Middlesex County Joint Health Insurance Fund
Prescription Drug Plan Document

Amended and Restated as of January 1, 2015

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INTRODUCTION

The Middlesex County Joint Health Insurance Fund (the "MCJHIF") maintains the Middlesex County Joint Health Insurance Fund Prescription Drug Plan (the "Plan") to provide Prescription Drug benefits to eligible Employees, their eligible Dependents and eligible Retirees of Participating Entities. This document sets forth the provisions, which, together with the materials, if any, incorporated by reference herein, constitute the Plan.

No oral interpretations can change this Plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

MCJHIF fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of an Employer and who has begun to perform the duties of his or her job with the Employer.

Brand Name means a trade name medication.

Child or Children means, the son(s), daughter(s), stepson(s), or stepdaughter(s) of an Employee, including any individual(s) legally adopted by the Employee, placed with the Employee for legal adoption by the Employee, or placed with the Employee as a foster child by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction who has not yet reached age 26, without regard to such child's marital status, residence or financial dependence on the Employee.

Claims Administrator means Express Scripts, Inc. The Claims Administrator can be contacted at:
Express Scripts, Inc.
PO Box 14711
Lexington, Kentucky 40512
Web site: **www.express-scipts.com**
Phone :**(877) 567-5538**

Compound Medication is a medication that consists of two or more ingredients that are weighed, mesasured, prepared or mixed according to the prescription order.

Covered Charge(s) means those medically necessary services or supplies that are covered under this Plan.

Covered Employee is an Employee who is covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Dependent is a Covered Employee's (1) Spouse; (2) Child or Children; or (3) dependent natural child(ren), stepchild(ren), adopted child(ren), foster child(ren) or child(ren) placed with a Covered Employee in anticipation of adoption who is (a) incapable of self-sustaining employment by reason of mental illness, mental retardation or physical handicap, (b) primarily dependent upon the Covered Employee for support and maintenance, (c) unmarried, and (d) covered under this Plan when reaching age 26. With respect to Dependents addressed in (3), above, the Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching age 26, subsequent proof of the child's disability and dependency. After such two (2) year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a physician of the Plan Administrator's choice, at this Plan's expense, to determine the existence of such incapacity. A Dependent shall also include the child of a Covered Employee who is an alternate recipient under a qualified medical child support order.

Employee means a person who the Employer classifies as an active, common-law Employee of the Employer, who is regularly scheduled to work for the Employer in an employee/employer relationship.

Employer is Middlesex County Administration, Middlesex County Board of Social Services or Middlesex County Utility Authority, as applicable.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Family Unit is the Covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of Prescription Drugs compiled by the Claims Administrator that are covered under this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any U.S. Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Late Enrollee means a Participant who enrolls under the Plan other than during the first 60-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Plan means the Middlesex County Joint Health Insurance Fund Prescription Drug Plan as described in this document.

Plan Administrator means the Middlesex County Joint Health Insurance Fund.

Participant is any Employee or Dependent who is covered under this Plan.

Plan Year means the calendar year.

Prescription Drug means any of the following: a U.S. Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of a sickness or injury.

Retiree is a retiree, as defined in writing by the Human Resources Department for each Employer.

Spouse means the legally recognized marital partner of a Covered Employee. The Plan Administrator may require documentation proving a legal marital relationship.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of injury or sickness to perform the normal activities of a person of like age and sex in good health.

ELIGIBILITY, COST OF PLAN, ENROLLMENT, EFFECTIVE DATE, COVERAGE DURING LEAVE AND TERMINATION PROVISIONS

ELIGIBILITY

The Middlesex County Joint Health Insurance Fund consists of seven (7) county government entities, located in Middlesex County New Jersey. As of January 1, 2012, only the following three (3) MCJHIF entities participate in the Plan (hereinafter a "Participating Entity").

(1) Middlesex County Board of Social Services
(2) Middlesex County Utility Authority
(3) Middlesex County Administration

Eligibility Requirements: Eligibility for employee, retiree and dependent coverage under the Plan is determined by the Participating Entity. Coverage parameters including the effective date/termination date of coverage, dependent eligibility and retiree eligibility are detailed in written documents maintained by the respective entities, which shall be incorporated herein by reference. The coverage parameters may differ between the Participating Entities

COST OF PLAN

MCJHIF shares the cost of Employee and Dependent coverage under this Plan with the Covered Employees.

ENROLLMENT

Enrollment Requirements: An Employee must enroll for coverage by completing the enrollment application (which includes electing the desired tier of coverage) along with a payroll deduction authorization.

Timely or Late Enrollment

(1) **Timely Enrollment** - Enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 60 days after the person becomes eligible for the coverage.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Children terminates coverage, the coverage for the Children may be continued by the lone remaining Covered Employee as long as his or her coverage has been continuous.

(2) **Late Enrollment** - Enrollment will be late if it is not made on a "timely" basis.

If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

Open Enrollment

Each year during the annual open enrollment period, eligible Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them and their Dependents.

Each year during the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment Event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Covered Employee who fails to make an election during open enrollment will automatically retain his or her present Plan coverage election.

Participants will receive detailed information regarding open enrollment from their Employer.

Special Enrollment Periods

An eligible Employee may elect to enroll for coverage under the Plan whenever a Special Enrollment Event occurs, provided that (a) the eligible Employee properly completes the Enrollment Requirements within 31 days of the Special Enrollment Event (60 days in the case of eligibility for or loss of eligibility for assistance under a state child health insurance program) and (b) the coverage election or change is consistent with the Special Enrollment Event. An election to add previously eligible but uncovered Dependents as the result of the acquisition of a new Dependent shall be considered to be consistent with such Special Enrollment Event.

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Special Enrollment Events: Such events include:

(1) **Individual loses other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 45 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals.

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals

who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Individual becomes Dependent of Employee. If:

(a) The Employee is a Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the spouse of the Covered Employee may be enrolled as a Dependent of the Covered Employee if the spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received; or

(b) in the case of a Child's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or

(d) in the case of domestic partner relationship, on the first day of the plan year after the date of registration of the domestic partner relationship.

(3) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of the Social Security Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

Rehiring a Terminated Employee: A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

EFFECTIVE DATE

Effective Date of Employee Coverage: An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirements of the Plan.

(2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage: A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When Employee Coverage Terminates: Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated;
(2) The date the Employee fails to satisfy the requirements of an eligible Employee;
(3) The date the Employee terminates employment with the Employer;
(4) The date the Employee waives coverage under the Plan;
(5) The last day of the calendar month in which the Employee fails to pay the applicable premium or coverage cost when due.

When Dependent Coverage Terminates: A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death.
(3) The date a covered spouse loses coverage due to loss of dependency status.
(4) On the last day of the calendar month that a Child ceases to be a Dependent.
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

COVERAGE DURING LEAVE

Coverage During Periods of Employer-Certified Disability Leave: A person may remain eligible for a limited time if active employment ceases due to disability. This continuance will end as follows:

For disability leave only: the end of the disability leave but not longer than the twelve (12) calendar month period that next follows the month in which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Coverage During Family and Medical Leave: Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 and the regulations promulgated thereunder by the U.S. Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Coverage During Military Leave: Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may have to pay up to 102% of the full premium under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) The Employee’s premium payment obligation begins on the first day of the continuation coverage. The initial premium payment must be made within 45 days after the date of election. Subsequent payments are due monthly on the first day of each month but will be accepted if made within a 30-day grace period following the premium payment due date. Continuation coverage will be cancelled if payments are not received by the end of the grace period.

(4) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

(5) If the Employee does not return to work at the end of the military leave, the Employee may be required to reimburse his or her Employer for the cost of the premiums paid by such Employer to maintain coverage during the military leave of absence.

(6) In addition to the rights an Employee has under USERRA, an Employee and his/her Dependents (if any) also are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue the health coverage they had (if any). The 24 months of continuation of health care coverage under USERRA runs concurrently with continuation of health care coverage provided under COBRA

SCHEDULE OF BENEFITS

Verification of Eligibility

You should call the Claims Administrator to verify eligibility for Plan benefits **before** you incur an expense.

PRESCRIPTION DRUG BENEFIT

ACCOUNT AND COPAY STRUCTURE FOR Middlesex County Joint Health Insurance Fund						
Umbrella Group# MCJHIF1		Retail = Card and Direct - In and Out of Network for up to 34 DS or 100 units (whichever is greater)			Mail (up to 90 DS)	
Group #	Benefit Group Name	Retail Generic	Retail Brand	Prepacks**	Mail Generic	Mail Brand
MCJHIFCOU10	MCAFF- 3451	$5	$10	Single Copay	$5	$10
MCJHIFCOU11	CWA 1082 Hlth	$5	$10	Single Copay	$5	$10
MCJHIFCOU12	CWA 1082 Juv	$5	$10	Single Copay	$5	$10
MCJHIFCOU13	Planning Pro	$5	$10	Single Copay	$5	$10
MCJHIFCOU14	Planning Board	$5	$10	Single Copay	$5	$10
MCJHIFCOU15	Engineers Pro	$5	$10	Single Copay	$5	$10
MCJHIFCOU16	UPIU - 1426	$5	$10	Single Copay	$5	$10
MCJHIFCOU17	Investigators CA	$5	$10	Single Copay	$5	$10
MCJHIFCOU18	W & M 203	$5	$10	Single Copay	$5	$10
MCJHIFCOU19	I.A.F.F. 3527	$5	$10	Single Copay	$5	$10
MCJHIFCOU20	Extension S	$5	$10	Single Copay	$5	$10
MCJHIFCOU21	P.B.A. 214	$5	$10	Single Copay	$5	$10
MCJHIFCOU22	P.B.A. 214 Sup	$5	$10	Single Copay	$5	$10
MCJHIFCOU23	AP s	$5	$10	Single Copay	$5	$10
MCJHIFCOU31	Sheriffs LO	$5	$10	Single Copay	$5	$10
MCJHIFCOU32	Sheriffs SI	$5	$10	Single Copay	$5	$10
MCJHIFCOU33	Sheriffs SO	$5	$10	Single Copay	$5	$10
MCJHIFCOU34	Rangers PBA 156	$5	$10	Single Copay	$5	$10
MCJHIFCOU36	PBA 152	$5	$10	Single Copay	$5	$10
MCJHIFCOU37	PBA 152 Sup	$5	$10	Single Copay	$5	$10
MCJHIFCOU40	AFSCME 3440	$5	$10	Single Copay	$5	$10
MCJHIFCOU41	AFSCME 3256	$5	$10	Single Copay	$5	$10
MCJHIFCOU42	AFSCME 3460	$5	$10	Single Copay	$5	$10
MCJHIFCOU43	AFSCME 3841	$5	$10	Single Copay	$5	$10
MCJHIFCOU44	AFSCME 2226	$5	$10	Single Copay	$5	$10
MCJHIFNONUA	Non-Union Active	$5	$10	Single	$5	$10

				Copay		
MCJHIFCOCO03	County Cob 03	$5	$10	Single Copay	$5	$10
MCJHIFCOCO35	County Cob 35	$5	$10	Single Copay	$5	$10
MCJHIFCOU65DB03	County Pre-65 Direct-Bill 03	$0	$3	Single Copay	$0	$3
MCJHIFCOU65DB35	County Pre-65 Direct Bill 35	$3	$5	Single Copay	$3	$5
MCJHIFCOO65DB03	County Post-65 Direct-Bill 03	$0	$3	Single Copay	$0	$3
MCJHIFCOO65DB35	County Post-65 Direct Bill 35	$3	$5	Single Copay	$3	$5
MCJHIFCOU65PF03	County Pre-65 Prem Free 03	$0	$3	Single Copay	$0	$3
MCJHIFUCO65PF35	County Pre-65 Prem Free 35	$3	$5	Single Copay	$3	$5
MCJHIFCOO65PF03	County Post-65 Prem Free 03	$0	$3	Single Copay	$0	$3
MCJHIFCOO65PF35	County Post-65 Prem Free 35	$3	$5	Single Copay	$3	$5
MCJHIFSSACTU	Soc Svcs Act Union	$3	$5	Single Copay	$3	$5
MCJHIFSSACTNU	Soc Svcs Act Non-Union	$3	$5	Single Copay	$3	$5
MCJHIFSSCOBU	Soc Svcs Cob Union	$3	$5	Single Copay	$3	$5
MCJHIFSSCOBNU	Soc Svcs Cob Non-Union	$3	$5	Single Copay	$3	$5
MCJHIFSSU65DB03	Soc Svcs Pre-65 Direct Bill 03	$0	$3	Single Copay	$0	$3
MCJHIFSSU65PF03	Soc Svcs Pre-65 Prem Free 03	$0	$3	Single Copay	$0	$3
MCJHIFSSO65DB03	Soc Svcs Post-65 Direct Bill 03	$0	$3	Single Copay	$0	$3
MCJHIFSSO65PF03	Soc Svcs Post-65 Prem Free 03	$0	$3	Single Copay	$0	$3
MCJHIFUTACT	Util Active	$5	$10	Single Copay	$10	$20
MCJHIFUTCOB	Util Cobra	$5	$10	Single Copay	$10	$20
MCJHIFUTU65DB	Util Pre-65 Direct Bill	$5	$10	Single Copay	$10	$20
MCJHIFUTU65PF	Util Pre-65 Prem Free	$5	$10	Single Copay	$10	$20
MCJHIFUTO65DB	Util Post-65 Direct Bill	$5	$10	Single Copay	$10	$20
MCJHIFUTO65PF	Util Post-65 Prem Free	$5	$10	Single Copay	$10	$20

Preventive Medications are those medications prescribed to prevent the occurrence of a disease or condition for individuals with risk factors, or to prevent the recurrence of a disease or condition for individuals who have recovered, and do not include drugs used to treat an existing illness, injury or condition. Preventive medications may include those used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency. For additional information on Preventive Medications, please contact the Claims Administrator.

Copayment ..... $0 copayment

Type of Prescription

The following is a description of the three types of Prescription Drugs available through the Plan.

Generic: The chemical equivalent of its brand name counterpart. The cost of a brand name drug includes research, patent and advertising expenses. When the patent expires, other manufacturers are able to duplicate the drug at a

fraction of the cost. As a consumer, when you buy a generic drug, you are buying the same formula as the brand name without helping to pay the overhead. The U.S. Food and Drug Administration (FDA) must certify that a generic drug meets the same safety, strength and effectiveness standards as the original brand-name drug.

Brand-name Formulary: A brand-name drug that is on a preferred list. Formulary drugs are FDA approved and selected based on effectiveness and safety records. Typically, the Claims Administrator is able to negotiate a lower cost with the manufacturer for formulary drugs. That discount is passed on to you in the form of a lower copay. For the current list of formulary Prescription Drugs, log on to the Claims Administrator's website and check the list before you have a prescription filled, and talk to your doctor about alternatives if a recommended drug isn't on the list. The list is subject to change periodically, so make sure you check it for updates.

Brand-name Non-formulary: A brand-name drug that does not have a generic equivalent and/or is not on the formulary list described above or a brand-name drug that you choose even though a generic and/or formulary equivalent is available.

PRESCRIPTION DRUG BENEFITS

Type of Pharmacy

Following is a description of the three types of pharmacies where your prescriptions may be filled.

1. In-network Retail Pharmacy: A licensed retail pharmacy with which the Claims Administrator has executed an agreement to provide Prescription Drugs to Participants at reduced fees. You may purchase up to a 30-day supply of a Prescription Drug at an in-network retail pharmacy. At Retail, if the quantity is less than or equal to 100 units, then one Co pay will apply. If there are more than 100 units prescribed, the Co pay charged will be based on the number of days.

To find out if your pharmacy is a participating pharmacy, you may call the Claims Administrator or log onto the Claims Administrator's website.

2. Out-of-network Retail Pharmacy: A licensed retail pharmacy with which the Claims Administrator has not executed an agreement to provide Prescription Drugs to Participants at reduced fees. You may purchase up to a 30-day supply of a Prescription Drug at an in-network retail pharmacy. At Retail, if the quantity is less than or equal to 100 units, then one Co pay will apply. If there are more than 100 units prescribed, the Co pay charged will be based on the number of days.

3. Mail Order Pharmacy: A licensed pharmacy operated by the Claims Administrator or a subsidiary thereof where prescriptions are filled and delivered to Participants via a nationally recognized mail delivery service. You may order a 31 to 90-day supply of maintenance medications through the Mail Order Option. The copay for your Group for a 31 to 90-day supply through the Mail Order Option is listed above.

To get started, ask your doctor to write a new prescription for your plan's maximum days' supply of 90 days with refills up to 1 year, as appropriate. You may mail your prescriptions in the special envelope you receive with your enrollment materials or ask your doctor to call the Claims Administrator for instructions on how to fax them. If your order is faxed, your doctor must have your member number to complete the transaction. Your initial request may take 10 to 14 days to process. Mail Order refills maybe requested on line or by phone. To avoid a lapse in your medication, you should place refill orders 7 to 10 days before your existing supply is finished. For your convenience, you may request an email reminder to order refills.

The mail order drug benefit option is optional for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

For mail order forms or to request a refill, you may contact the Claims Administrator.

Copayments

The copayment that is applied to each covered Prescription Drug order placed through a retail pharmacy or mail order pharmacy is shown in the Schedule of Benefits, above. The copayment amount is not a Covered Charge under the medical Plan.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used see page 14 on how to submit for reimbursement.

Covered Prescription Drugs

Covered prescription drugs include medications, products and devices that have been approved by the U.S. Food and Drug Administration and which can, under state law, be dispensed only by prescription. These medications are also referred to as legend drugs. Over the counter (OTC) are items that can be purchased through the pharmacy and in some cases without a prescription as identified below. Unless listed under the “Exclusions” heading, covered prescription drugs include:

- Federal Legend Drugs
- State Restricted Drugs
- Insulin
- [OTC and Legend] Needles and Syringes
- Insulin Pumps and Accessories
- Injectable Contraceptives
- Emergency Contraceptives (Card and Direct)
- Plan B, through Age 16 (Card and Direct)
- Fertility Agents all dosage forms
- Accutane, though age 25
- Legend Anti-Obesity Preparations
- Depo-Provera/Depo-SubQProvera, up to a 90 day supply
- 91 Day Pre-Packaged Oral Contraceptives, up to a 91 day supply
- Nutritional Therapy for Specific Medical Conditions (OTC and Legend)
- Relenza/Tamiflu (Card and Direct)
- Inhaler Assisting Devices (OTC and Legend)
- Progesterone in Oil
- Antihemophilia Agents
- Systemed Self Injectable Drug List
- Diabetic Supplies/Insulin Needles, Syringes (OTC and Legend)
- Androgenic Agents all dosage forms
- Specialty Pharmacy Drug List
- Botox/Myobloc/Dysport/Xeomin
- Preventive Meds (Aspirin, Folic Acid, Iron), subject to age limitations
- Smoking Deterrents (age 18 and over)
- Pediatric Fluoride Vitamins Drops
- Drugs to Treat Impotency Except Yohimbine, for males only age 18 and over

The above list is intended to represent the types of Prescription Drugs covered under the Plan. To find out if a particular Prescription Drug is covered, or for information about limits on specific Prescription Drugs, you may contact the Claims Administrator.

Preauthorization

For your health and safety, your prescription drug coverage under the Plan includes utilization review of prescription drug usage. The Claims Administrator will evaluate and certify a participant's need for certain drugs, medicines and supplies, and may make formal assessments from time to time of the medical necessity, effectiveness, and appropriateness of prescription drug usage and treatment plans on a prospective, concurrent, or retrospective basis.

Certain drugs may require prior authorization by the Claims Administrator in order for the cost of such drugs to be paid or reimbursed under the Plan. The Plan reserves the right to limit benefits under the Plan in order to prevent the over-utilization of drugs or medicines. If patterns of over-utilization or misuse of drugs is detected, the Claims Administrator will notify your doctor and pharmacist. Your physician may request that the Claims Administrator review a decision denying authorization at any time. The following medications require preauthorization:

- Androgens and Anabolic Steroids
- Cosmetics (Botox, Dysport, Myobloc, Xeomin
- Growth Hormones –
- Multiple Sclerosis Therapy – Specialty PTPA

Quantity Limitations

- Retail prescriptions for 34 days or less are subject to one Copayment.
- Retail prescriptions for 35 to 60 days are subject to two Copayments
- Retail prescriptions for 61 days or more are subject to three Copayments.
- At Retail, if the quantity is less than or equal to 100 units, then one Copayment will apply. If there are more than 100 units prescribed, the Copayment charged will be based on the number of days as detailed above.
- Erectile Dysfunction Medications have quantity limitations based on accepted clinical guidelines and standards.

Other Benefit Limits

The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a physician.

(2) Refills up to one year from the date of order by a physician.

(3) Control drugs are only valid for a maximum of six months or less as defined by state regulations.

The Plan will not pay or reimburse the cost of:

(1) Any prescription that is for more than a 34-day supply at a retail pharmacy;

(2) Any prescription that is for more than a 90-day supply through the Mail Order Option; or

(3) Refills that exceed the number prescribed by the participant's physician, or any prescription that is filled more than one (1) year after the date the prescription is written.

The plan may impose quantity limits on certain medications at the time of fulfillment. Your pharmacist will let you know if quantity limits apply.

Expenses Not Covered

The following costs are “Excluded Costs” under the Plan:

(1) Costs for any Prescription Drugs which are not medically necessary or which are above reasonable and customary charges;

(2) Charges incurred by or for an individual before he or she became a participant in the Plan; and

(3) Costs of any of the following (unless specifically listed as a benefit under "Covered Drugs").

- Non-Federal Legend Drugs
- Compound Medications *
- Federal Legend Non-Drugs
- Non Federal Legend Non-Drugs
- Investigational Drugs
- Homeopathic Drugs
- Contraceptive Devices/Implantable Contraceptives
- Abortifacients Mifeprex
- Injectable Medications (except those listed as a Covered Expense)
- Synagis
- Ostomy Supplies
- Oral Hyperglycemics
- Nutritional Supplements and Combo Nutritional Products
- Biologicals, Immunization Agents, Vaccines, Allergy Sera, Blood or Blood Plasma Products
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Drugs labeled “Caution-limited by Federal law to investigational use”, or experimental drugs, even through a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order.
- Charges for the administration or injection of any drug.

*In the event a prescription for a Compound medication is rejected at the pharmacy, the member may:

- Contact the prescribing physician and request an alternative treatment;
- Appeal the denial as per the Claim Appeal Process as defined within this document;
- Pay for the Compound medication out of pocket with no guarantee that coverage will be allowed upon appeal.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

In-network
You do not need to file a claim for reimbursement when you use an In-network pharmacy or the mail order perscription drug option. Except for the amount of your copay, which is required at the time of purchase, these expenses are paid directly by the Plan.

Out-of-Network
When you have an expense that is not paid directly by the Plan (for example a prescription drug filled at an out-of-network pharmacy), you should submit a claim form to the Claims Administrator in order to be reimbursed. You will be asked for information and documentation necessary to determine whether your claim qualifies for reimbursement. This information may include receipts and other information from the dispensing pharmacy and a written statement that the expense has not been reimbursed and is not reimbursable under any health insurance policy or other benefit plan.

Claims for reimbursement for costs incurred during a Plan Year should be submitted to the Claims Administrator no later than twelve (12) months after the date charges for the service were incurred. To request claim forms, call the Claims Administrator or log onto the Claims Administrator's website.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Claims Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Pharmacy complete the provider's portion of the form.

(4) Send the above to the Claims Administrator.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator no later than twelve (12) months after the date charges for the supply or service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, 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 was 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.

(5) 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 Claim.

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Claims Appeal Procedure

For all claims other than member submitted paper claims:

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to the Claims Administrator at 8111 Royal Ridge Parkway, Irving, TX 75063. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to the Claims Administrator at 8111 Royal Ridge Parkway, Irving, TX 75063. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for 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 claimant

or the ability of the claimant to regain maximum function, or 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. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 800-864-1135 or send a written request to the Claims Administrator at 8111 Royal Ridge Parkway, Irving, TX 75063, Attn: Urgent Appeals. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For member submitted paper claims:

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. To request reimbursement you will send your claim to the Claims Administrator at P.O. Box 14711, Lexington, KY 40512. If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30 day period if additional information is needed to process the claim, and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to the Claims Administrator at 8111 Royal Ridge Parkway, Irving, TX 75063.

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provision on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to our appeal. This information should be mailed to the Claims Administrator at 8111 Royal Ridge Parkway, Irving, TX 75063. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or

additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level, you also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

External Review Procedure

You also may have the right to obtain an independent external review.

If a claimant's medical claim has been denied at the final level of appeal, the claimant may submit the claim (whether pre-service or post-service) for Federal external review by an independent review organization (IRO). Claims for external review must be submitted to the Plan Administrator within four months of the date that a claimant receives a letter denying the claim at the final level for appeal. The IRO's determination is final and binding.

Preliminary Review

The Plan Administrator will conduct a preliminary review of the appeal to determine if the request:

- is complete, but not eligible for external review. In particular, an external review is not available where the denial is based on a failure to meet the requirements for eligibility under the Plan.
- is not complete.

The Plan will notify the claimant of its preliminary determination within one business day after completing its review. If a request is not complete, the claimant will be notified of the materials or information needed to complete the claim and have the remainder of this four-month submission period (or, if it would last longer, a 48-hour period, following receipt of the notice) to complete the request.

Referral to IRO

The Plan will assign each eligible and complete claim to one of the accredited IROs that has been selected to conduct external reviews under the Plan in accordance with procedures that aim to preserve the IRO's independence and impartiality. The Plan will furnish to the IRO documents and information relevant to a claim within five business days of the assignment.

The IRO is required to notify a claimant that his or her request for external review has been accepted as eligible for review. The claimant will have ten business days from receipt of this notice to submit additional information to the IRO in support of the appeal. This information will be forwarded to the service administrator, which may reconsider its prior decision to deny the claim or otherwise respond to the IRO with regard to such information. If the service administrator decides to grant the appeal in view of the additional information provided by the claimant, it will notify the claimant and the assigned IRO and the external appeal will terminate.

The IRO will review all of the information and documents timely received and other relevant information that it determines is necessary to review. The IRO will make a decision that is independent of any decision that has preceded it regarding the claim and provide written notice of its decision to the claimant and the service representative within 45 days after the IRO receives the request for the external review.

Expedited External Review

In the event that a claimant has a claim for urgent care, he or she may request external review on an expedited basis. A claimant may make this request after receiving any claim denial, whether or not all appeal levels have been exhausted. The procedures for expedited external review are generally the same as for other external reviews, except that determinations will be made (and notices will be provided) as soon as possible, and information will be transmitted in an expeditious manner to provide for a final external determination that is made as expeditiously as the

circumstances require. In any event, the IRO will make its determination within 72 hours after the IRO receives the request for an expedited external review. Notice of the IRO's determination does not need to be provided in writing initially, but written notice confirming the determination must be provided within 48 hours of the initial verbal notice

Additional details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur prescription drug charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the prescription drug charges. Accepting benefits under this Plan for those incurred prescription drug expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-prescription drug charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred prescription drug expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred prescription drug expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for prescription drug charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for prescription drug expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay prescription drug benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights

or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any prescription drug benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect prescription drug charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for prescription drug expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for prescription drug benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for prescription drug charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Administrator or its designee 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 shall 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, 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 will be final and binding on all interested parties. If the Plan Administrator's designee resigns, dies or is otherwise removed from the position, **MCJHIF** may appoint a new designee as soon as reasonably possible.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

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

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Middlesex County's workforce are designated as authorized to receive Protected Health Information from ("the Plan") in order to perform their duties with respect to the Plan: Middlesex County's Human Resources Department.

COMPLIANCE WITH HIPAA SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

COMPLIANCE WITH NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) - Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

COBRA RIGHTS

If you elect to participate in the Plan, continuation coverage under those plans may be available to you, your spouse, or your Dependents for a limited period of time if you cease participation in the plan because of certain “qualifying events,” such as termination of employment (other than due to gross misconduct), reduction in hours, divorce, death, a child’s ceasing to meet the plan’s definition of Dependent. Such continued participation will be at your expense. Continued participation will be on a pretax basis only if you continue to receive wages from the Employer.

Special COBRA rights apply to employees who have been terminated or have experienced a reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under the federal Trade Act of 1974. If you qualify, you are entitled to a second opportunity to elect COBRA coverage for yourself and certain family members, but only if you did not previously elect COBRA coverage and only within a limited, 60 day period (or less) and only during the 6 month period after your group health plan coverage ended. If you think you may qualify, contact Human Resources for more details.

For more information about COBRA rights, see the “Summary of Rights and Obligations Regarding Continuation of Group Health Plan Coverage,” a copy of which has been furnished to you and your spouse (if covered under the plan). Please contact the Human Resources Department if you need another copy.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the Covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

BY THIS AGREEMENT, the Middlesex County Joint Health Insurance Fund Prescription Drug Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Middlesex County Joint Health Insurance Fund on or as of the day and year indicated herein.

By_____

Printed Name_____

Date_____

Witness _____

Printed Name_____

Date_____