Lake Erie Regional Council (LERC)

Wellington Exempted Village Schools

Prescription Drug Plan

Effective Date: July 1, 2015

CONTACT INFORMATION

CVS Caremark
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24 hours a day/7 days a week
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Paper claim reimbursement information:
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Lake Erie Regional Council
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INTRODUCTION

This booklet summarizes the main provisions of the prescription drug section of the Wellington Exempted Village Schools Prescription Drug Plan effective July 1, 2015, as provided through the Lake Erie Regional Council (LERC). It describes the prescription drug benefits as they apply to eligible employees. Nothing in the plan or in this document is intended to provide employees, former employees or dependents with a vested right to any benefits and/or any rights for continued employment.

We encourage you to read this booklet carefully and share it with your family members covered under the plan. If you have any questions about your benefits, please contact CVS Caremark or the insurance department at Lake Erie Regional Council (LERC).

Please note that this booklet is only a summary. Complete details of the prescription drug plan are contained in the group health contract. If there is any difference between the information in this booklet and in the group health contract, the group health contract will govern.

The plan sponsor reserves the right to interpret, to amend and to terminate this plan, in whole or in part, at any time and for any reason.

ELIGIBILITY

Please refer to your medical plan booklet for eligibility information.

COVERAGE EFFECTIVE DATE

Please refer to your medical plan booklet for coverage effective date information.

ENROLLMENT

If you are eligible for benefits and elect medical coverage through the Wellington Exempted Village Schools, you are automatically covered under this prescription drug plan.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT RIGHTS

If you or your eligible dependent(s) experience a special enrollment event as described below, you or your eligible dependent(s) may be entitled to enroll in the plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the plan, you may request enrollment for you and your eligible dependent(s) under a different option offered by the employer for which you are currently eligible if available. If you are not already enrolled in the plan, you must request special enrollment for yourself in addition to your eligible dependent(s). You and all of your eligible dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new dependent.** If you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the plan: employee only; spouse only; employee and spouse; dependent child(ren) only; employee and dependent child(ren); employee, spouse and dependent child(ren). Enrollment of dependent children is limited to the newborn or adopted children or children who became dependent children of the employee due to marriage. Dependent children who were already dependents of the employee but not currently enrolled in the plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected dependent(s) that are not already enrolled in the plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage)**. If coverage was declined under the plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible dependent(s) may request special enrollment in the plan. This provision applies to loss of eligibility as a result of any of the following:
  - divorce;
  - cessation of dependent status (such as reaching the limiting age);

- death of the employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the employee's or dependent's other coverage, special enrollment may be requested in the plan for you and all of your eligible dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in the plan for you and all of your eligible dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under the plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; or (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected dependent(s) that are not already enrolled in the plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment. Individuals who enroll in the plan due to a special enrollment event will not be considered late entrants.

PLAN ENROLLMENT CHANGES

Please refer to your medical plan booklet for information as to when you can change your plan enrollment during the plan year.

PLAN COVERAGE AND COST

This plan is self-funded with contributions from both the Wellington Exempted Village Schools and eligible employees. The plan also is part of the Wellington Exempted Village Schools' Section 125 flexible benefit plan that allows you to elect health care coverage and to pay your contributions on a pre-tax

basis. This tax savings advantage allows you to have a portion of your compensation deducted from your pay check before your taxes are calculated. Because of this, you pay for your coverage with pre-tax dollars, you pay fewer taxes and you take home more pay. CVS Caremark administers the prescription drug benefit described in this document.

BENEFITS AT A GLANCE

PRESCRIPTION BENEFIT PLAN COPAY / MEMBER COST SHARE OVERVIEW*		
Prescription Services	**SHORT-TERM RETAIL (up to a 34-day supply)**	**LONG-TERM MAIL SERVICE (up to a 90-day supply)**
Generic Medications – Ask your doctor or other prescriber if there is a generic available, as these general cost less	$10	$20
Preferred Brand-Name Medications – If a generic is not available or appropriate, as your doctor or other prescriber to prescribe from your plan's preferred drug list	$20	$40
Non-Preferred Brand -Name Medications – You will pay for the most for medications not on your plan's preferred drug list	$30	$60
Annual Maximum Out-of-Pocket	Integrated with medical plan: $6,600 single/$13,200 family	

*Any prescription for preventive care under the Affordable Care Act will be paid at 100%.

Where to Fill Your Prescription
Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication.

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS Caremark retail network.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money and it will be more convenient to use the mail services for these prescriptions.

DRUG COVERAGE

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
Federal Legend Drugs	Yes	Yes	
Over the Counter Drugs	No	No	
Allergy Serums (RX, INJ)	Yes	Yes	
Cosmetic Products not Including Acne Medications (RX)			
Anti-wrinkle Agents (RX)	No	No	
BOTOX COSMETIC (RX, INJ)	No	No	
Depigmenting Agents (RX)	Yes	Yes	
Hair Growth Stimulants (RX)	No	No	
Hair Removal Agents (RX)	No	No	
Nutritional Supplements (RX, INJ)			
Injectable Nutritional Supplements (RX, INJ)	No	No	
Oral Nutritional Supplements (RX, INJ)	No	No	
Rx Devices other than Respiratory (RX, INJ)			
Elastic Bandages & Supports (RX, INJ)	No	No	
GI-GU Ostomy & Irrigation Supplies (RX, INJ)	No	No	
Other Rx Devices (RX, INJ)	No	No	
Vaccines/Toxoids (RX, INJ)	No	No	
Contraceptives (RX, INJ)	See additional coverages below for more information		
Contraceptive-Ring (Nuvaring) (RX)	Yes	Yes	
Device Contraceptives (RX) (RX)	Yes	Yes	
Emergency Kit Contraceptives (RX)	Yes	Yes	
Injectable Contraceptives (RX, INJ)	Yes	Yes	
Oral Contraceptives	Yes	Yes	
Transdermal Contraceptives	Yes	Yes	
Erectile Dysfunction (RX, INJ)			
Injectable Erectile Dysfunction (RX, INJ)	Yes	Yes	
Inter-Urethral Erectile Dysfunction (RX)	Yes	Yes	
Oral Erectile Dysfunction (RX)	Yes	Yes	
Fertility Medications (RX, INJ)			
Injectable Fertility Medications (RX, INJ)	No	No	
Oral Fertility Medications (RX)	No	No	
Acne Medications (RX)			

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
Retinoids (RX)	Yes	Yes	Yes
Anabolic and Androgen Medications (RX, INJ)			
Anabolics (RX)	No	No	
Androgens (RX, INJ)	Yes	Yes	
Compounds (RX)	Yes	Yes	
Diet Medications (RX)			
Anorexiants (RX)	No	No	
Anti-Obesity (RX)	No	No	
Influenza Treatments			
Inhaler Influenza Treatments (RX)	Yes	Yes	
Oral Influenza Treatments (RX)	Yes	Yes	
Migraine Medications(RX, INJ)			
Injectable Migraine Medications (RX, INJ)	Yes	Yes	
Nasal Spray Medications (RX)	Yes	Yes	
Oral Migraine Medications (RX)	Yes	Yes	
Suppository Migraine Medications (RX)	Yes	Yes	
Nail Fungal Treatment (RX)			
Oral Nail Fungal Treatment (RX)	Yes	Yes	
Topical Nail Fungal Treatment (RX)	Yes	Yes	
Smoking Cessations (RX)			
Oral Smoking Cessation (RX))	Yes	Yes	
Smoking Cessation Gum (RX)	Yes	Yes	
Smoking Cessation Inhaler(RX)	Yes	Yes	
Smoking Cessation Patch (RX)	Yes	Yes	
Smoking Cessation Spray (RX)	Yes	Yes	
Diabetic Medicines & Supplies (OTC, RX, INJ)			
Alcohol Wipes (OTC)	No	No	
Glucose Monitors (OTC, RX)	No	No	
Injectables other than Insulin (OTC, RX, INJ)	Yes	Yes	
Insulin (OTC ,RX, INJ)	Yes	Yes	
Lancet Devices (OTC, RX, INJ)	No	No	
Lancets (OTC)	No	No	

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
Strips (OT, RX)	No	No	
Syringes (OTC,RX, INJ)	Yes	Yes	
Emergency Allergic Kits (RX, INJ)	Yes	Yes	
Pre-Natal Vitamins (RX)	Yes	Yes	
Respiratory Therapy Supplies (RX)			
Aerochambers/Inpirease/Spacers (RX)	No	No	
Nebulizers (RX)	No	No	
Peak Flow Meters (RX)	No	No	
Vitamins (RX, INJ)			
Injectable Vitamins (Rx, INJ)	No	No	
Nasal Gel Vitamins (Rx, INJ)	No	No	
Oral Vitamins (RX)	No	No	
Biotech/Specialty Medicines (RX, INJ)			
Anti-viral Monoclonal Antibodies (Synagis) (RX, INJ)	Yes	Yes	
Biotech Respiratory Agents (RX, INJ)	Yes	Yes	
Blood Plasma/Blood Transfusion Agents (RX, INJ)	No	No	
Enzyme Deficiency Agents (RX, INJ)	Yes	Yes	
Growth Hormones (RX, INJ)	No	No	
Growth Hormones Releasing Agent (RX, INJ)	No	No	
Hematopoietic Growth Factors, (RX, INJ)	Yes	Yes	
Infectious Disease Therapies, (RX, INJ)	Yes	Yes	
Interferons (RX, INJ)	No	No	
LHRH Analog (RX, INJ)	Yes	Yes	
Miscellaneous (RX, INJ)	Yes	Yes	
Multiple Sclerosis Agents (RX, INJ)	Yes	Yes	
Oncology Therapies (RX, INJ)	Yes	Yes	
Psoriasis (RX, INJ)	Yes	Yes	
Pulmonary Arterial Hypertension (RX, INJ)	Yes	Yes	
Rheumatoid Arthritis (RX, INJ)	Yes	Yes	
Transplant Therapies (Rx, INJ)	Yes	Yes	
Botulinum Toxins (Non-Cosmetic/Essential) (Rx, INJ)	No	No	
Blood Factors/Clotting Factors (RX, INJ)	Yes	Yes	
Immunosuppressive Agents (RX, INJ)	Yes	Yes	

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
Other Injectables (RX, INJ)	Yes	Yes	Yes
Syringes Other Than Insulin (RX, INJ)	No	No	
Additional Coverages Not Outlined in Above Categories			
ACTOS PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
ADHD Drugs (RX)	Yes	Yes	
ADVICOR PA REF# 717 –A (RX)	Yes	Yes	Yes
ALTROPREV PA REF# 717-A (RX)	Yes	Yes	Yes
ALVESCO PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
ANDROGEL PA REF# 717-A (RX)	Yes	Yes	Yes
ARTHROTEC PA REF# 717-A (RX)	Yes	Yes	Yes
ASACOL HD PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
ATACAND HCT PA REF# 717-A (RX)	Yes	Yes	Yes
ATACAND PA REF# 717-A (RX)	Yes	Yes	Yes
AXIRON PA REF# 717-A (RX)	Yes	Yes	
BECONASE AQ PA REF# 717-A (RX)	Yes	Yes	Yes
BREEZE 2 STRIPS AND KITS Prior Auth Ref# 717-A (OTC, RX)	Yes	Yes	Yes
BREO ELLIPTA PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
BREVOXYL PA REF# 717 –A (RX)	Yes	Yes	Yes
CONTOUR NEXT STRIPS AND KITS Prior Auth Ref# 717-A (OTC, RX)	Yes	Yes	Yes
CONTOUR STRIPS AND KITS Prior Auth Ref# 717-A (OTC, RX)	Yes	Yes	Yes
CONTROLLED SUBS-C2, C3,C4,C5 (RX,INJ)	Yes	Yes	
DELZICOL PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
DESI DRUGS (OTC, RX)	Yes	Yes	
DETROL LA PA REF# 717-A (RX)	Yes	Yes	Yes
DIOVAN HCT PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
DYMISTA PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
EDARBI PA REF# 717-A (RX)	Yes	Yes	Yes
EDARBYCLOR PA REF# 717-A (RX)	Yes	Yes	Yes
ERECTILE DYSF AGNT-REF 84 H-FEAT PRGM (RX, INJ)	Yes	Yes	
FLECTOR PA REF# 717-A (RX)	Yes	Yes	Yes

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
FORTAMET PA REF# 717-A (RX)	Yes	Yes	Yes
FORTESTA PA REF# 717-A (RX)	Yes	Yes	
FREESTYLE TEST STRIPS PA REF# 719-A (OTC, RX)	Yes	Yes	Yes
FUZEON (RX, INJ)	Yes	Yes	
GENOTROPIN PA REF# 717-A (RX)	Yes	Yes	Yes
GLUMETZA PA REF# 717-A (RX)	Yes	Yes	Yes
HCR-CONTDC CERVICAL CAPS (RX)	Yes	Yes	No copay
HCR-CONTDC DIAPHRAGMS (RX)	Yes	Yes	No copay
HCR CONTRACEPTIVES ALL (OTC, RX)	Yes	Yes	No copay
HCR VITD (OTC, RX)	Yes	Yes	No copay
HCRA-CMK HCR ASPIRIN (OTC, RX)	Yes	Yes	No copay
HCRAV-CMK HCR VACCINES FOR ADULTS (OTC, RX)	Yes	Yes	No copay
HCRAV-CMK HCR VACCINES FOR CHILDREN/ADULTS (RX, INJ)	Yes	Yes	No copay
HCRCONTID-IMPLANTS (RX)	Yee	Yes	No copay
HCRCONTID-IUD (RX)	Yes	Yes	No copay
HCRCONTIDVAGINAL RING (RX)	Yes	Yes	No copay
HCRCONTIN-INJECTABLE (RX, INJ)	Yes	Yes	No copay
HCRCV-CMK HCR VACCINES FOR CHILDREN (RX, INJ)	Yes	Yes	No copay
HCRFA-CMK HCR FOLIC ACID (OTC, RX)	Yes	Yes	No copay
HCRFS-CMK HCR FLUORIDE SUPPLEMENT (OTC, RX)	Yes	Yes	No copay
HCRIS-CMK HCR IRON SUPPLEMENT (OTC, RX)	Yes	Yes	No copay
HCRNRP-CMK HCR NICOTINE REP PROD (OTC, RX)	Yes	Yes	No copay
HCRZC-CMK HCR GxZYBAN CHANTIX (RX)	Yes	Yes	No copay
HECORIA PA REF# 717-A (RX)	Yes	Yes	Yes
HUMALOG MIX 50/50 PA REF# 717-A (RX, INJ)	Yes	Yes	Yes
HUMALOG MIX 75/25 PA REF# 717-A (RX, INJ)	Yes	Yes	Yes
HUMALOG PA REF# 717-A (RX, INJ)	Yes	Yes	Yes
HUMUILIN 70/30 PA REF# 717-A (OTC, RX, INJ)	Yes	Yes	Yes
HUMUILIN N PA REF# 717-A (OTC, RX, INJ)	Yes	Yes	Yes
HUMUILIN R PA REF# 717-A (OTC, RX, INJ)	Yes	Yes	Yes

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
INJ. ERECTILE DYSF Prior Auth (RX, INJ)	Yes	Yes	Yes
INTERMEZZO PA REF# 717-A (RX)	Yes	Yes	Yes
JALYN REF# 717-A (RX)	Yes	Yes	Yes
KAZANO Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
KOMBIGLYZE XR PA REF# 717-A (RX)	Yes	Yes	Yes
LASTACAFT PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
LESCOL XL PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
LEVITRA PA REF# 717-A (RX)	Yes	Yes	Yes
LIPITOR PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
LIPTRUZET Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
LIVALO PA REF# 717-A (RX)	Yes	Yes	Yes
LUMIGAN PA REF# 717-A (RX)	Yes	Yes	Yes
MAXAIR PA REF# 717-A (RX)	Yes	Yes	Yes
NEOBENZ MICRO PA REF# 717-A (RX)	Yes	Yes	Yes
NESINA Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
NUTROPIN/NUTORPIN AQ PA REF# 717-A (RX)	Yes	Yes	Yes
OLEPTRO PA REF# 717-A (RX)	Yes	Yes	Yes
OLUXE –E PA REF# 717-A (RX)	Yes	Yes	Yes
OMNARIS PA REF# 717-A (RX, INJ)	Yes	Yes	Yes
OMNITROPE PA REF# 717-A (RX)	Yes	Yes	Yes
ONGLYZA PA REF# 711-A (RX)	Yes	Yes	Yes
ORAL ERECTILE DYSF Prior Auth (RX)	Yes	Yes	Yes
OSENI Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
OXYTROL SANCTURA XR PA REF# 720-A (Rx)	Yes	Yes	Yes
PLAVIX PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
PREVACID PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
PROTONIX PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
QNASL PA REF# 717-A (RX)	Yes	Yes	Yes
RAYOS PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
RHINOCORT AQUA PA REF# 717-A (RX)	Yes	Yes	Yes
RIOMET PA REF3 717-A (RX)	Yes	Yes	Yes
ROZERM PA REF# 717-A (RX)	Yes	Yes	Yes
RYZOLT PA REF# 717-A (RX)	Yes	Yes	Yes

TYPE OF MEDICATION	Covered through Mail Service?	Covered through Network Retail Pharmacies?	Quantity or Other Limitations?
SAIZEN PA REF# 717-PA (RX)	Yes	Yes	Yes
SEASONALE (+like Ext Cyc OCs) (RX)	Yes	Yes	Yes
SUBOXONE FILM PRIOR AUTH REF 717-A BR & RX (RX)	Yes	Yes	Yes
TESTIM PA REF# 717-A (RX)	Yes	Yes	Yes
TEV-TROPIN PA REF# 717-A (RX)	Yes	Yes	Yes
TEVETEN HCT PA REF# 717-A (RX)	Yes	Yes	Yes
TEVETEN PA REF# 717-A (RX)	Yes	Yes	Yes
TOVIAZ PA REF# 717-A (RX)	Yes	Yes	Yes
TRADJENTA PA REF#717-A (RX)	Yes	Yes	
TRICOR Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
TUDORZA PRESSAIR Prior Auth Ref# 717-A (RX)	Yes	Yes	Yes
VALTREX PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
VENTOLIN HFA PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes
VERAMYST PA REF# 717-A (RX)	Yes	Yes	Yes
XOPENEX HFA PA REF# 717-A (RX)	Yes	Yes	Yes
YOHIMBINE-YOCON (RX)	No	No	
ZETONNA PRIOR AUTH REF 717-A (RX)	Yes	Yes	Yes

Care Outside the United States

Prescription drugs purchased outside of the United States are covered under the plan. However, if you are overseas and need to purchase prescription drugs due to an emergency, eligible prescription drugs that are purchased will be covered.

You will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a paper claim reimbursement form to CVS Caremark for reimbursement.

PRIOR AUTHORIZATION

CVS Caremark prior authorization criteria are developed to ensure safe, effective and appropriate utilization of selected drugs. The physician writing the prescription must confirm that the patient has met the evidence-based criteria in order to obtain an override to cover the specific drugs and for the claims to be paid. Prior authorizations are set up by the Plan. Any drugs that require a prior authorization in this plan are indicated in the DRUG COVERAGE chart.

QUANTITY LIMITATIONS

Any drug that has a quantity limitation is indicated in the DRUG COVERAGE chart.

EXCLUSIONS

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, the Lake Erie Regional Council (LERC), in conjunction with CVS Caremark, will assess the feasibility of covering the drug as well as the application of any coverage restriction or limitation.

The plan covers charges for drugs and medicines which, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a physician. Drug exclusions will also be indicated in the DRUG COVERAGE chart if applicable.

PLEASE NOTE: Effective April 1, 2012, select non-formulary drugs that were previously covered under the plan will no longer be covered. Coverage for certain drugs is excluded from the Plan unless medical necessity can be demonstrated by your physician through a prior authorization process. If medical necessity is demonstrated and the prior authorization is approved, the drug will be covered at a non-preferred coverage tier. For a list of excluded drugs, please go to www.caremark.com/druglist or call (855) 230-5548 which is the number on the back of your ID card for more information.

RETAIL OR MAIL SERVICE

Your prescription plan offers two ways to get your medication – through a CVS Caremark retail network pharmacy or CVS Caremark mail service pharmacy. Use a CVS Caremark participating network pharmacy when filling short-term prescriptions for medications such as antibiotics. Use the CVS Caremark mail service to fill your long-term prescriptions. Mail service is a cost-effective choice for long-term medications because you can generally get up to a 90-day supply for less than what you would pay for the same supply at retail.

Retail Prescription Drugs

You can receive a short-term prescription drug (those prescribed for 30 days or less) at any CVS Caremark participating network pharmacy. Just give the pharmacist your CVS Caremark ID card along with your prescription. You will pay the applicable cost share listed in the BENEFITS AT A GLANCE chart. You will pay your cost share for your prescription at the time of purchase. The plan pays the remainder. If your plan has a minimum cost share in place and your responsibility is less than that minimum cost share, you are only required to pay the lesser of the two. If you do not have your CVS Caremark ID card, you will still have coverage. Pay for the full amount of the prescription and save the original receipt. Complete a paper claim reimbursement form and submit with your original receipt to the address on the inside cover of this document. You can receive a paper claim reimbursement form by contacting

CVS Caremark at the Customer Service phone number on your CVS Caremark ID card or by visiting www.caremark.com. CVS Caremark will then reimburse you for the portion that the plan would pay.

Mail Service Prescription Drugs

The mail service can be utilized for long-term maintenance medications. Mail order prescriptions cover up to a 90-day prescription or a 90-day refill of that prescription. Tell your prescribing physician that you have a mail order prescription program. That will inform them that you need a 90-day prescription for the medication you need to take. Complete a mail service order form and send to CVS Caremark along with your prescription and the applicable cost share. Please note that it can take up to 2-3 weeks to receive your prescription in the mail so please plan accordingly. You can order refills on your mail order prescriptions by phone or by visiting the internet at www.caremark.com. This will cut down the time it takes for you to receive your prescriptions back.

Retail Refill Restriction

This plan does not have a retail refill restriction. As a result, you are not required to use the mail order component of the plan. However, as a reminder, you will see potential cost savings by using the mail order component of the plan because you can generally receive a 90 day supply for less than what you would pay for the same supply at retail

CLINICAL SOLUTIONS

Specialty Guideline Management

Specialty Guideline Management evaluates the appropriateness of drug therapy for specialty medications according to evidence based guidelines both before the initiation of therapy and on an ongoing basis. This solution is available for all specialty conditions and outreach is made to both you and the prescriber to evaluate the therapy.

The Specialty Guideline Management program requires approval of treatment for select medicines. Under this program, there will be a review of clinical information for approval of treatment with these medicines. Decisions are based on nationally recognized guidelines and are administered by a CVS Caremark clinical specialist.

WEBSITE TOOLS

www.caremark.com

Caremark.com allows you to get the most from your prescription drug benefit through interactive decision support tools, personalization and dynamic messaging. To begin the registration process, you can click the **Not registered yet?** link on www.caremark.com. Here you will follow a few simple steps to create a username and password that will allow you to access your information and all of the features of the site.

To register on www.caremark.com:

1. Click on the **Not registered yet?** link
2. Enter the information on the registration form
3. Create a new username to protect your privacy
4. Create a unique challenge question and answer

Online Pharmacy

- Access fast and convenient mail service for new prescriptions and online refills
- Check order status for all CVS Caremark mail service orders; phone, online and paper
- Expedite new prescription mail service orders with FastStart
- Print or view prescription history and My Drug List
- Explore lower-cost options with iBenefit icons and the savings center
- Make informed decisions with Check Drug Cost and therapeutic alternatives
- Find local pharmacy information and driving directions
- Print forms or ID cards
- Connect with CVS Caremark online through Ask-A-Pharmacist or Customer Care
- Receive alerts or eNewsletters in their inbox or secure message center
- Spanish translation of online pharmacy content

Health and Wellness

- Check interactions of prescriptions, vitamins and foods
- Find drug information about prescription and over-the-counter medicines
- Search health and wellness articles and use interactive tools and calculators
- Find health information about specific conditions through the self-care centers
- Link to specialty pharmacy services

APP TOOLS

You can also manage your CVS Caremark prescription benefits from your smart phone. No matter how or where you access the site, your information is saved in real time, so it's always up to date.

CVS Pharmacy App

For faster access to the features you love, download the CVS/pharmacy app for your smart phone. Search for CVS Pharmacy **and the app will appear. This app will help you:**

- Order prescriptions by scanning your refills or via Rapid Refill (no sign in required) or via your prescription history
- Refill prescriptions
- Transfer prescriptions
- Access your CVS.com account
- Request an ExtraCare card

- View ExtraCard information (send offers to your ExtraCare Healthcare Card, view weekly ads, sign up for deals and more)
- Schedule a flu shot
- Find MinuteClinic locations (retail medical clinic inside some CVS pharmacies)
- Sign up for offers and emails
- And more

Caremark App

You also have the ability to download the CVS Caremark app. Do a search for **CVS Caremark** on your phone and the app will appear. This app will help you:

- Secure Login & Registration
- Refill a Prescription
- Request a new Prescription (FastStart)
- View Prescription History
- Check Order Status
- Check Drug Cost
- Find a Pharmacy
- And more

HOW TO SUBMIT A CLAIM

Payment for Prescriptions:

The purchase of drugs through a CVS Caremark participating network pharmacy maximizes prescription drug benefits. No claim forms are needed when you use a CVS Caremark ID card at a CVS Caremark participating network pharmacy. You are responsible for paying any deductible or cost share at the time of purchase.

The claim forms that include specific instructions on claim filing can be obtained from CVS Caremark by calling the number in the front of this document. Paper claim reimbursement forms must be mailed to the address indicated on the claim form.

All claims relating to benefits covered under the plan must be filed within the 12 month period following the date in which the service is received. This is called the claims filing deadline.

The CVS Caremark Claims and Appeals Process

Definitions

The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Plan benefit. A rescission of coverage shall also be treated as an Advance Benefit Determination. Such denial, reduction, termination or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations.

However, with respect to requests for External Review initiated on or after September 20, 2011, only Adverse Benefit Determinations of a Claim Involving Medical Judgment will be eligible for External Review.

Claim – A request for a plan benefit that is made in accordance with the plan's established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of you, your family, or your provider.

Post-Service Claim – A Claim for a plan benefit that is not a Pre-Service Claim.

Pre-authorization – CVS Caremark's pre-service review of your initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by the plan sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for pre-authorization.

Urgent Care Claim – A claim for a medication, service or product where a delay in processing the Claim: (i) could seriously jeopardize your life or health, and/or could result in your failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without the requested medication, service, or product.

Pre-authorization Review:

CVS Caremark will implement the prescription drug cost containment programs requested by the plan sponsor by comparing your requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that your request for pre-authorization cannot be approved, that determination will constitute an adverse benefit determination.

Appeals of Adverse Benefit Determinations:

If an adverse benefit determination is rendered on your claim, you may file an appeal of that determination. The appeal of the adverse benefit determination must be made in writing and submitted to CVS Caremark within 180 days after you receive notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, you and/ or your attending physician may submit an appeal by calling CVS Caremark.

Appeals should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the claim.

The appeal and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark Inc
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Rx Claim Platform Fax Number for Appeals: (866) 443-1172
QL Claim Platform Fax Number for Appeals: (866) 689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.

CVS Caremark's Review:

The review of your claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirement of ERISA and any related laws. You will be accorded all rights granted to you under ERISA and any related laws.

CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If you appeal CVS Caremark's decision, you can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization (IRO).

Timing of Review:

Pre-Authorization Review – CVS Caremark will make a decision on a Pre-Authorization request for a plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

Pre-Service Claim Appeal – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives your appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, you may appeal that decision by providing the information described above. A decision on your second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If you are appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first and second-level appeals, combined).

Post-Service Claim Appeal – CVS Caremark will make a decision on appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

Scope of Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS Caremark shall:

- Take into account all comments, documents, records and other information you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable plan documents:
- Follow reasonable procedures to ensure that the applicable plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly-situated members; and
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If you appeal CVS Caremark's denial of a Pre-Service Claim, and request an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination:

Following the review of your claim, CVS Caremark will notify you of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will also be communicated by telephone or fax.) This notice will include:

- Information sufficient to identify the claim involved including date of service and prescription involved;
- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent plan provision on which the Adverse Benefit Determination was based;
- A description of any additional information necessary for the claim to be completed and the reason why such additional information is necessary;
- A statement that you are entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guidelines, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon written request.
- Availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Action Section 2793.

If, after exhausting your internal appeals, you are not satisfied with the Final Internal Adverse Benefit Determination, you may choose to participate in the external review program. The following terms are used herein to describe the Federal External Review services provided by CVS Caremark:

Definitions

Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the "deemed exhaustion" rules of the ACA.

Independent Review Organization (IRO) – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to the requirements of the ACA.

Claim Involving Medical Judgment – A Claim for prescription drug benefits involving, but not limited to, decisions based on the Plan's standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

Federal External Review Process (Expedited)

A member may request an expedited External Review:

- If the member receives an Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, and the member has filed a request for an expedited internal appeal; or
- If the member receives a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves: (i) a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Request for Review:

If the member's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the member or the member's physician may request an expedited external review by calling the Customer Care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include the member's name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited External Review may be faxed; member contact information and coverage denial description, and supporting documentation may be faxed to the attention CVS Caremark External Review Appeals Department at fax number (866) 689-3092.

All requests for expedited review must be clearly identified as "urgent" at submission.

Preliminary Review:

Immediately on receipt of a member's request for expedited External Review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard External Review. Immediately upon completing this review, CVS Caremark will notify the member that: (i) the member's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO:

Upon determining that a member's request is eligible for expedited External Review, CVS Caremark will assign an IRO to review the member's claim. CVS Caremark will provide or transmit all necessary

documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review the member's Claim again and will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeals process.

Timing of the IRO's Determination:

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review the member's Claim again and will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeals process.

The IRO must provide the member and CVS Caremark, on behalf of the plan, with notice of its determination as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member's request for External Review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the member and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review:

CVS Caremark will be responsible only for conducting the preliminary review of a member's request for External Review, ensuring that the member is timely notified of the decision as to eligibility for External Review, and for assigning the request for External Review to an IRO.

The actual External Review of a member's appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the External Review performed by an IRO.

Federal External Review Process (Non-Expedited)

Request for Review:

A Plan member whose Claim Involving Medical Judgment is denied may request, in writing, an External Review of such claim within 4 months after receiving notice of the Final Internal Adverse Benefit Determination. The member's request should include the member's name, contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial. The member's request for External Review and supporting documentation may be mailed or faxed to CVS Caremark.

CVS Caremark

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

Preliminary Review:

Within 5 days of receiving a plan member's request for External Review, CVS Caremark will conduct a "preliminary review" to ensure that the request qualifies for External Review. In this preliminary review, CVS Caremark will determine whether:

- The member is or was covered under the plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the member's failure to meet the Plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
- The member has exhausted the Plan's internal appeal process (unless the member's claim is "deemed exhausted" under the ACA); and
- The member has provided all the information and forms necessary to process the External Review.

In addition, CVS Caremark will review the member's request for External Review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that the request does not involve a Claim Involving Medical Judgment, it will forward the member's request for External Review to an IRO for further review. The IRO determines whether the member's request for External Review involves a Claim Involving Medical Judgment as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that: (i) the member's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO:

If the member's request for External Review is complete and the member's Claim is eligible for External Review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have 10 days to provide the IRO with any additional information the member wants the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the plan and the plan sponsor. The IRO may consider information beyond the records for the member's denied claim, such as:

- The member's medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the plan, the member, or the member's treating physician;
- The terms of the plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;
- Any applicable clinical review criteria developed and used on behalf of the plan (unless the criteria are inconsistent with the terms of the plan or applicable law); and
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the member's request for External Review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of IRO's Determination:

The IRO will provide the member and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review.

The IRO's notice will contain:

- A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount and the reasons for the previous denials);
- The date the IRO received the External Review assignment from CVS Caremark, and the date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or to the member;
- A statement that the member may still be eligible to seek judicial review of any adverse External Review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the member.

Reversal of the Plan's Prior Decision:

If CVS Caremark, acting on the plan's behalf, receives notice from the IRO that it has reversed the prior adverse determination of the member's claim, CVS Caremark will immediately provide coverage or payment for the claim.

Authority as Claims Fiduciary:

CVS Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit claims arising under the plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS Caremark shall have, on behalf of the plan, sole and complete discretionary authority to determine these claims conclusively for all parties.

CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO.

COORDINATION OF BENEFITS

There is no coordination of benefits on this plan.

TERMINATION OF COVERAGE

Please refer to your medical plan booklet for termination of coverage information.

COBRA CONTINUATION RIGHTS

What is COBRA Continuation Coverage?

Under federal law, you and/or your dependents must be given the opportunity to continue health coverage when there is a "qualifying event" that would result in loss of coverage under the plan. You and/or your dependents will be permitted to continue the same coverage under which you or your dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the plan:

- your termination of employment for any reason, or
- your reduction in work hours.

For your dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the plan:

- your death;

- your divorce; or
- for a dependent child, failure to continue to qualify as a dependent under the plan.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your dependent(s) have elected COBRA continuation coverage and one or more dependents experience another COBRA qualifying event, the affected dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce; or, for a dependent child, failure to continue to qualify as a dependent under the plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the plan administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the plan administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within a timely fashion;
- cancellation of your district's policy with the vendor, as applicable;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the plan would terminate coverage of you or your dependent or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your dependents move out of the employer's service area or the employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the employer's service area. If the employer offers another benefit option, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your employer is required to provide you and/or your dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the plan begins (or the plan first becomes subject to COBRA continuation requirements, if later). If you and/or your dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your dependents within the following timeframes:
  (a) if the plan provides that COBRA continuation coverage and the period within which an employer must notify the plan administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the plan;
  (b) if the plan provides that COBRA continuation coverage and the period within which an employer must notify the plan administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which employers must provide notice of a qualifying event to the plan administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the plan administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-

marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active employee or family member. For example:

- If the employee alone elects COBRA continuation coverage, the employee will be charged 102% (or 150%) of the active employee premium. If the spouse or one dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within those 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the plan may be suspended during this time. Any providers who contact the plan to confirm coverage during this time may be informed that coverage has

been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your dependent(s) experience one of the following qualifying events, you must notify the plan administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce;
- Your child ceases to qualify as a dependent under the plan; or
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the plan, name and address of the employee covered under the plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such dependent under your COBRA continuation coverage. However, only your newborn or adopted dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your dependent spouse and any dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.\