

PRESCRIPTION DRUG BENEFIT under

Saint Louis University Health Plans (Choice Plus Plan and QHDHP)

Administered By

Express Scripts

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If you need assistance in Spanish to understand this document, you may request it for free by calling Customer Service at the number on Your Identification Card.

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Introduction

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the pharmacy benefit plan (the "Plan") offered by Saint Louis University. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Customer Service at the number shown on your ID card.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The prescription drug benefits are subject to the Limitations and Exclusions, Copayments, Coinsurance and Deductible requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Schedule of Benefits

Express Scripts	Choice Plus Plan		QHDHP	
	Retail (34-day supply)	Mail Order (90-day supply)	Retail (34-day supply)	Mail Order (90-day supply)
Prescription Drug Costs				
Tier 1	\$10	\$25	Medical deductible, then 10% coinsurance	
Tier 2	25% coinsurance \$30 min-\$50 max	25% coinsurance \$75 min-\$125 max	Medical deductible, then 10% coinsurance	
Tier 3	50% coinsurance \$50 min-\$100 max	50% coinsurance \$125 min-\$250 max	Medical deductible, then 25% coinsurance	
Tier 4	20% coinsurance up to \$200 max	N/A	Medical deductible, then 10% coinsurance	N/A
Preventive Medications	Priced according to the tier in which they fall		Covered at 100%, no deductible	
Out-of-Pocket Maximum (Includes Rx Copays and Coinsurance)				
Individual	\$1,500		Combined with Medical	
Family	\$3,000		Combined with Medical	

Note: A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Customer Service.

Note: Some drugs may be covered at no cost to You as part of the Plan's compliance with the Affordable Care Act (ACA). Please contact the Customer Service telephone number on Your identification card.

Prescription Drugs

See the Schedule of Benefits for any applicable Copayment, Coinsurance, Deductible and Benefit Limitation information.

The pharmacy benefits available to you under this Plan are managed by Express Scripts (ESI). ESI offers a nationwide network of retail pharmacies as well as a Mail Service Pharmacy and provides clinical management services.

The management and other services Express Scripts provides includes, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Mail Service Pharmacy. Express Scripts also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on Your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a Prescription, the Network pharmacist is informed of the Prior Authorization requirement through the Pharmacy's computer system. The PBM uses pre-approved criteria, developed by the Pharmacy and Therapeutics Committee which is reviewed and adopted by the Claims Administrator. The Claims Administrator may contact Your Provider if additional information is required to determine whether Prior Authorization should be granted. The Claims Administrator communicates the results of the decision to both You and Your Provider. If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in the "Right to Appeal" provision of this Benefit Booklet. (The provision appears in the "Claims and General Information" section.)

Examples of items that may require prior authorization include medications used to treat rheumatoid arthritis, growth deficiency, cancer and hepatitis C. For the current list of these Drugs, please contact the Customer Service telephone number on Your Identification card. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations, and exclusions. Your Provider or Network Pharmacist may check with the Claims Administrator to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Specialty Pharmacy Network

The PBM's Specialty Pharmacy, Accredo, is available to Members who use Specialty Drugs. "Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications, or conditions;
- Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

You may obtain the information on the Network Specialty Pharmacy and covered Specialty Drugs by calling the Customer Service telephone number on Your Identification Card or review the lists on the Claims Administrator's website at www.express-scripts.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) may be covered without any Copayment/Coinsurance. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.

Days Supply

The number of days supply of a Drug, which You may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the **Schedule of Benefits**.

Formulary

The Plan follows a drug Formulary in determining payment and Covered Services.

Tiers

The determination of tiers is made by the Plan and is based upon clinical information and, where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same condition. Additional factors include the availability of over-the-counter alternatives and, where appropriate, certain clinical economic factors.

- **Tier 1** This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.
- **Tier 2** This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.
- **Tier 3** This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.
- **Tier 4** This tier will contain specialty medications or injectables.

Special Clinical Programs

From time to time the Claims Administrator may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Dispense as Written (DAW) Program

In many cases, a generic equivalent of a prescribed brand name drug may achieve equal clinical outcomes for a much lower cost to both You and the Plan. As such, the DAW program stipulates that if You request a specific brand name drug when your physician has indicated that a generic form of the prescribed medication may be substituted, You will pay the difference in cost between the requested brand name drug and the generic equivalent.

Step Therapy

Step Therapy manages drug costs within specific therapy classes by ensuring that patients try a front-line or step one drug (usually generics) before a higher cost back-up or step two brand-name drug is covered. Within specific therapy classes, multiple drugs are available to treat the same condition. Step Therapy points a new patient to a front-line or step one, lower cost, clinically effective drug in each therapy group. Evidence-based clinical protocols are used to select front-line or step one drug.

Prior Authorization

Some drugs listed on the formulary require pre-approval before they can be covered by your plan. Prior Authorization is a process based on objective clinical criteria. The list of drugs requiring Prior Authorization includes drugs that the plan needs to monitor as appropriate for your medical condition. It also includes drugs that could be used for non-medical reasons – for example, a drug that could also be used for cosmetic purposes. Prior authorization and medical exceptions apply qualitative and quantitative standards to determine drug coverage by the pharmacy benefit. Express Scripts offers prior authorization review services 24 hours a day, 365 days a year. Requests are made through the Contact Center to ensure that physicians and pharmacists have quick, easy access to prior authorization information.

Drug Quantity Management

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied with each purchase is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per purchase and per days' supply.

Saveon SP

- Only available under the Plus plan
- a specialty pharmacy co-pay assistance program;
- certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum; although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant; and
- Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance

Payment of Benefits

The amount of benefits paid is based upon whether You receive the Covered Services from a Network Pharmacy or the Mail Service Program. It is also based upon which Tier the Claims Administrator has classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Claims Administrator retains the right at the Claims Administrator's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which You are responsible are shown in the Schedule of Benefits.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present Your written Prescription Order from Your Physician and Your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file Your claim for You.

Specialty Drugs - You or Your Physician can order Your Specialty Drugs directly from Accredo, simply call the Customer Service telephone number on the back of Your ID card. If You or Your Physician orders Your Specialty Drugs from Accredo, they will work with You and Your Physician to obtain Prior Authorization and to coordinate the shipping of Your Specialty Drugs directly to You or Your Physician's office. Your patient care coordinator will also contact You directly when it is time to refill Your Specialty Drug Prescription.

The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from Your Physician, or have Your Physician fax the Prescription to Express Scripts. Your Physician may also phone in the Prescription to the Express Scripts' Mail Service Pharmacy. You will need to submit the applicable Coinsurance and/or Copayment amounts to the PBM's Mail Service when You request a Prescription or refill.

Limitations and Exclusions

Non Covered Prescription Drug Benefits

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities, which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Fertility Drugs.

- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices, or products, they are not Covered Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Most Compound Drugs.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Plan for additional information on these Drugs.

Non-Covered and Excluded Services

The following section indicates items, which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items, which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
2. Charges for treatment received before coverage under this option began or after it is terminated.
3. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
4. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
5. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
6. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
7. Prescription Drugs covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit; prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in a physician's office; home infusion or home IV therapy.
8. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
9. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
10. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
11. Services provided in a Halfway House.
12. Treatment or drugs prescribed by a non-licensed Provider,; prescription drugs provided by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; prescription drugs provided to the Member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
13. Services or supplies provided by a member of your family or household.

14. Charges or any portion of a charge in excess of the Allowed Amount as determined by the Claims Administrator.
15. Prescription drugs for which payment has been made under the federal Medicare program.
16. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
17. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
18. The following drugs are not covered: Zolgensma, abortifacients, anti-obesity drugs, depigmentation agents, photo aged skin products, drugs for cosmetic purposes, hair growth agents, homeopathic drugs, implantable contraceptives, Yohimbine, serums, toxoids, vaccines, durable medical equipment, drugs with an over the counter equivalent, and fluoride products.

Eligibility

Coverage for the Employee

Note: You must be enrolled in a University Medical plan in order to have prescription drug coverage.

Eligibility You are eligible to enroll in the Plan if you are a regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 32 hours per week on a regular and continuous basis. You are also eligible to enroll in the Plan if you are a former active employee who retired on or after age 60 with seven years or more of continuous full time service with Saint Louis University. In the event of a temporary layoff or work stoppage due to a health pandemic, any benefit eligible employee enrolled in the plan at the time of the temporary layoff is still considered an eligible employee for benefit purposes, regardless of hours worked during the temporary layoff.

Medical faculty with a joint appointment with the Veteran's Administration are considered to be full time. Saint Louis University Employees under the terms of this program as long as the University paid portion of total compensation exceeds \$5,000 per year.

Your eligible Dependents may also participate in the Plan.

An eligible Dependent is considered to be:

- your Spouse,
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Voluntary Enhanced Retirement Program (VERP) will be available to full-time University Participants on the St. Louis campus who meet one of the following requirements as of June 30, 2014:

- At least 60 years old with seven or more qualified continuous years of service at the University;
- Age plus qualified continuous years of service (a minimum of five years required) equal to at least 75; or
- Subsidized pre-65 retiree medical coverage for up to five years or to age 65, whichever occurs first.

This Benefit Booklet describes the benefits an Employee may receive under this prescription drug plan. The Employee is also called a Subscriber.

Coverage for the Employee's Dependents

New Hires

Enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Employer.

Late Enrollees

If the Employee or the Employee's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period, unless there is a change in family status..

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.

An individual who declined coverage must have certified in writing that he or she was covered by another health plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An un-enrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by the Employee or the Employee's prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options. Employees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the “**Late Enrollees**” provision in this section.

Newborn and Adopted Children

You must contact Your Employer within 31 days to add a newborn or adopted child.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
 - An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”).
 - Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see “When Coverage Terminates”);
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

When Coverage Terminates

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases the last day of the month in which the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Certification of Prior Creditable Coverage

If Your coverage under this Plan is terminated, You and Your covered Dependents will receive a certification that shows Your period of coverage under the health benefit plan. You may need to furnish the certification if You become eligible under another group health plan. You may also need the certification to buy, for yourself or Your family, an individual policy that does not exclude coverage for medical conditions that were present before Your enrollment. You and Your Dependents may request a certification within 24 months of losing coverage under the health benefit plan.

You may also request a certification be provided to You at any other time, even if You have not lost coverage under this plan. If You have any questions, contact the customer service telephone number listed on your Identification Card for the insurance company providing healthcare coverage.

Continuation of Coverage

Federal Law - COBRA

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." 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 covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
<p><u>For Spouses/ Dependents:</u></p> <p>A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</p> <p>Covered Employee's Entitlement to Medicare</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Employee</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependents:</u></p> <p>Loss of Dependent Child Status</p>	<p>36 months</p>

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

Second qualifying event

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have

received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the *Employer* will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the employee's coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at www.dol.gov/ebsa.

Claims Review and Appeal Procedures

Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: 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 Express Scripts Coverage Review Department at 1 800-753-2851 or the prescriber may submit a completed coverage review form to Fax 1 877- 329-3760. Forms may be obtained online at www.express-scripts.com/services/physicians/. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing to Express Scripts Attn: Benefit Coverage Review Department, PO 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 which, 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 1 800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful)	Patient: letter
Standard Post-Service*	30 days	Prescriber: Fax (letter if fax not successful)	Prescriber: Fax (letter if fax not successful)
Urgent	72 hours**	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. 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
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

If the patient’s situation meets the definition of urgent under the law, an urgent appeal 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 which, 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 phone or fax:

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of appeal	Decision Timeframe	Notification of Decision
	Decisions are completed as soon as possible from receipt of request but no later than:	

		Approval	Denial
Standard Pre-Service*	15 days	Patient: automated call (letter if call not successful)	Patient: letter
Standard Post-Service*	30 days	Prescriber: Fax (letter if fax not successful)	Prescriber: Fax (letter if fax not successful)
Urgent	72 hours**	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review

How to request a level 2 appeal after a level 1 appeal has been denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 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
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal 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 which, 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 phone or fax

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful)	Patient: letter
Standard Post-Service*	30 days	Prescriber: Fax (letter if fax not successful)	Prescriber: Fax (letter if fax not successful)
Urgent	72 hours**	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

Filing a Paper Claim – Retail Pharmacy Claims

If you pay full cost for a prescription from a retail pharmacy and wish to file for reimbursement of your claim (less the applicable co-payment or so the cost applies toward your deductible or co-insurance) on a paper claim form, you may obtain a claim form at www.express-scripts.com. You may pay full cost for a prescription if you obtain a prescription from a non-participating (non-network) retail pharmacy.

Please read the claim form carefully, fill it out completely and sign it. Along with the completed and signed paper claim form, you must submit the following information to Express Scripts:

- Patient name, relationship to covered Colleague, gender and date of birth;
- Pharmacy name and address;
- Prescribing physician's name and DEA #;
- Date prescription filled;
- Drug name, strength and NDC number;
- Rx number;
- Quantity;
- Days supply; an
- Price.

Prescription drug claim forms and receipts must be submitted to:

Express Scripts, Inc.
Attn: Commercial Claims
Lexington, KY 40512-4711

When you submit a paper claim to Express Scripts for reimbursement after you have already received a drug or supply, Express Scripts will make a decision and you will be notified of that decision within 30 days following Express Scripts' receipt of the claim.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims or payment involving all media (paper or electronic) may

invalidate any payment or claims and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain Prescription Drugs.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
 1. **the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan;**
 - or
 2. **You fail to cooperate.**
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

General Information

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Express Scripts has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Express Scripts' Notice, contact the customer service number on Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in Your Explanation of Benefits is the final determination and You will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not

pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Express Scripts has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time You receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with Your claim. All services will be subject to appropriateness of care. The Plan will reimburse You directly. Payment will be based on the Maximum Allowed Amount. Assignments of benefits to foreign providers or facilities cannot be honored.

You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

Health Benefits Coverage Under Federal Law

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification card or refer to the Claims Administrator's website, www.myuhc.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.myuhc.com.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 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.

Also, under federal law, plans 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.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

**All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Schedule of Benefits.**

If You would like more information on WHCRA benefits, call Your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

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.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- The Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.

Specific Plan Information Required by ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each Member in an employee benefit Plan. This information is outlined below.

- **Plan Name:** Saint Louis University Welfare Benefit Plan
- **Plan Sponsor:** Saint Louis University
Lindell Office Building – First Floor
3545 Lindell Blvd. -
St. Loui, MO 63103
(314)977-2360
- **Plan Number:** 518
- **Employer I.D. Number:** 43-0654872
- **Participating Employer:** Saint Louis University
- **Type of Plan:** The Plan is a prescription drug program under an Employee welfare benefit plan providing group medical benefits.
- **Plan Year Ends:** 12/31
- **Type of Administration/Funding:** Prescription drug benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Express Scripts on behalf of Saint Louis University
- **Plan Administrator:** Saint Louis University
Lindell Office Building – First Floor
3545 Lindell Blvd. -
St. Loui, MO 63103
(314)977-2360
- **Agent for Service of Legal Process:** Welfare Benefitl Plan
Saint Louis University
Lindell Office Building – First Floor
3545 Lindell Blvd. -
St. Loui, MO 63103
(314)977-2360
- **Description of Benefits.**
The Plan Description sets forth the benefits provided under this Prescription Drug Benefit. A brief explanation of these benefits may be found in the section entitled "**Schedule of Benefits**". A more detailed description of the benefits appears in the sections entitled "**Benefits**".
- **Eligibility for Participation.**
The eligibility requirements for participation under this Prescription Drug Benefit are set forth in the Plan Description in the section entitled "Eligibility".
- **Claims Procedures.** The Summary Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims

Administrator or the Plan Administrator. Note that the Claims Administrator is neither the Plan Administrator nor the administrator for the purposes of ERISA.

- **Review of Claim Denial.** If Your claim is denied in whole or in part, You will receive a notice of the denial. The notice will explain the reason for the denial.

You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request with the Claims Administrator for a review. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

Your request for review must be filed within 60 days after the receipt of the written notice of denial of a claim. A decision will be rendered no later than 30 days after the receipt of the request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision after the review shall be in writing and shall include specific reasons for the decision. This decision shall include specific reference to the pertinent benefit provisions of the Plan on which the decision is based. In any event, the Plan Administrator shall have the final authority regarding the disposition of disputed claims.

Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary financial report.

In addition to creating rights for You and other Employees, ERISA imposes duties on the people responsible for the operation of Your Employee benefit Plan. The people who operate Your Plan are called plan fiduciaries. They must handle Your Plan prudently and in the best interest of You and other Plan Members and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your right under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have Your claims reviewed and reconsidered.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such case, the court may require the Plan Administrator to provide You the materials and pay You up to \$110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order You to pay these expenses, for example, if it finds Your claim is frivolous. If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Benefit Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or the Claims Administrator. In addition to this information, if this Plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to You, they will apply in place of any similar claim procedure rules included in this Benefit Booklet.

Urgent Care. The Plan must notify You, within 72 hours after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If Your request for benefits does not contain all the necessary information, the Plan must notify You within 24 hours after receiving it and tell You what information is missing. Any notice to You by the Plan will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give the Plan the additional information needed to process Your request for benefits. You may give the Plan the additional information needed orally by telephone or in writing by facsimile or other fast means.

If Your request for benefits is denied in whole or in part, You will receive a notice of the denial within 72 hours after the Plan's receipt of the request for benefits or 48 hours after receipt of all the information needed to process Your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the Plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after the Plan receives Your appeal, if Your claim is still considered urgent under the circumstances at the time of the appeal, the Plan must notify You of the decision. The Plan will notify You orally by telephone or in writing by facsimile or other fast means. If Your claim is no longer considered urgent, it will be handled in the same manner as a non-Urgent Care pre-service or post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Plan must notify You, within 15 days after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If the Plan needs more than 15 days to determine Your benefits, due to reasons beyond its control, the Plan must notify You within that 15-day period that more time is needed to determine Your benefits. But, in any case, even with an extension, the Plan cannot take more than 30 days to determine Your benefits. If You do not properly submit all the necessary information for Your claim, the Plan must notify You, within 5 days after receiving it and tell You what information is missing. You have 45 days to provide the Plan with the information needed to process Your request for benefits. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If Your claim is denied in whole or in part, You will receive a written notice of the denial within the time frame noted above after the Plan has all the information needed to process Your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the Plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received, the Plan must notify You of the decision. The notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with Your illness or Injury, the Plan decides to reduce or end the benefits that had been approved for You, in whole or in part:

- The Plan must notify You sufficiently in advance of the reduction in benefits, or the end of benefits, to allow You the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to You, the Plan must explain the reason for reducing or ending Your benefits and the plan provisions upon which the decision was made.
- To keep the benefits You already have approved, You must successfully appeal the decision to reduce or end those benefits. You must make Your appeal to the Plan at least 24 hours prior to the occurrence of the reduction or ending of benefits. If You appeal the decision to reduce or end Your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits,

Your appeal will be treated as if You were appealing a non-Urgent Care denial of benefits (see "Urgent Care" above).

- If Your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, the Plan must notify You of the decision regarding Your appeal within 72 hours of the receipt of Your appeal. If Your appeal of the decision to reduce or end Your benefits is denied, in whole or in part, the Plan must explain the reason for the denial of benefits and the Plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an Urgent Care denial of benefits (see "Urgent Care" above).

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Plan must notify You, within 30 days after receiving Your request for benefits, that the request has been received and what Your benefits are determined to be. If more than 30 days are needed to determine Your benefits, due to reasons beyond the Plan's control, the Plan must notify You within that 30-day period that more time is needed to determine Your benefits. But, in any case, even with an extension, the Plan cannot take more than 45 days to determine Your benefits. If You do not submit all the necessary information for Your claim, the Plan must notify You, within 30 days after receiving it and tell You what information is missing. You have 45 days to provide the information needed to process Your claim. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If Your claim is denied in whole or in part, You will receive a written notice of the adverse benefit determination within the time frame stated above after the Plan has all the information needed to process Your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving Your appeal, the Plan must notify You of the decision. The notice to You of the decision will be in writing.

Note: You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Plan and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information the Plan or the Claims Administrator has regarding Your case will be released to You or an attorney only by written authorization from Your provider and/or the Hospital.

- **Please Note: ERISA appeals will be administered by the Claims Administrator. Any appeals should be sent to Express Scripts, Inc.**

Assistance with Your Questions

If you have any questions about your Plan, You should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

