your current drug coverage is at least as good as Medicare's.

Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state you had creditable prescription drug coverage that was expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are **not** considered creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, look in your *Medicare & You* handbook, or call Medicare toll free at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

- You were without creditable coverage for less than 63 days in a row.
- You receive Extra Help from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the letter you receive stating you have to pay a late enrollment penalty. Call OptumRx to find out more about how to do this. OptumRx contact information is on page 1 of this document.

Important: If applicable, do not stop paying your Part D late enrollment penalty while you are waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premium.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium; however, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you are required to pay an extra amount, the Social Security Administration (not your Medicare plan) will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your benefit check from Social Security, the Railroad Retirement Board, or the Office of Personnel Management. The amount will be withheld no matter how you usually pay your plan premium, unless your monthly benefit is not enough to cover the extra amount owed. If your benefit check is not enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 What can you do if you disagree about paying an extra Part D amount?

If you disagree with paying an extra amount due to your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213, TTY 1-800-325-0778.

Section 10.3 What happens if you do not pay the extra Part D amount?

If you are required to pay the extra amount and do not pay it, the Centers for Medicare & Medicaid Services will disenroll you, and you will lose prescription drug coverage.

Chapter 5. Asking the plan to pay its share of the costs for covered drugs

SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes, when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back. (Paying you back is often called "reimbursing" you.) Asking for reimbursement in the first three examples below are types of coverage decisions. (For more information about coverage decisions, go to Chapter 7 of this document.)

Here are examples of situations in which you may need to ask our plan to pay you back:

1. **When you use an out-of-network pharmacy to get a prescription filled**
   - If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please call OptumRx for more information. OptumRx contact information is on page 1 of this document.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back for our share of the cost.

2. **When you pay the full cost for a prescription because you do not have your ID card with you**
   - If you do not have your plan ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you need to pay if you do not have your card.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back for our share of the cost.

3. **When you pay the full cost for a prescription in other situations**
   - You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
     - For example, the drug may not be on the plan's Drug List (Formulary), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 (What to do if you have a problem or complaint) has more information about how to file an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt and prescription label (usually attached to the pharmacy bag), to document the payment you have made. It is a good idea to make a copy of your documentation for your records.

To make sure we get all information we need to make a decision, you can fill out our claim form to make your request for payment. You do not have to use the form, but it helps us process the information faster. Either download a copy of the form from **optumrx.com**, or call OptumRx and ask for the form. OptumRx contact information is on page 1 of this document.

Mail your request for payment, together with all documentation needed, to us at this address:

OptumRx
Attn: Manual Claims
PO Box 29044
Hot Springs, AR 71903

Be sure to contact OptumRx if you have any questions. You can also call if you want to give us more information about a request for payment you have already sent us.

SECTION 3 We will consider your request for payment

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information; otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but your share to you within 14 days. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the drug is **not** covered, or you did **not** follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for the drug, you can file an appeal

If you think we have made a mistake in turning you down, you can file an appeal. If you file an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. Below are some examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you do not have your plan member ID card with you
- When you pay the full cost for a prescription in other situations

For details on how to make this appeal, go to Chapter 7 (What to do if you have a problem or complaint).The appeals process is a legal process with detailed procedures and important deadlines. If filing an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals, and gives definitions of terms such as “appeal.” Then, after you have read Section 4, you can go to Section 5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage sooner.

Below are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs.

1. When you buy the drug for a price that is lower than our price

- If applicable, when you are in the Deductible Stage or Coverage Gap Stage, you can buy your drug at a network pharmacy for a price that is lower than our price.
    - For example, a pharmacy might offer a special price on the drug, or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations, and your drug must be on our Drug List (Formulary).
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: If you are in the Deductible Stage or Coverage Gap Stage, we may not pay for any share of these drug costs, but sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage sooner.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

- Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs, but sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage sooner.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions; therefore, you cannot file an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you

Our plan has free interpreter (translation) services available to answer questions from non-English-speaking members. OptumRx has special telephone equipment that is used for people who have difficulty hearing or speaking. Upon request, we can also give you information in braille, large print, or other alternate formats at no cost if you need it.

We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To request information from us in a way that works for you, call OptumRx. OptumRx contact information is on page 1 of this document.

Section 1.2 We must ensure that you get timely access to your covered drugs

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 of this document explains what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. The pharmacy provides you a written notice, called a “Notice of Privacy Practice,” that explains these rights and how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who is not providing or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have authorized in writing to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others.

You have the right to look at and receive copies of your records that we keep on file. (We are allowed to charge you a fee for making copies.) You also have the right to ask us to make additions or corrections to your records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purpose that is not routine.

If you have questions or concerns about the privacy of your personal health information, please call OptumRx. OptumRxcontact information is on page 1 of this document.

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us. If you want any of the following kinds of information, call OptumRx:

- **Information about our plan** - To request that a copy of plan information be mailed to you, contact OptumRx.
- **Information about our network pharmacies** - You have the right to get information from us about the pharmacies in our network. For an up-to-date list of pharmacies in the plan's network, visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab). For more detailed information about our pharmacies, you can call OptumRx.
- **Information about coverage and rules you must follow when using your coverage** - To get details on your Part D prescription drug coverage, see Chapters 3 and 4 of this document, plus the plan's Drug List (Formulary). These chapters, together with the Formulary, tell you what drugs are covered and explain rules you must follow and restrictions to your coverage for certain drugs. If you have questions about the rules or restrictions, call OptumRx.

- **Information about why something is not covered and what you can do about it** - If a Part D drug is not covered for you or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation, even if you received the drug from an out-of-network pharmacy.

If you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change our decision. You can ask us to change the decision by filing an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this document. It provides details about how to file an appeal if you want us to change our decision. (Chapter 7 also explains how to make a complaint about quality of care, waiting times, and other concerns.) If you want to ask our plan to pay our share of the cost for a covered Part D prescription drug, see Chapter 5 of this document.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes, people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means if you want to, you can:

- Fill out a written form to **give someone legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself

The legal documents you use in these situations to give your directions in advance are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for healthcare** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor. Also provide a copy of the form to the person you have authorized to make decisions on your behalf. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether or not you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the State Department of Health.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this document explains what to do. It provides details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, file an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, file an appeal, or make a complaint—**we are required to treat you fairly.**

Section 1.7 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019, TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it is **not** about discrimination, you can get help dealing with the problem you have by calling:

- **OptumRx Member Services** – OptumRx contact information is on page 1 of this document.
- **Your State Health Insurance Assistance Program** - For details about this organization and how to contact it, refer to the appendix at the end of this document.
- **Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

Section 1.8 How to get more information about your rights

There are several ways to get more information about your rights:

- **Call OptumRx.** OptumRx contact information is on page 1 of this document.
- **Call your State Health Insurance Assistance Program.** For details about this organization and how to contact it, refer to the appendix at the end of this booklet.
- **Contact Medicare**

- Visit medicare.gov to read or download the publication "Your Medicare Rights & Protections."
- Call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, call OptumRx. We are here to help.

Get familiar with your covered drugs and the rules you must follow to get these covered drugs. Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.

- Chapters 3 and 4 provide details about your coverage for Part D prescription drugs.

If you have other prescription drug coverage besides our plan, you are required to tell us. Please call 1-855-235-0294 to let us know.

- We are required to follow rules set by Medicare to make sure you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **coordination of benefits** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We will help you.

Tell your doctor and pharmacist that you are enrolled in our plan. Show your plan ID card whenever you get your Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

- To help your doctors and other healthcare providers give you the best care, learn as much as you can about your health problems. Give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- If you have questions, be sure to ask. Your doctors and other healthcare providers are supposed to explain things in a way you can understand. If you ask a question and you do not understand the answer you are given, ask again.

Pay what you owe. As a plan member, you are responsible for these payments:

- You must pay your plan premiums (if applicable) to continue being a member of our plan. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (fixed amount) or coinsurance (percentage of total cost). Chapter 4 explains what you must pay for your Part D prescription drugs.
- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- If you are required to pay a late enrollment penalty, you may be disenrolled if you stop paying your late enrollment penalty amount.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount to remain a member of the plan.

Tell us if you move. If you are going to move, contact FAIA immediately to update your records to ensure you receive all necessary correspondence.

Call OptumRx for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Phone numbers and calling hours for OptumRx are on the first page of this document.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first.

Your health and satisfaction are important to us. When you have a problem or concern, we hope you will try an informal approach first and **call OptumRx**. OptumRx contact information is on page 1 of this document. We will work with you to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes, you might need a formal process for dealing with a problem you have as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and filing appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you have. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and may be difficult to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

It can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you deal with your problem and to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you, but in some situations, you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you have. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in the appendix at the end of this document.

You can also get help and information from Medicare

For more information and help with handling a problem, you can also contact Medicare:

- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227),TTY 1-877-486-2048, 24 hours a day, 7 days a week
- **Visit medicare.gov**

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you do not need to read this whole chapter. You only need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE.**

Is your problem or concern about your benefits or coverage?

This includes problems about whether or not particular medical care or prescription drugs are covered, the way in which they are covered, and problems related to payment for medical care or prescription drugs.

Yes My problem is about benefits or coverage.

Go to **Section 4** of this chapter **(A guide to the basics of coverage decisions and appeals)**.

No My problem is **not** about benefits or coverage.

Skip ahead to **Section 7** at the end of this chapter **(How to make a complaint about quality of care, waiting times, member service, or other concerns)**.

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and filing appeals: the big picture

The process for coverage decisions and filing appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not, as well as the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage, or about the amount we will pay for your prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. Usually, there is no problem. We decide the drug is covered and pay our share of the cost. But in some cases we might decide the drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can file an appeal.

Filing an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you file an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review, we give you our decision.
If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected

to our plan. If you are not satisfied with the decision for the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or filing an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or if you decide to appeal a decision:

- You can **call OptumRx**. OptumRx contact information is on page 1 of this document.
- To **get free help from an independent organization** not connected with our plan, contact your State Health Insurance Assistance Program. (For contact information, see the appendix at the end of this document.)
- You should **consider getting your doctor or other prescriber involved**, if possible, especially if you want a fast (expedited) decision. In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber cannot request every appeal. They can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative." (See next item for information about "representatives.")
- You can **ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or to file an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - If you want a friend, relative, your doctor or other prescriber, or another person to be your representative, call OptumRx and ask for the Appointment of Representative form to give that person permission to act on your behalf. The form must be signed by you and by the person you would like to act on your behalf. You must give our plan a copy of the signed form.
- You also have the right to **hire a lawyer to act for you**. You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify; however, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or file an appeal

?	Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 5.1 This section explains what to do if you have problems getting a Part D drug or if you want us to pay you back for a Part D drug

As a member of our plan, your benefits include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as

long as they are included in our plan's Drug List (Formulary) and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Drug List, rules and restrictions on coverage, and cost information, see Chapter 3 (Using the plan's coverage for your Part D prescription drugs) and Chapter 4 (What you pay for your Part D prescription drugs).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a **coverage determination**.

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us if a drug is covered for you and whether or not you satisfy any applicable coverage rules. (For example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section explains both how to ask for coverage decisions and how to request an appeal. Use the following chart to help you determine which part has information for your situation.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that is not on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can file an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Below are three examples of exceptions that you or your doctor or other prescriber can ask us to make.

1. Covering a Part D drug for you that is not on our plan's Drug List (Formulary)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception**.

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to the drug. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 3.)

2. Removing a restriction on the plan's coverage for a covered drug - There are extra rules or restrictions that apply to certain drugs on the plan's Drug List. (For more information, go to Chapter 3.)

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception**.

- The extra rules and restrictions on coverage for certain drugs may include:
  - **Being required to use the generic version** of a drug instead of the brand-name drug
  - **Getting plan approval in advance** before we will agree to cover the drug for you (This is sometimes called "prior authorization.")
  - **Being required to try a different drug first** before we will agree to cover the drug you are asking for (This is sometimes called "step therapy.")
  - **Quantity limits** - For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier** - Every drug on the plan's Drug List is in a cost-sharing tier. In general, the lower the cost-sharing tier, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **tier exception**.

- If your drug is in Tier 3, you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 1 or Tier 2, if an alternative drug is available in the requested tier. This would lower your share of the cost for the drug. Tier exceptions are not permitted for any drug in the high-cost drug tier (Tier 4), if applicable.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons.

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tier exception, we will generally *not* approve your request for an exception unless all alternative drugs in the lower cost-sharing tiers do not work as well for you.

Our plan can say yes or no to your request.

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you, and that drug continues to be safe and effective for treating your condition.

- If we say no to your request for an exception, you can ask for a review of our decision by filing an appeal. Section 5.5 explains how to file an appeal if we say no.

The next section explains how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. (For details about contacting us, go to Chapter 2.)
- **You or your doctor, or someone else who is acting on your behalf, can ask for a coverage decision.** Section 4 of this chapter explains how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 5 of this document (Asking the plan to pay its share of the costs for covered drugs). Chapter 5 describes the situations in which you may need to ask for reimbursement. It also describes how to send the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. We call this the "doctor's statement." Your doctor or other prescriber can fax or mail the statement to our plan, or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. (See Sections 5.2 and 5.3 for more information about exception requests.)
- **We must accept any written request**, including a request submitted on the Coverage Determination Request Form, which is available on our website.

If your health requires it, ask us to give you a "fast decision."

Legal Terms	A **fast decision** is called an **expedited decision**.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

- To get a fast decision, you must meet two requirements:
  - You are asking for a drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
    - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
    - The letter will also explain how you can file a complaint about our decision. It explains how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
    - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. (Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.)
- **If our answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
    - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. (Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.)

- **If our answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. (Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.)
- **If our answer is yes** to part or all of what you requested, we are also required to make payment to you within **14 calendar days** after we receive your request.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to file an appeal.

- If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 5.5 Step-by-step: How to file a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	When you start the appeals process by filing an appeal, it is called the **first level of appeal** or a **Level 1 Appeal**. An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination**.

Step 1: You contact our plan and file your **Level 1 Appeal**. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- To start your appeal, you or your representative, or your doctor or other prescriber, must contact our plan.
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, refer to Chapter 2, Section 1.

Make your appeal in writing by submitting a signed request.

- If you are asking for a standard appeal, make your appeal by submitting a written request.
- If you are asking for a fast appeal, you may make your appeal in writing or you may call OptumRx. OptumRx contact information is on page 1 of this document.

- **We must accept any written request**, including a request submitted on the Coverage Determination Request Form, which is available at **optumrx.com**.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- You can ask for a copy of the information in your appeal and add more information.
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal."

Legal Terms	A **fast appeal** is also called an **expedited appeal**.

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast decision in Section 5.4 of this chapter.

Step 2: Our plan considers your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to within 72 hours.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a standard appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes** to part or all of what you requested:
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to file another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 5.6 Step-by-step: How to file a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by filing another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the **Independent Review Organization** is the **Independent Review Entity.** It is sometimes called the **IRE**.

Step 1: To file a **Level 2 Appeal**, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to file a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you file an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not

a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for fast appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for standard appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes** to part or all of what you requested:
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision to not approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an **Administrative Law Judge**.

- **If the answer is yes**, the appeals process is over. What you asked for in the appeal has been approved.
- **If the answer is no**, the appeals process may (or may not) be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with you appeal.
  - Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the answer is yes**, the appeals process is over. What you asked for in the appeal has been approved.
- **If the answer is no**, the appeals process may (or may not) be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal.

If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, member service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, this section is not for you. Instead, you need to use the process for coverage decisions and appeals found in Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is **only** used for certain types of problems**.** This includes problems related to quality of care, waiting times, and the member service you receive.

Below are examples of the kinds of problems handled by the complaint process. If you have any of these kinds of problems, you can "make a complaint."

Complaint	Example
Quality of your medical care	Are you unhappy with the quality of the care you have received?
Respecting your privacy	Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor member service, or other negative behaviors	Has someone been rude or disrespectful to you? Are you unhappy with how our Member Services has treated you? Do you feel you are being encouraged to leave the plan?
Waiting times	Have you been kept waiting too long by pharmacists, by our Member Services, or by other staff at the plan? Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	Do you believe we have not given you a notice that we are required to give? Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.)	The process of asking for a coverage decision and filing appeals is explained in Sections 4, 5, and 6 of this chapter. If you are asking for a decision or filing an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a fast coverage decision or a fast appeal, and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for making a complaint is "filing a grievance"

Legal Terms	What this section calls a **complaint** is also called a **grievance**. Another term for **making a complaint** is **filing a grievance**. Another way to say **using the process for complaints** is **using the process for filing a grievance**.

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly—either by phone or in writing.

- Usually, **calling OptumRx is the first step**. If there is anything else you need to do, we will let you know. OptumRx contact information is on page 1 of this document.
- If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and send it to us. If you do this, it means that we will use our formal procedure for answering grievances. Here is how it works:

  Send your complaint in writing and mail it to us at:

  OptumRx
  Attn: Part D Grievances
  PO Box 3410
  Lisle, IL 60532-3410

- Whether you call or write, you should contact OptumRx right away. The complaint must be made within 60 days after you had the problem you want to complain about.
- If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you an answer within 24 hours.

Legal Terms	What this section calls a **fast complaint** is also called a **fast grievance**.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 days**, but we may take up to 44 days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or do not take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint to our plan about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about **quality of care**, you also have two extra options:

- You can **make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in the appendix at the end of this document. If you make a complaint to this organization, we will work with them to resolve your complaint.
- Or you can **make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/medicarecomplaintform.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

Chapter 8. Ending your coverage in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in the FAIA Medicare Prescription Drug Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave but we are required to end your membership. Section 5 explains about situations when we must end your coverage.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period or the Special Enrollment Period

Members of the FAIA Medicare Prescription Drug Plan fall into a Special Enrollment Period because you are part of an Employer Group Waiver Plan, which means you are allowed to end your membership anytime throughout the year.

What can you do? You can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

- Another Medicare Prescription Drug Plan.
- Original Medicare without a separate Medicare Prescription Drug Plan.

  – or –

- A Medicare Advantage Plan. A Medicare Advantage Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage Plans also include Part D prescription drug coverage.

If you enroll in most Medicare Advantage Plans, you will automatically be disenrolled from FAIA this plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that plan and keep the our FAIA plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare Prescription Drug Plan or to drop Medicare prescription drug coverage.

Please note: If you disenroll from a Medicare Prescription Drug Plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable drug coverage" is drug coverage that meets Medicare's minimum standards.)

When will your membership end? Your coverage will usually end on the first day of the month after we receive your request to change your plan.

Please note: Before disenrolling from FAIA our plan, you should first contact the plan you wish to enroll in and confirm that they will accept your application. If they enroll you, you will automatically be disenrolled from FAIA our plan.

Section 2.2 Where can you get more information about when you can end your enrollment?

If you have any questions or would like more information on when you can end your enrollment, you can:

- **Call OptumRx.** OptumRx contact information is on page 1 of this document.
- Find the information in the ***Medicare & You*** handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - Download a copy from medicare.gov or order a printed copy by calling Medicare at the number below.
- **Contact Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

SECTION 3 How do you end your membership in our plan?

Section 3.1 You end your membership by enrolling in another plan

To end your membership in our plan, you simply enroll in another Medicare plan; however, there are a couple of exceptions.

One exception is when you want to switch from our plan to Original Medicare *without* a Medicare Prescription Drug Plan. In this situation, you must contact the FAIA and ask to be disenrolled from our plan.

Another exception is if you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. In this case, you can enroll in that plan and keep the FAIA Medicare Prescription Drug Plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare Prescription Drug Plan or to drop your Medicare prescription drug coverage.

The table below explains how you should end your coverage in our plan.

If you would like to switch from our plan to:	This is what you should do:
Another Medicare Prescription Drug Plan	Enroll in the new Medicare Prescription Drug Plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
A Medicare health plan	Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from our plan when your new plan's coverage begins. If you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that new plan and keep FAIA our plan for your drug coverage. If you want to leave our plan, you must either enroll in another Medicare Prescription Drug Plan or ask to be disenrolled. To ask to be disenrolled, you must send us a written request. **Contact OptumRx** if you need more information on how to do this. OptumRx contact information is on page 1 of this document. You can also **contact Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.
Original Medicare without a separate Medicare Prescription Drug Plan. **Note:** If you disenroll from a Medicare Prescription Drug Plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4 for more information about the late enrollment penalty.	**Send us a written request to disenroll.** Contact OptumRx if you need more information on how to do this. OptumRx contact information is on page 1 of this document. You can also **contact Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048, 24 hours a day, 7 days a week and ask to be disenrolled.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan.

If you leave the FAIA Medicare Prescription Drug Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our plan.

You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our home delivery pharmacy services.

SECTION 5 The FAIA Medicare Prescription Drug Plan must end your coverage in certain situations

Section 5.1 When must we end your coverage?

The FAIA Medicare Prescription Drug Plan must end your coverage with our plan if any of the following happen:

- You no longer have Medicare Part A and/or Part B.
- You move out of the United States, District of Columbia, Puerto Rico, or Guam for more than 12 months.
- You become incarcerated.
- You are no longer a United States citizen or lawfully present within the service area.
- You lie about, or withhold information about, other insurance you have that provides prescription drug coverage.
- You intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- You continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- You let someone else use your member ID card to get prescription drugs.
  - If we end your coverage because of this reason, Medicare may have your case investigated by the Inspector General.
- You do not pay any applicable plan premiums as required by FAIA.
  - We must notify you in writing to end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, **Medicare** will disenroll you from our plan and you will lose prescription drug coverage.
- You no longer meet the FAIA plan's eligibility requirements.

Where can you get more information?
You can **call OptumRx** if you have questions or would like more information on when we can end your membership. OptumRx contact information is on page 1 of this document.

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your coverage. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage*, and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location, within the service area. All organizations that provide Medicare Prescription Drug Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed at the end of this document). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare secondary payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, as a Medicare Prescription Drug Plan sponsor, we will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any state laws.

SECTION 4 Notices about fraud, waste, and abuse

Fraud, waste, and abuse is a serious matter. It is in your best interest to protect yourself from fraudulent schemes. CMS has partnered with a national Medicare Drug Integrity Contractor (MEDIC) to help detect, correct, and prevent fraudulent behavior within Medicare Part C and Medicare Part D. In collaboration with CMS, the MEDIC has developed several pamphlets that are designed to provide you with critical information related to fraud, waste, and abuse. They include information on what to look for and how to report it if you suspect that you may have

been subjected to fraud. These pamphlets can be found online at **optumrx.com** on the “Forms” page.

Chapter 10. Definitions of important words

Appeal – An appeal is something you file if you disagree with a decision to deny a request for healthcare services or prescription drugs, or payment for services or drugs you already received. You may also file an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan does not pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in filing an appeal.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug; however, generic drugs are manufactured and sold by other drug manufacturers, and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $6,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs Medicare.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Copayment – Amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost Sharing –Amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific drug is received; or (3) any “coinsurance” amount (a percentage of the total amount paid for a drug that a plan requires when a specific drug is received).

Cost-Sharing Tier – Every drug on the Drug List is in a cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether or not a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription is not covered by your plan, this is not considered a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage.

Covered Drugs – The term we use to mean all prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug List (Formulary) – A list of covered Part D drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Employer Group Waiver Plan (EGWP) – Medicare Part D plan that is sponsored by a former employer, union, or trustees of a fund.

Evidence of Coverage (EOC) and Disclosure Information – This document (along with any other attachments, riders, or other optional coverage selected) explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (formulary exception), or allows you to get a non-preferred drug at the preferred cost-sharing level (tier exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or if the plan limits the quantity or dosage of the drug you are requesting (utilization management exception).

Extra Help/Low-Income Subsidy – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial Coverage Stage – The stage in your benefits where you pay a copayment or coinsurance for your drugs until your Part D out-of-pocket costs have reached the $6,350 limit for the calendar year.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The federal health insurance program for people 65 or older, some people under 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan (Medicare Part C) –A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service

(PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member – An individual with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – Department within our plan that is responsible for answering your questions about your enrollment, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and Prescription Drug Plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers' payment amounts established by Congress. You can see any doctor, hospital, or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your Drug List or "Formulary" for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Premium – The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our Drug List. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the Drug List.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other healthcare experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers. See the appendix at the end of this document for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

Quantity Limit – A utilization management tool designed to limit use of selected drugs for quality, or safety reasons. The limit may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – Geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan and, in the case of network plans, where a network must be available to provide services.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare.

Step Therapy – A utilization management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or 65 and older. SSI benefits are not the same as Social Security benefits.

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
CO	Colorado Bridging the Gap	1-303-692-2783 or 1-303-692-2716
CT	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled - (PACE)	1-800-423-5026 or 1-860-269-2029
DE	Delaware Prescription Assistance Program (PDAP)	1-800-996-9969 Ext 2
DE	Delaware Chronic Renal Disease Program	1-800-464-4357 1-302-424-7180
ID	Idaho AIDS Drug Assistance Program (IDAGAP)	1-800- 926-2588 or 1-208-334-5943
IN	HoosierRx	1-866-267-4679 or 1-317-234-1381
MA	Massachusetts Prescription Advantage	1-800-243-4636 Ext 2
MD	Maryland Senior Prescription Drug Assistance Program (SPDAP)	1-800-551-5995
ME	Maine Low Cost Drugs for the Elderly or Disabled Program	1-866-796-2463
MO	Missouri Rx Plan	1-800-375-1406
MT	Montana Big Sky Rx Program	1-866-369-1233 or 1-406-444-1233
NC	North Carolina HIV SPAP	1-877-466-2232 or 1-919-733-7301
NJ	New Jersey Senior Gold Prescription Discount Program	1-800-792-9745
NJ	New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)	1-800-792-9745
NJ	Division of Medical Assistance and Health Services	1-800-356-1561
NV	Nevada Senior Rx Program & Disability Rx	1-866-303-6323 or 1-775-687-4210
NY	New York State Elderly Pharmaceutical Insurance Coverage (EPIC)	1-800-332-3742 or 1-717-651-3600
PA	Pharmaceutical Assistance Contract for the Elderly (PACE) Pennsylvania PACE Needs Enhancement Tier (PACENET)	1-800-225-7223
PA	Special Pharmaceutical Benefits Program for Mental Health and for HIV/AIDS	1-800-433-4459 (Mental Health) 1-800-922-9384 (HIV/AIDS)

Contact information is subject to change throughout the year.
Please call agencies for most up-to-date information.

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
RI	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	1-401-462-3000 or 1-401-462-0740
TX	Texas Kidney Health Care Program (KHC)	1-800-222-3986 or 1-512-776-7150
TX	Texas HIV State Pharmacy Assistance Program (SPAP)	1-800-255-1090 Ext 3004
VA	Virginia HIV SPAP	1-855-362-0658
VI	U.S. Virgin Islands Senior Citizens Affairs Pharmaceutical Assistance Program	1-340-774-0930
VT	VPharm	1-800-250-8427 or 1-802-879-5900
WA	Washington State Health Insurance Pool	1-800-877-5187
WI	Wisconsin SeniorCare	1-800-657-2038
WI	Wisconsin Chronic Renal Disease and Wisconsin Cystic Fibrosis Program	1-800-947-9627 or 1-800-362-3002

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
AL	Alabama Medicaid Agency	1-800-362-1504 or 1-334-242-5000
AK	Alaska Department of Health and Social Services	1-800-780-9972 or 1-907-465-3030
AR	Arkansas Department of Human Services	1-800-482-5431 or 1-501-682- 8233
AZ	Arizona Health Care Cost Containment	1-800-523-0231 or 1-602-417-4000
CA	California Department of Health Services	1-916-636-1980
CO	Colorado Department of Health Care Policy and Financing	1-800-221-3943 or 1-303-866-2993
CT	Connecticut Department of Social Services	1-800-842-1508 or 1-860-424-4908
DC	District of Columbia Department of Health	1-202-442-5955
DE	Delaware Health and Social Services	1-800-372-2022 or 1-302-255-9500
FL	Florida Agency for Health Care Administration	1-888-419-3456
GA	Georgia Department of Community Health	1-404-656-4507
HI	Hawaii Department of Human Services	1-800-316-8005 or 1-808-524-3370
IA	Iowa Department of Human Services	1-800-338-8366 or 1-515-256-4606
ID	Idaho Department of Health and Welfare	1-877-456-1233
IL	Illinois Department of Healthcare and Family Services	1-800-843-6154 or 1-800-226-0768
IN	Indiana Family and Social Services Administration	1-800-403-0864 or 1-317-233-4454
KS	Kansas Department of Health and Environment	1-800-792-4884
KY	Kentucky Cabinet for Health Services	1-800-635-2570 or 1-502-564-4321
LA	Louisiana Department of Health	1-888-342-6207 or 1-855-229-6848 Spanish: 1-877-252-2447
MA	Massachusetts Office of Health and Human Services	1-800-841-2900 or 1-617-573-1770
MD	Maryland Department of Health and Mental Hygiene	1-877-463-3464 or 1-410-767-6500
ME	Maine Department of Health and Human Services	1-207-287-3707

Contact information is subject to change throughout the year.
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MN	Minnesota Department of Human Services	1-800-657-3672 or 1-651-431-2801
MO	Missouri Department of Social Services	1-800-735-2466 or 1-573-751-3221
MS	Mississippi Division of Medicare	1-800-421-2408 or 1-601-359-6050
MT	Montana Department of Public Health and Human Services	1-800-362-8312
NC	North Carolina Department of Health and Human Services	1-800-662-7030 or 1-919-855-4100
ND	North Dakota Department of Human Resources	1-800-472-2622 or 1-701-328-2310
NE	Nebraska Department of Health and Human Services System	1-855-632-7633 or 1-402-471-3121
NH	New Hampshire Department of Health and Human Services	1-800-852-3345 Ext 4344 or 1-603-271-4344
NJ	New Jersey Department of Human Services	1-800-356-1561
NM	New Mexico Department of Human Services	1-888-997-2583 or 1-505-827-3100
NV	Nevada Department of Health and Human Services	1-800-992-0900 1-775-684- 0615
NY	New York Office of Medicaid Inspector General	1-800-541-2831 or 1-518-473-3782
OH	Ohio Department of Job and Family Services	1-800-324-8680
OK	Oklahoma Health Care Authority	1-800-522-0310 or 1-405-522-7300
OR	Oregon Health Authority	1-800-527-5772 or 1-503-945-5944
PA	Pennsylvania Department of Public Welfare	1-800-692-7462
RI	Rhode Island Executive Office of Health and Human Services	1-401-462-5300
SC	South Carolina Department of Health and Human Services	1-888-549-0820 or 1-803-898-2500
SD	South Dakota Department of Social Services	1-800-597-1603 or 1-605-773-3495
TN	Tennessee Bureau of TennCare	1-800-342-3145 Spanish: 1-866-311-4290
TX	Texas Health and Human Services Commission	1-877-541-7905 or 1-512-424-6500
UT	Utah Department of Health	1-800-662-9651 or 1-801-538-6155

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VA	Virginia Department of Medical Assistance Services	1-804-786-7933
VI	Puerto Rico and Virgin Islands Medicaid Office	1-787-765-2929
VT	Vermont Agency of Human Services	1-800-250-8427 or 1-802-871-3009
WA	Washington Health Care Authority	1-800-562-3022 TTY: 711 (in state)
WI	Wisconsin Department of Health Services	1-800-362-3002 or 1-608-266-1865
WV	West Virginia Department of Health and Human Resources	1-800-642-8589 or 1-304-558-1700
WY	Wyoming Department of Health	1-866-571-0944 1-307-777-7656

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State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
AL	Medicaid Agency of Alabama	1-800-362-1504	1-334-242-5000	n/a
AK	Alaska Department of Health and Social Services	1-800-780-9972	1-907-465-3030	n/a
AR	Department of Human Services of Arkansas	1-800-482-5431	1-501-682-8233	1-800-482-8988
AZ	AHCCCS (a.k.a. Access) (formerly Health Care Cost Containment of Arizona)	1-800-523-0231	1-602-417-7000	1-602-417-7700
CA	California Department of Health Services	n/a	1-916-636-1980	n/a
CO	Department of Health Care Policy and Financing of Colorado	1-800-221-3943	1-303-866-3513	n/a
CT	Department of Social Services of Connecticut	1-800-842-1508	1-860-424-4908	n/a
DC	Department of Health - District of Columbia	n/a	1-202-639-4030	n/a
DE	Delaware Health and Social Services	1-800-372-2022	1-302-255-9500	n/a
FL	Florida Agency for Health Care Administration	1-866-762-2237	1-850-487-1111	n/a
GA	Georgia Department of Community Health	1-800-869-1150	1-404-656-4507	n/a
HI	Department of Human Services of Hawaii	1-800-316-8005	1-808-524-3370	1-800-316-8005
IA	Department of Human Services of Iowa	1-800-338-8366	1-515-256-4606	n/a
ID	Idaho Department of Health and Welfare	n/a	1-208-334-6700	n/a
IL	Illinois Department of Healthcare and Family Services	1-800-226-0768	1-217-782-4977	n/a
IN	Family and Social Services Administration of Indiana	1-800-403-0864	1-317-233-4454	n/a
KS	DCR / Kansas Department of Health and Environment	1-800-766-9012	1-785-296-3981	n/a

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State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
KY	Cabinet for Health Services of Kentucky	1-800-635-2570	1-502-564-4321	n/a
LA	Louisiana Department of Health	1-888-342-6207	1-855-229-6848	1-877-252-2447
MA	Office of Health and Human Services of Massachusetts	1-800-841-2900	n/a	n/a
MD	Department of Health and Mental Hygiene	1-800-456-8900	1-410-767-5800	n/a
ME	Maine Department of Health and Human Services	1-800-977-6740	n/a	n/a
MI	Michigan Department Community Health	1-800-642-3195	1-517-373-3740	n/a
MN	Department of Human Services of Minnesota – MinnesotaCare	1-800-657-3672	1-651-431-2801	n/a
MO	Department of Social Services of Missouri - MO HealthNet Division	1-800-392-2161	1-573-751-3425	n/a
MS	Office of the Governor of Mississippi	1-800-421-2408	1-601-359-6050	n/a
MT	Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources	1-800-362-8312	n/a	n/a
NC	North Carolina Department of Health and Human Services	1-800-662-7030	1-919-855-4100	n/a
ND	North Dakota Department of Human Resources	1-800-755-2604	1-701-328-2321	n/a
NE	Nebraska Department of Health and Human Services System	1-855-632-7633	1-402-471-3121	n/a
NH	New Hampshire Department of Health and Human Services	1-800-852-3345	1-603-271-4344	n/a
NJ	Department of Human Services of New Jersey	1-800-356-1561	n/a	1-800-356-1561
NM	Department of Human Services of New Mexico	1-888-997-2583	1-505-827-3100	1-800-432-6217
NV	Nevada Department of Health and Human Services Division of Welfare and Supportive Services	1-800-992-0900	1-702-631-7098	n/a

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State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
NY	Office of Medicaid Inspector General (formerly New York State Department of Health)	1-800-541-2831	1-518-473-3782	n/a
OH	Department of Job and Family Services of Ohio - Ohio Health Plans	1-800-324-8680	n/a	n/a
OK	Health Care Authority of Oklahoma	1-800-522-0310	1-405-522-7171	n/a
OR	Oregon Health Authority	1-800-527-5772	1-503-945-5712	n/a
PA	Department of Public Welfare of Pennsylvania	1-800-692-7462	n/a	n/a
RI	Executive Office of Health and Human Services	n/a	1-401-462-5300	n/a
SC	South Carolina Department of Health and Human Services	1-888-549-0820	1-803-898-2500	n/a
SD	Department of Social Services of South Dakota	1-800-597-1603	1-605-773-3495	1-800-305-9673
TN	Bureau of TennCare	1-800-342-3145	n/a	1-866-311-4290
TX	Health and Human Services Commission of Texas	1-877-541-7905	1-512-424-6500	n/a
UT	Utah Department of Health	1-800-662-9651	1-801-538-6155	1-800-662-9651
VA	Department of Medical Assistance Services	n/a	1-804-786-7933	n/a
VT	Agency of Human Services of Vermont	1-800-250-8427	1-802-871-3009	n/a
WA	Health Care Authority (formerly Department of Social and Health Services of Washington)	1-800-562-3022	n/a	n/a
WV	West Virginia Department of Health & Human Resources	1-800-642-8589	1-304-558-1700	n/a
WI	Wisconsin Department of Health Services	1-800-362-3002	1-608-266-1865	n/a
WY	Wyoming Department of Health	n/a	1-307-777-7656	n/a

Contact information is subject to change throughout the year.
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State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
AK	Alaska Department of Health and Social Services	1-907-465-3030
AL	State Health Insurance Assistance Program (SHIP)	1-800-243-5463
AR	Seniors Health Insurance Information Program (SHIIP)	1-800-224-6330
AZ	Arizona State Health Insurance Assistance Program (SHIP)	1-800-432-4040
CA	Health Insurance Counseling & Advocacy Program (HICAP)	1-800-434-0222
CO	Senior Health Insurance Assistance Program (SHIP)	1-888-696-7213
CT	Connecticut Program for Health Insurance Assistance, Outreach, Information & Referral Counseling and Elig. Screening (CHOICES)	1-800-994-9422
DC	Health Insurance Counseling Project (HICP)	1-202-994-6272
DE	ELDERinfo	1-800-336-9500
FL	SHINE (Serving Health Insurance Needs of Elders)	1-800-963-5337
GA	Georgia Cares	1-800-669-8387
HI	Sage PLUS	1-888-875-9229
IA	Senior Health Insurance Information Program (SHIIP)	1-800-351-4664
ID	Senior Health Insurance Benefits Advisors (SHIBA)	1-800-247-4422
IL	Senior Health Insurance Program (SHIP)	1-800-548-9034
IN	State Health Insurance Assistance Program (SHIP)	1-800-452-4800
KS	Senior Health Insurance Counseling for Kansas (SHICK)	1-800-860-5260
KY	State Health Insurance Assistance Program (SHIP)	1-877-293-7447
LA	Senior Health Insurance Information Program (SHIIP)	1-800-259-5301
MA	Serving Health Information Needs of Elders (SHINE)	1-800-243-4636
MD	Senior Health Insurance Assistance Program	1-800-243-3425
ME	Maine State Health Insurance Assistance Program	1-800-262-2232
MI	Medicare/Medicaid Assistance Program (MMAP)	1-800-803-7174
MN	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line	1-800-333-2433
MO	Community Leaders Assisting the Insured of MO (CLAIM)	1-800-390-3330
MS	MS Insurance Counseling and Assistance Program (MICAP)	1-800-948-3090
MT	Montana Health Insurance Assistance Program (SHIP)	1-800-551-3191
NC	Seniors' Health Insurance Information Program (SHIIP)	1-800-443-9354

Contact information is subject to change throughout the year.
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State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
ND	Senior Health Insurance Counseling Program (SHIC)	1-888-575-6611
NE	Nebraska Senior Health Insurance Information Program (SHIIP)	1-800-234-7119
NH	NH SHIP - ServiceLink Resource Center	1-866-634-9412
NJ	State Health Insurance Assistance Program (SHIP)	1-800-792-8820
NM	New Mexico ADRC/ SHIP Benefits Counseling	1-800-432-2080
NV	State Health Insurance Advisory Program (SHIP)	1-800-307-4444
NY	Health Insurance Information Counseling and Assistance Program (HIICAP)	1-800-701-0501
OH	Ohio Senior Health Insurance Information Program (OSHIIP)	1-800-686-1578
OK	Senior Health Insurance Counseling Program (SHIP)	1-800-763-2828
OR	Senior Health Insurance Benefits Assistance (SHIBA)	1-800-722-4134
PA	APPRISE	1-800-783-7067
RI	Senior Health Insurance Program (SHIP)	1-401-462-0510
SC	Insurance Counseling Assistance and Referrals for Elders (I-CARE)	1-800-868-9095
SD	Senior Health Information and Insurance Education (SHIINE)	1-800-536-8197
TN	TN SHIP	1-877-801-0044
TX	Health Information, Counseling and Advocacy Program (HICAP)	1-800-252-9240
UT	Health Insurance Information Program (HIIP)	1-801-538-3910
VA	Virginia Insurance Counseling and Assistance Project (VICAP)	1-800-552-3402
VT	State Health Insurance and Assistance Program (SHIP)	1-800-642-5119
WA	Statewide Health Insurance Benefits Advisors (SHIBA) Helpline	1-800-562-6900
WI	Wisconsin SHIP (SHIP)	1-800-242-1060
WV	West Virginia State Health Insurance Assistance Program (WV SHIP)	1-877-987-4463
WY	Wyoming State Health Insurance Information Program (WSHIIP)	1-800-856-4398

Contact information is subject to change throughout the year.
Please call agencies for most up-to-date information.

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
AK	Livanta BFCC-QIO Program	1-877-588-1123
AL	KEPRO	1-844-430-9504
AR	KEPRO	1-844-430-9504
AZ	Livanta BFCC-QIO Program	1-877-588-1123
CA	Livanta BFCC-QIO Program	1-877-588-1123
CO	KEPRO	1-844-430-9504
CT	Livanta BFCC-QIO Program	1-866-815-5440
DC	KEPRO	1-844-455-8708
DE	KEPRO	1-844-455-8708
FL	KEPRO	1-844-455-8708
GA	KEPRO	1-844-455-8708
HI	Livanta BFCC-QIO Program	1-877-588-1123
IA	KEPRO	1-855-408-8557
ID	Livanta BFCC-QIO Program	1-877-588-1123
IL	KEPRO	1-855-408-8557
IN	KEPRO	1-855-408-8557
KS	KEPRO	1-855-408-8557
KY	KEPRO	1-844-430-9504
LA	KEPRO	1-844-430-9504
MA	Livanta BFCC-QIO Program	1-866-815-5440
MD	KEPRO	1-844-455-8708
ME	Livanta BFCC-QIO Program	1-866-815-5440
PaMI	KEPRO	1-855-408-8557
MN	KEPRO	1-855-408-8557
MO	KEPRO	1-855-408-8557
MS	KEPRO	1-844-430-9504
MT	KEPRO	1-844-430-9504
NC	KEPRO	1-844-455-8708

Contact information is subject to change throughout the year.
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Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
ND	KEPRO	1-844-430-9504
NE	KEPRO	1-855-408-8557
ND	KEPRO	1-844-430-9504
NE	KEPRO	1-855-408-8557
NH	Livanta BFCC-QIO Program	1-866-815-5440
NJ	Livanta BFCC-QIO Program	1-866-815-5440
NM	KEPRO	1-844-430-9504
NV	Livanta BFCC-QIO Program	1-877-588-1123
NY	Livanta BFCC-QIO Program	1-866-815-5440
OH	KEPRO	1-855-408-8557
OK	KEPRO	1-844-430-9504
OR	Livanta BFCC-QIO Program	1-877-588-1123
PA	Livanta BFCC-QIO Program	1-866-815-5440
PR	Livanta BFCC-QIO Program	1-866-815-5440
RI	Livanta BFCC-QIO Program	1-866-815-5440
SC	KEPRO	1-844-455-8708
SD	KEPRO	1-844-430-9504
TN	KEPRO	1-844-430-9504
TX	KEPRO	1-844-430-9504
UT	KEPRO	1-844-430-9504
VA	KEPRO	1-844-455-8708
VI	Livanta BFCC-QIO Program	1-866-815-5440
VT	Livanta BFCC-QIO Program	1-866-815-5440
WA	Livanta BFCC-QIO Program	1-877-588-1123
WI	KEPRO	1-855-408-8557
WV	KEPRO	1-844-455-8708
WY	KEPRO	1-844-430-9504

Contact information is subject to change throughout the year.
Please call agencies for most up-to-date information.

Nondiscrimination notice and access to communication services
OptumRx and its family of affiliated Optum companies do not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

We provide assistance free of charge to people with disabilities or whose primary language is not English. To request a document in another format, such as large print, or to get language assistance such as a qualified interpreter, please call the number located on the back of your prescription ID card (TTY 711). Representatives are available 24 hours a day, 7 days a week.

If you believe we have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can send a complaint to:

OptumRx Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344

Phone: **1-800-562-6223 (TTY 711)**
Fax: 1-855-351-5495
Email: **Optum_Civil_Rights@Optum.com**

If you need help filing a complaint, please call the number located on the back of your prescription ID card (TTY 711). Representatives are available 24 hours a day, 7 days a week. You can also file a complaint directly with the U.S. Department of Health and Human Services online, by phone, or by mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at:
https://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free **1-800-368-1019**, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your health plan ID card.

Multi-language interpreter services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免**費**為您提供語言協助服務。**請撥打會員**卡所列的免付**費會員電話號碼**。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសា**ខ្មែរ(Khmer)**សេវាជំនួយភាសារបស់ឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.