HURON-ERIE SCHOOL EMPLOYEE INSURANCE ASSOCIATION HEALTH BENEFIT PLAN

PRESCRIPTION DRUG SUMMARY

MINIMUM VALUE PLAN

October 1, 2018

TABLE OF CONTENTS

INTRODUCTION

This Summary contains general information about the prescription drug benefits available to you as a Covered Person in the Huron-Erie School Employee Insurance Association Health Benefit Plan (the "Plan") offered to you by your school district, as a member of the Huron-Erie School Employee Insurance Association ("HESE"). The prescription drug benefits described in this Summary are administered by Express Scripts, Inc. ("ESI") and are separate from any prescription drug benefits that are available under your medical plan administered by Medical Mutual.

All persons who meet the following criteria are covered by the Plan and are referred to in this Summary as **Covered Persons, you or your**. They must:

- pay for coverage if necessary; and
- satisfy the eligibility conditions specified by the Plan.

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors, hospitals or pharmacies, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

This Summary does not contain all the terms and conditions of your prescription drug coverage, and is subject in all respects to any information that may be provided to you, at any time or from time to time, by the Plan, HESE or ESI for the purpose of clarification, correction or otherwise. HESE has the exclusive right to interpret and apply the terms of this Summary. This Summary may be modified by riders and amendments or superseded and replaced by a new Summary. Many words used in this Summary have special meanings. These words will appear capitalized. Capitalized words that are not defined in this Summary shall have the same meaning, as appropriate, as set forth in your Medical Mutual Benefit Book for the Plan's medical benefits.

The decision about whether to pay any claim, in whole or in part, is within the sole discretion of HESE and ESI, subject to any available reviews and appeals. Benefits will be determined and administered in accordance with the administrative policies and procedures of ESI.

The Plan includes drug coverage management, copayment assistance and other utilization, clinical and cost savings programs. Certain prescription drugs may require a prior authorization for which your doctor will need to provide additional information to determine coverage. Coverage for certain medications may require prior use of another medication first. Some medications may be subject to a quantity limit based on manufacturer recommendations for general prescribing. For more detailed information regarding drug coverage, please contact an ESI representative using the telephone number located on your prescription benefit ID card. You can also register online at www.express-scripts.com to obtain more information on drug coverage and your cost under the Plan, or download the ESI mobile app. on your mobile device.

SCHEDULE OF BENEFITS

Benefit Period: Calendar Year

Dependent Age Limit: The end of the month of the 26th birthday.

Minimum Value Plan				
Prescription Drugs				
Copayment	**Retail**	**Specialty Retail**	**Home Delivery**	**Specialty Home Delivery**
Generic	$10.00	$200.00	$20.00	$400.00
Formulary	$50.00	$200.00	$100.00	$400.00
Non-Formulary	$100.00	$200.00	$200.00	$400.00
Utilization Management				
Prior Authorization		Yes		
Step Therapy		Yes		
Drug Quantity Management		Yes		
Exclusive Maintenance Mail Order		Yes		
Exclusive Specialty		Yes		

This Schedule of Benefits shows your financial responsibility for prescription drug benefits under the Plan. After you have paid the amounts indicated in the Schedule of Benefits, the Plan covers the remaining liability for the covered charge, subject to benefit maximums. The covered charge is the maximum amount that can be considered for prescription drug benefit payment by the Plan. Out-of-pocket maximum(s) and deductibles that may apply will renew each benefit period.

ELIGIBILITY

Enrolling for Coverage

Eligible Employees may enroll for individual prescription drug coverage or they may enroll themselves and their Eligible Dependents in family prescription drug coverage, as permitted by the Plan. Under individual coverage, only the Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered. Coverage will not begin until your enrollment has been approved by the Plan and you have been given an effective date.

Covered Person

A Covered Person is the Card Holder, and if family coverage is in force, the Card Holder's Eligible Dependents.

Card Holder

A Card Holder is an Eligible Employee of a HESE member school district who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or HESE legally mandated continuation of coverage.

Eligible Employee

An Eligible Employee is:

An employee of a HESE member school district who meets the eligibility requirements of such member including working the required number of hours that such member requires for eligibility.

Eligible Dependents

An Eligible Dependent is:

- the Card Holder's spouse;
- the Card Holder's or spouse's:
    - natural children;
    - stepchildren;
    - children placed for adoption and legally adopted children;
    - children for whom either the Card Holder or Card Holder's spouse is the legal guardian or custodian; or
    - any children who, by court order, must be provided health care coverage by the Card Holder or Card Holder's spouse.

To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits. Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Card Holder for support due to a physical handicap or intellectual disability which renders them unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a physician. You must notify the Plan of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

Ineligible Persons

Ineligible persons under the Plan include dependent spouses that are deemed to be ineligible for their own employer's group health plan by virtue of being an Eligible Dependent under the Plan. Such a plan generally states that a dependent spouse who can be covered under another plan (most commonly a spouse's plan) must enroll under that plan and is ineligible for coverage as an employee under his or her own plan's coverage.

Such plans are often, but not always, called Medical Expense Reimbursement Plans or MERPs. **The Plan will not cover any dependent spouse who is required by the terms of his or her own plan to enroll in the Plan.**

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except as otherwise required by law. The Plan provides

benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Plan will promptly notify affected Card Holders if a medical child support order is received. The Plan will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Plan will determine whether the order is acceptable and notify each affected Card Holder of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

Coverage starts at 12:01 a.m. on your effective date. Your effective date is determined by the Plan. No benefits will be provided for services, supplies or charges incurred before your effective date.

CHANGES IN COVERAGE

HIPAA Special Enrollment Rights

If you are declining enrollment in the Plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact the benefits office at your school district. Also, for more details please refer to your Medical Mutual Benefit Book.

TERMINATION OF COVERAGE

How and When Your Coverage Stops

Your coverage as described in this Summary stops:

- When the Card Holder fails to make the required contributions.
- On the date that a Covered Person stops being an Eligible Dependent. You are responsible for notifying the Plan immediately of any change to the eligibility status of an Eligible Dependent.
- On the date that a Card Holder becomes ineligible.
- On the date a final decree of divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.

- Immediately upon notice if:
    - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
    - a Covered Person intentionally misrepresents a material fact provided to ESI or HESE or commits fraud or forgery. If your coverage is rescinded, you will be given 30 days' advance written notice, during which time you may request a review of the decision.

RESCISSION OF COVERAGE

A rescission of coverage means that your coverage is retroactively terminated to a particular date, as if you never had coverage under the Plan after the date of termination. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. You will be provided with 30 calendar days' advance notice before your coverage is rescinded in accordance with this paragraph. You have the right to request an internal appeal of a rescission of your coverage.

Your coverage may also be retroactively terminated for any period of time for which you did not pay the required contribution to coverage, including COBRA premiums.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Medical Mutual Benefit Book or contact the benefits office at your school district.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section.

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. The employer must notify the plan administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the benefits office at your school district within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care

Act (ACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the benefits office at your school district know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the benefits office at your school district.

Plan Contact Information

If you have any questions, please contact the benefits office at your school district.

HOW YOUR PRESCRIPTION DRUG PLAN WORKS

Your ID Card

When you first enroll in the prescription drug coverage, you will receive prescription drug identification cards from ESI. If you elect more than coverage for yourself, you will receive two cards in your name. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling ESI Member Services at 1-844-586-5348. In an emergency, you are able to print a temporary identification card from ESI's website, www.express-scripts.com. It is important to remember to use your prescription drug plan ID card at the pharmacy rather than your medical plan insurance card.

When You Need to Fill a Prescription

When you need to fill a prescription, to receive the highest level of coverage, you can choose to go to your local participating retail pharmacy or, for home delivery, use the ESI Pharmacy. Regardless of whether you choose a local retail pharmacy or the ESI Pharmacy, generic drugs are used to fill prescriptions whenever possible unless your doctor specifies otherwise. If you are prescribed a non-preferred brand-name drug, the pharmacist may contact your doctor to suggest that a non-preferred brand-name drug be substituted with a comparable drug from ESI's National Preferred Formulary list. Your doctor decides whether or not to switch to the formulary drug.

ESI also provides "safety checks" at both its retail and home delivery pharmacies. Examples include checking for possible drug allergies or adverse interactions, incorrect dosage or strength and age- and sex-appropriate drugs. If there are any problems, ESI contacts your doctor. ESI, and not the Plan, is solely responsible for these safety checks.

If you choose to have your prescription filled at a non-participating pharmacy, either at home or away (including while you are traveling outside the United States), you will need to pay 100% of the cost of your prescription. You may then submit a claim to ESI for reimbursement. ESI will reimburse you for the approved amount minus your applicable deductible and copayment.

Retail Pharmacies

ESI has contracted with thousands of retail pharmacies, including most major drug stores. These retail pharmacies in the ESI National Plus Network are referred to as "participating pharmacies." To locate a participating pharmacy close to your home or other location, you can call ESI Member Services at 1-844-586-5348 or check ESI's website at www.express-scripts.com.

Exclusive Specialty

You are required to fill your maintenance medications through the ESI Specialty Pharmacy (Accredo) or pay 100% of the cost of those medications at retail.

ESI Pharmacy for Home Delivery

ESI offers the ESI Pharmacy to fill your long-term prescriptions through home delivery. You will also have the convenience of having your medications delivered right to you. You are required to fill your maintenance medications through the ESI Home Delivery after the 2nd retail fill or pay 100% of the cost of those medications at retail.

Covered Medications

The Plan provides coverage for federal legend drugs which are drug products bearing the legend, "Caution: Federal law prohibits dispensing without a prescription." The Plan also covers certain prescription supplies, oral contraceptives and some compound medications.

For the Plan to cover a prescription, the prescribed item must meet the following requirements:

- It must be a prescription written by a physician and not have exceeded the accepted date range of validity. Prescriptions for all drugs other than controlled substances are valid for one year from the date they were written. Controlled substance prescriptions are valid for six months from the date they are written.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a pharmacy.
- It must not be listed as an exclusion under the Plan.

Prescription drugs covered by the Plan are classified as either generic or brand-name drugs. Brand-name drugs are then considered either preferred brand-name (part of the ESI formulary) or non-preferred brand-name (non-formulary).

Preventive Drugs Covered at 100%

To comply with the ACA, the Plan covers certain drugs at 100%. For information on how preventive medications are covered with the limitations and exclusions that apply as required under the ACA, please use the "Price a Medication" application on the ESI website, www.express-scripts.com. This application will tell you whether a drug is covered, the cost and if any limitations or exclusions (like step therapy, prior authorization or quantity limits) apply. The ACA preventive drug list is subject to change as ACA guidelines are updated or modified.

The Formulary and Changes to It

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the Plan, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's formulary. The Plan uses the ESI National Preferred Formulary. The Plan's formulary is updated periodically and is subject to change. To get the most up-to-date list of drugs on the formulary, visit www.express-scripts.com.

Drugs that are excluded from the Plan's formulary are not covered under the Plan unless approved in advance through a formulary exception process managed by ESI on the basis that (1) the drug requested is medically necessary and essential to the patient's health and safety and/or (2) all formulary drugs comparable to the excluded drug have been tried by the patient. If approved through that process, the applicable formulary copayment would apply for the approved drug based on the Plan's cost share structure. Without this approval, if you or a covered dependent selects drugs excluded from the formulary, you will be required to pay the full cost of the drug without any reimbursement under the Plan. If your physician believes that an excluded drug meets the requirements described above, your physician should take the necessary steps to initiate a formulary exception review.

The formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing formulary tier.
- Additional drugs may be excluded from the formulary.
- A restriction may be added on coverage for a formulary-covered drug (e.g. prior authorization).
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the formulary, as you may not have received notice that a drug has been removed from the formulary. Certain drugs even if covered on the formulary will require prior authorization in advance of receiving the drug. Other formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step-therapy. As with all aspects of the formulary, these requirements may also change from time to time.

ESI Specialty Pharmacy Services

Specialty medications are drugs that are used to treat complex conditions including but not limited to cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Accredo Health Group, Inc., an ESI Specialty Pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Counseling, scheduled delivery and safety checks are just a few of the services that Accredo provides.

Under the Plan, all of your specialty medications must be filled through the Accredo Specialty Pharmacy mail order service. The mail service copayment you have to pay will be based on the type of drug you are requesting (generic, preferred brand-name drug, non-preferred brand-name drug). If you do not go through the Accredo Specialty Pharmacy, you will pay the full cost for that drug.

Limitations

If you are uncertain whether the drug that your physician has prescribed is covered by the Plan, please call ESI at 1-844-586-5348 to confirm. If you want to know if a specific drug is covered under the Plan, go to the "Price a Medication" application on the ESI website, www.express-scripts.com. That application will indicate whether a drug is covered, what it will cost and if any limitations or exclusions apply. For more information about limitations and exclusions, visit www.express-scripts.com.

Supply Limits

Some prescription drugs are subject to supply limits based on ESI's criteria. Supply limits, which are subject to periodic review and modification by ESI, may restrict the amount dispensed per prescription order or refill and/or the amount dispensed for each month's supply. Limits are based on manufacturer suggested prescribing guidelines and may change from time to time. This does not affect the day supply limits which are part of the plan design and would only change if the plan design is changed. You may obtain information on maximum dispensing limits by either visiting www.express-scripts.com or by contacting ESI at 1-844-586-5348.

Quantity Management

To help promote safe and effective drug therapy consistent with plan limits, certain covered medications may have quantity restrictions. These quantity restrictions are based on product labeling or clinical guidelines and are subject to periodic review and change. Examples include drugs used for hormone supplementation, multiple sclerosis and oncology drugs. Visit www.express-scripts.com for details on drugs with quantity restrictions or call ESI Member Services at 1-844-586-5348.

Prior Authorization

For certain medications, the Plan requires a coverage review or "prior authorization" by ESI before benefits will be paid. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, ESI asks your physician for more information than what is on the prescription before the medication may be covered under the Plan.

The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. To find out whether a medication requires a coverage review, log in to www.expess-scripts.com anytime.

Prior authorizations, when approved, are typically approved for a one year period, unless otherwise noted.

Your physician may contact ESI to request a prior authorization approval.

Step Therapy Requirements

Step therapy is a program designed to help you save money by using the most cost effective treatments if you have certain conditions that require maintenance medications. It requires that you try a first line alternative, often a generic medication, to treat your condition. Then, based on your physician's review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization as described in the "Prior Authorization" section fall into this step therapy program. Please contact ESI Member Services at 1-844-586-5348 or visit www.express-scripts.com for more specific information on the program.

Drug Coverage Provided by Your Medical Plan

Prescription drugs that are dispensed to you while in a hospital, either as an Inpatient or as an outpatient at an approved outpatient facility, or while a patient in your doctor's office, are covered under your medical plan and not your prescription drug plan and follow your medical plan provisions. You must follow normal medical claim procedures for reimbursement for these drugs. Refer to your Medical Mutual Benefit Book for details on filing medical claims.

COPAYMENT ASSISTANCE PROGRAM

The Plan has implemented a specialty drug copayment assistance program. Certain specialty prescription drugs are considered non-essential health benefits under the Plan and the cost of such drugs will not be applied towards satisfying the participant's out-of-pocket maximum or deductible. Although the cost of the copayment assistance program drugs will not be applied towards satisfying a participant's out-of-pocket maximum or deductible, the cost of the copayment assistance program drugs will be reimbursed by the manufacturer at no cost to the participant.

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") is the process to coordinate pharmacy benefits when two or more health or pharmacy plans cover the same person(s) – one as Primary and one as Secondary.

In the event you have dual coverage through another family member, secondary pharmacy claims manually submitted on your benefits under the Plan will pay all, a portion, or none of the balance of a claim after the primary payment has been made by another plan. The Plan, in conjunction with ESI, follows coordination of benefits rules established by HESE to allow claims to be processed at primary and then secondary.

When using a primary and secondary coverage, note that the Plan and each other plan may require you to follow its benefit requirements including, but not limited to: prior authorizations, network pharmacies, and quantity limits. Please review program descriptions of each plan to understand how benefit rules apply to your prescription.

For all mail order claims and retail claims (except as noted below), a COB claim must be submitted by you after the primary plan has processed the charges and delivered to you an explanation of benefits or receipt. You must utilize the Prescription Drug Reimbursement/Coordination of Benefits Claim Form found on the ESI website or available by contacting ESI customer service. The Prescription Drug

Reimbursement/Coordination of Benefits Claim Form must be submitted along with the primary plan's receipt/documentation as noted on the Form. The COB reimbursement formula used by the Plan is: Discounted Network Price (i.e., what the claim would have cost if processed as primary under the Plan) minus Member Copay. Major/big box retail store pharmacies may be willing to process COB claims at the retail store if you provide them with your primary and secondary coverage information.

If the Plan pays more for the covered benefit than the applicable COB rules require, the Plan or ESI has the right to recover excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's and ESI's right to recover excess payments.

EXPRESS SCRIPTS REVIEWS AND APPEALS OVERVIEW

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

You have the right to request an initial review for a medication that is not covered at point of sale at either retail or home delivery pharmacies to be covered or to be covered at a higher benefit (e.g., lower copayment, higher quantity). The first request for coverage is called the initial coverage review. ESI reviews both clinical and administrative coverage review requests:

- Clinical coverage review requests: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Initial Coverage Review

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing pharmacist may call the ESI Coverage Review Department at 1-800-753-2851 or the prescriber may submit a completed coverage review form by faxing it to the number provided on the form. Forms may be obtained online at www.express-scripts.com/services/physicians. Home delivery coverage review requests are automatically initiated by the ESI Home Delivery Pharmacy as part of filling the prescription.

To request an initial coverage review, you, your physician or your dispensing pharmacist must submit specific information in writing to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one where, in the opinion of the patient's provider, the patient's health may be in serious

jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-844-586-5348.

Denial Process

An initial coverage review will be denied if the information needed to make a determination is not received from the prescriber within 45 days of the decision timeframe or the information received does not meet the approval standards. An appeal request for further review can be initiated at that point.

How to Request Appeals After Coverage Review Has Been Denied

Mandatory Level 1 Appeal

Upon receipt of a denial notice, a Covered Person or authorized representative can request a level 1 appeal with ESI within 180 days from receipt of a denial notice. You must complete this mandatory internal appeal before any additional action is taken, except under certain circumstances as described below. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Description of why the claimant disagrees with the denial

For clinical appeal requests, call/fax/mail to:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-753-2851 (for expedited requests)
Fax: 1-877-852-4070

For administrative appeal requests, call/fax/mail to:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-753-2851 (for expedited requests)
Fax: 1-877-328-9660

Notice of approval or denial will be sent out to you and your prescriber through mail or fax.

If your claim is denied at the mandatory level 1 appeal, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and the eligibility requirements, are described below.

External Review Process

ESI has established an external review process to examine coverage decisions under certain circumstances. The request for external review must be made within four months from your receipt of the notice of denial from the mandatory level 1 appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the internal mandatory appeal process unless under applicable law you are not required to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review or, if you do not receive a timely internal appeal decision);
3. You are or were covered under the Plan at the time the service was requested or, in the case of retrospective review, were covered under the Plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External review will be conducted by Independent Review Organizations (IRO) accredited by a nationally recognized accrediting organization. You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

ESI is required by law to provide to the IRO conducting the review a copy of the records that are relevant to your condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

External Review for Non-Urgent Care Claim Appeals

A request for an external review of a non-expedited or non-urgent claim must be in writing and should be addressed to ESI at:

Express Scripts
Attn: External Review Department
P.O. Box 66588
St. Louis, MO 63166-6588

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you 10 business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available

under State or Federal law to ESI, the Plan, or you. If the IRO reverses the adverse benefit determination, ESI will provide coverage or payment for the claim.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for urgent or expedited claims may be requested orally or electronically or in writing and should be addressed to:

Express Scripts
Attn: External Review Department
P.O. Box 66588
St. Louis, MO 63166-6588

You may request an external review for urgent or expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to ESI, the Plan or you. If the IRO reverses the adverse benefit determination, ESI will provide coverage or payment for the claim.

Voluntary Internal Review Process

If your mandatory level 1 appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by ESI. All requests for appeal must be made by writing to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the internal mandatory appeal.

The voluntary internal review may be requested at the conclusion of the mandatory level 1 appeal. The request for the voluntary internal review must be received by ESI within 60 days from the receipt of the mandatory level 1 appeal decision. ESI will complete its review of the voluntary internal appeal within 30 days from receipt of the request.

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the provider relating to the claim, without regard to whether such information was submitted or considered in the mandatory level 1 appeal.

Level of Review to Plan Sponsor

If you have completed all available levels of appeal with ESI, you may have the option to appeal an adverse benefit determination directly to the sponsor of your Plan. If you would like more information, please contact your school district's benefits office.

Alternative Options

You can decide at any time during this process to either pay out of pocket or ask your prescriber for a covered alternative as stipulated in your benefit plan's design.

RIGHT OF SUBROGATION AND REIMBURSEMENT

Subrogation

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for prescription drugs, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for prescription drugs. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for prescription drugs. The Plan's right of subrogation for the total amount the Plan paid for prescription drugs is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. Furthermore, the Plan shall not bear any costs, expenses or attorney fees incurred by you, your beneficiary or personal representative in the prosecution of any claim for recovery. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

You, your beneficiary or personal representative shall execute and deliver any documents as may be required by the Plan and do whatever else is necessary for the Plan to protect and exercise its subrogation rights, and you or such persons shall do nothing to prejudice the Plan's right hereunder. If you, your beneficiary or personal representative does prejudice the Plan's rights hereunder, such prejudicial action, among other things, shall bar you or such persons from receiving benefits under the Plan.

Reimbursement

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for prescription drugs, you must repay the Plan any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including your own insurer, from which

you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for prescription drugs. The Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for prescription drugs. The Plan's right of reimbursement for the total amount the Plan paid for prescription drugs is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. Furthermore, the Plan shall not bear any costs, expenses or attorney fees incurred by you, your beneficiary or personal representative in the prosecution of any claim for recovery. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

You, your beneficiary or personal representative shall execute and deliver any documents as may be required by the Plan and do whatever else is necessary for the Plan to protect and exercise its reimbursement rights, and you or such persons shall do nothing to prejudice the Plan's right hereunder. If you, your beneficiary or personal representative does prejudice the Plan's rights hereunder, such prejudicial action, among other things, shall bar you or such persons from receiving benefits under the Plan.

Your Duties

- You must provide the Plan or its designee any information requested by the Plan or its designee within 5 days of the request.
- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least 30 days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

The Plan shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. The Plan's determination will be final and conclusive.