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PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

KPPC PHARMACY BENEFIT PROGRAM
PLAN DOCUMENT & SUMMARY DESCRIPTION

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM AND A COPY OF THE SIGNED PLAN DOCUMENT TO:

Keenan & Associates
2355 Crenshaw Blvd. Suite 200
Torrance, CA 90501
Attention: Gerard A. Healy % dkong@keenan.com

The Plan Sponsor recognizes that it has full responsibility for the contents of the employee benefit document attached hereto and that, while Keenan & Associates, its employees and/or subcontractors, may have assisted in the preparation of the document, it is the Plan Sponsor who is responsible for the final text and meaning. The Plan Sponsor further certifies that the document has been fully read, understood, and describes its intent with regard to the employee benefit plan.

PLAN SPONSOR: LAKESIDE INDUSTRIES, INC.

By: ______________________ Date: 8/19/2020
AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

Attachment: C2-20200811

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

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KPPC PHARMACY BENEFIT PROGRAM
PLAN DOCUMENT & SUMMARY DESCRIPTION

KEENAN PHARMACY PURCHASING COALITION

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IMPORTANT NOTICE FROM THE PLAN SPONSOR ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan Sponsor and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription d rug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- ✓ **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- ✓ **The Plan Sponsor has determined that the prescription drug coverage offered under the Program is, on average for all Program Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage under the Program will not be affected and will coordinate with the Medicare Part D coverage. If you decide to join a Medicare drug plan and drop this coverage, be aware that you and your dependents will be able to get this coverage back.

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When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage under the Program and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. You'll get this notice each year when you receive this summary description and Plan Document. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage…

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY Users should call 1-877-486-2048).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

Date: January 1, 2020
Name of Sponsor: Lakeside Industries, Inc.
Contact: Human Resources
Address: P. O. Box 7016
6505 – 226th Place SE, Suite 200
Issaquah, WA 98027

Phone Number: (425) 313-2625

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ARTICLE I. PHARMACY PROGRAM

1.1 INTRODUCTION

This document describes the Plan Sponsor's KPPC Pharmacy Benefit Program (the "Program") and serves as the Program's plan document and summary description. It describes the pharmacy benefits as they apply to Eligible Employees and family members who are participants in the Program as of the first day of the Plan Year in which the Program was effective.

This plan document and summary description should be read carefully and shared with family members. For more information about Prescription Drugs, contact Express Scripts, Inc. by calling the telephone number found on the back of the ID Card or by going to Express-Scripts.com. For more general information about Prescription Drugs, vitamins and health conditions, log on to Express-Scripts.com and select "Resource Center." If there are any other questions about pharmacy benefits, you may also contact the Plan Sponsor (See Article XI for Plan Sponsor contact information).

The Program is self-funded so the Program's success is dependent upon the choice and use of Program benefits. With costs always on the rise, cost-conscious use of Program benefits will better assure the ability to continue to offer quality coverage to Program Participants.

This document represents the official plan document and summary description and will determine how questions will be resolved. If there is any difference between the information in this document and other documents, this document, as the official plan document, will govern actual rights and benefits under the Program.

Failure to follow the eligibility or enrollment requirements of the Program or related Medical Plan may result in delay of coverage or no coverage. Reimbursement from the Program can be reduced or denied because of certain provisions, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing claims, lack of coverage, fraud or intentional misrepresentation or failure to comply with the terms and conditions of the Program.

A Program Participant should contact the Pharmacy Benefit Manager to obtain additional information, free of charge, about Program coverage of a specific benefit, particular drug, treatment, test or any other aspect of Program benefits or requirements.

1.2 SOLICITUD DE INFORMACION EN ESPAÑOL (SPANISH LANGUAGE OFFER OF ASSISTANCE)

Este documento está escrito en inglés y contiene un resúmen de los derechos y beneficios de su plan de seguro. Si usted tiene dificultad en comprender cualquier parte de este documento, comuníquese con los administradores se puede encontrar en el artículo XI.

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ARTICLE II. FEDERAL LAWS

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact.

2.1 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Program makes available a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Program. The Notice of Privacy Practices can be found either attached to this document as Appendix C. Otherwise, it can be found with the Medical Plan or requested from the Plan Sponsor.

2.2 THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act is a Federal law that was enacted to provide for parity in the application of mental health and substance use disorder benefits with medical/surgical benefits. In general, a group health plan that provides medical/surgical benefits and benefits for mental health and substance use disorders must offer benefits for covered mental health conditions and covered substance use disorders that are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits under the Program. The standards for medical necessity of certain drugs may be requested by contacting Express Scripts.

2.3 PREGNANCY DISCRIMINATION ACT

Generally, coverage must be provided for pregnancy-related conditions in the same manner as coverage is provided for Illness. The Pregnancy Discrimination Act applies to pregnancy-related conditions of an Employee or a dependent spouse/domestic partner, as may be applicable, who is covered under the Program. This requirement does not necessarily apply to pregnancy-related conditions of a child of an Employee.

2.4 MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER OF FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed in **Appendix A**, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in the Program if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have any questions about enrolling in your employer plan, contact the U. S. Department of Health and Human Services Centers for Medicare & Medicaid Services at www.cms.hhs.gov or call 1-877-267-2323, Option 4, extension 61565.

2.5 QUALIFIED (NATIONAL) MEDICAL SUPPORT ORDERS (QMSCO)

An eligible dependent child of an Employee will include a child who is adopted by the Employee or placed with the Employee for adoption prior to age 18 and a child for whom the Employee or covered dependent spouse/domestic partner, as may be applicable, is required to provide coverage due to a Medical Support Notice which, if applicable, is determined by the Plan Administrator to be a Qualified Medical Child Support Order. These orders include a judgment, decree or order issued by a court of "competent jurisdiction" or through an administrative process established under State law and having the force and effect of law under State law and, if applicable, satisfies the QMCSO requirements of ERISA § 609(a). If applicable, Program Participants may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.

2.6 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform active service in any of the uniformed services of the United States, you have the right to elect to continue your existing group health plan coverage for you and your dependents for up to 24 months while in the uniformed services; and even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your group health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., PCEs) except for service-connected illnesses or injuries.

2.7 FAMILY AND MEDICAL LEAVE ACT (FMLA)

If a covered Employee ceases active employment due to an approved Family Medical Leave of Absence, then coverage availability will continue under the same terms and conditions that would have applied had the Employee continued in active employment. Contributions will remain at the same levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

2.8 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

If coverage ceases because of certain "Qualifying Events," you may have the right to purchase continuation of coverage for a temporary period of time. Qualifying Events include termination of Employee's employment, reduction in an Employee's hours of employment, divorce, or legal separation of Employee and spouse, death of an Employee, and a child's loss of dependent status.

2.9 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Group health plans are prohibited from using genetic information to discriminate in health benefits. GINA prohibits the use of genetic information to discriminate in health benefits, including charging a person higher premiums based solely on a genetic predisposition to

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developing a disease in the future. Under GINA, the Program is prohibited from requesting or requiring an individual or family member to undergo a genetic test. However, GINA does not limit the authority of a health care professional to request an individual to undergo a genetic test as part of the treatment of the individual, nor does it preclude a group health plan from obtaining or using the minimum necessary results of a genetic test in order to make a determination regarding payment.

2.10 NOTICE OF NETWORK PHARMACIES

The Program has contacted with Pharmacies to maximize the efficient delivery of benefits. A list of Pharmacies that participate in the Program can be accessed immediately by using the web address found on the ID Card or can be requested from the Pharmacy Benefit Manager without charge.

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ARTICLE III. DEFINITIONS

The following terms have special meanings and when used in the Program will be capitalized.

3.1 **Accredo** is a pharmacy that provides specialty medications while providing personalized pharmacy care for patients diagnosed with chronic Illness.

3.2 **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act, as amended.

3.3 **Allergy Serums** means extracts of biological substances that cause allergic reactions in sensitive individuals. These are used to desensitize the patient over time and primarily administered in the allergist's office (routine allergy shots).

3.4 **Biologicals/Vaccines/Immunization Agents** are non-self-injectable products that are generally classified as vaccinations and are covered under the medical plan.

3.5 **Brand Name** means a Covered Prescription to which a manufacturer has assigned a unique proprietary trade name and which, when dispensed, can only be the drug bearing such manufacturer's trade name.

3.6 **Calendar Year** means January l through December 31 of the same year.

3.7 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

3.8 **Code** means the Internal Revenue Code of 1986, as amended.

3.9 **Contraceptive Devices (diaphragms, IUDs)** are birth control devices that prevent conception through a barrier method.

3.10 **Contraceptives, Implantable** are systemic contraceptives that contain progestin only or a combination of estrogen and progestin. Systemic contraceptives inhibit ovulation or prevent a fertilized egg from being implanted and are used to prevent pregnancy. They may also be used to treat endometriosis and abnormal menstruation.

3.11 **Contraceptives, Emergency Kit** are the "morning-after" pills that are taken orally once.

3.12 **Contraceptives, Injectable** is a quarterly birth-control injection that is administered in a doctor's office.

3.13 **Covered Prescription** has the meaning described in Article V.

3.14 **Dependent** means the individuals described in Article IV.

3.15 **Eligibility or "Eligible"** means the requirements that must be satisfied in order to participate in the Program.

3.16 **Eligible Employee** means an Employee who has satisfied the requirements for participation in the Program as described in Article IV.

3.17 **Eligible Class(es) of Employees** means Employees who are eligible for participation in the Medical Plan.

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3.18 **Employee** means an individual who is an employee of the Employer and who is paid through the Employer's payroll system.

3.19 **Employer** means the Plan Sponsor.

3.20 **Enrollment Date** is the first day of coverage under the Program.

3.21 **ESI** means Express Scripts, Inc.

3.22 **Experimental and/or Investigational** means procedures, studies, tests, drugs or equipment that is any of the following:

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated does or effectiveness in comparison to conventional treatments;
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board as required and defined by Federal regulations or other official actions (especially those of the FDA);
- Other facilities studying substantially the same drug refer to it as Experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect;
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings;
- It cannot lawfully be marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use;
- It is a subject of a current investigation of new drug or new device application on file with the FDA; or
- It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA.

3.23 **FDA** means the U.S. Food and Drug Administration.

3.24 **Fertility Medications (oral, injectable)** are used to induce ovulation or to stimulate follicle development in patients undergoing Assisted Reproductive Technology (ART) (e.g., in-vitro fertilization).

3.25 **FMLA** means the Family and Medical Leave Act.

3.26 **Formulary and Non-Formulary Prescription Drugs or Medicines** are Prescription Drugs that are categorized into tiers and priced according to the tier in which they are placed on the Formulary listing. Non-Formulary Prescription Drugs or Medicines are not described within the Formulary listing.

3.27 **Generic Prescription Drug** is a Prescription Drug known by its chemical name and is produced and sold under that chemical formulation name.

3.28 **Genetic Information** means information about (i) an individual's genetic tests or the genetic tests of family members; (ii) the manifestation of a disease or disorder in family members (i.e. family medical history); and (iii) any request for genetic services or receipt of genetic services by a Program Participant or family member. The term

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genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman), genetic information about the fetus and, with respect to an individual using assisted reproductive technology, genetic information about the embryo.

3.29 **HIPAA** means the Health Insurance Portability and Accountability Act.

3.30 **Home Delivery Pharmacy** means a Pharmacy Benefit Manager that legally dispenses by mail.

3.31 **Illness** means a bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

3.32 **Inhaler Assisting Devices** are devices that help children and adults use their asthma inhalers more effectively.

3.33 **Injury** means a physical injury to the body caused by unexpected external means.

3.34 **Legend Drugs** are all drugs regulated as prescription drugs by the FDA or by a State as Restricted Drugs.

3.35 **Medical Plan** means the Employer's major medical plan(s) that are served by this Program and part of the Lakeside Industries, Inc. Group Medical and Dental Plan (Plan Number 501).

3.36 **Medically Necessary** means care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not Experimental or Investigational; and is the most appropriate level of services which can be safely provided to the patient. All of these criteria must be satisfied. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator or its delegate has the discretionary authority to decide whether care or treatment is Medically Necessary.

3.37 **Medicare** means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

3.38 **Non-Participating Pharmacy** means a Pharmacy that is not part of the Express Scripts network of Pharmacies.

3.39 **Open Enrollment Period** means that period of time prior to the beginning of the Plan Year during which an Employee may enroll or terminate participation in the Program, or change coverage or categories of coverage.

3.40 **OTC Diabetic Supplies and Insulin** are necessary testing and administering supplies for people with diabetes. Diabetic supplies include: alcohol swabs, lancets (only), urine/blood test strips and tapes (only), blood glucose testing monitors (only), Insulin syringes (with or without needles) and Insulin.

3.41 **OTC Drugs** means drugs or medicines purchased over-the-counter that do not require a prescription and often are less expensive than Prescription Drugs.

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3.42 **Participating Pharmacy** means a Pharmacy that is within the Express Scripts network of Pharmacies.

3.43 **Pharmacy** means an establishment where Prescription Drugs are legally dispensed.

3.44 **Pharmacy Benefit Manager** means Express Scripts, Inc. who administers the claims under this Program.

3.45 **Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency and is acting within the scope of their license.

3.46 **Plan Administrator** means the entity found at Article XI, or its delegate, that is administering this Program.

3.47 **Plan Sponsor or Sponsor** means the entity found at Article XI that is sponsoring the Program.

3.48 **Plan Year** means that period described in Article XI.

3.49 **Prescription Drug** means any of the following: an FDA approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable Insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

3.50 **Program** means the Shenendehowa Central School District KPPC Pharmacy Benefit Program as described herein and as may be amended from time to time.

3.51 **Program Participant** is any Employee or Dependent who is covered under this Program.

3.52 **Self-Injectable Medications** are self-administered injectable drugs or medications including those medications that are available in parenteral form and considered suitable for patient self-administration.

3.53 **Substance Use Disorder** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

3.54 **Therapeutic Vitamins** are vitamins that are used to supplement important nutritional needs of certain populations. Some are also used to treat certain types of anemia.

3.55 **USERRA** means the Uniform Services Employment and Reemployment Rights Act.

3.56 **Vaccines/Immunization Agents** are injections generally given in a clinic setting or doctor's office.

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ARTICLE IV. ELIGIBILITY AND EFFECTIVE DATES

4.1 ELIGIBILITY

(a) **Eligible Classes of Employees**. All Employees of the Employer who are eligible for benefits under the Medical Plan are eligible to participate in the Program.

(b) **Eligibility Requirements for Employee Coverage**. A person is eligible for coverage under the Program on the first day that they are eligible for coverage under the Medical Plan.

(c) **Eligible Dependents**. An eligible Dependent is any individual who is eligible for coverage as a dependent under the Medical Plan.

(d) **Eligibility Requirements for Dependent Coverage**. A Dependent will become eligible for Dependent coverage on the first day that the Employee is eligible for coverage. At any time, the Program may require proof that a Dependent qualifies or continues to qualify as a Dependent.

4.2 ENROLLMENT

(a) **Enrollment Requirements**. An Eligible Employee must timely enroll for coverage by completing and signing an enrollment application for the Medical Plan. Enrollment in the Program is contingent on enrollment in the Medical Plan.

(b) **Enrollment Requirements for Newborn or Newly Adopted Children.** A newborn or newly adopted child of a Program Participant who has enrolled in the Program with Dependent coverage is automatically enrolled in this Program for 21 days. However, to continue coverage of the child beyond 21 days, a new election is required timely. An Employee who is not enrolled in the Program who has a newborn or newly adopted child may have a Special Enrollment Right as described below.

(c) **Timely Enrollment.** The enrollment will be "timely" if the completed enrollment application is received by the Plan Administrator or its delegate at such time and in such manner that the Plan Administrator requires subject to the Program eligibility requirements, either initially or under a Special Enrollment Right.

4.3 SPECIAL ENROLLMENT RIGHTS

The enrollment date for anyone who enrolls under a Special Enrollment Right is described below:

Enrollment in the Program is contingent on enrollment in one of the Medical Plans offered by the Plan Sponsor. Based upon enrollment in the Medical Plan:

(a) **Individuals Losing Other Coverage**—An Employee or Dependent who is eligible, but not enrolled in this Program, may enroll if each of the following conditions is satisfied:

(i) The Program was previously offered to the individual;

(ii) If required by the Plan Sponsor, the Employee stated in writing, at the time that coverage was offered, that the other coverage was the reason for declining enrollment;

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(iii) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or Employer contributions towards the coverage was terminated;

(iv) The Employee or Dependent requests enrollment in this Program not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions as described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received; and

(v) If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment Right.

(b) **Increase in the Number of Dependents**—An Eligible Employee may enroll in the Program or make an election to add or change coverage with respect to a new Dependent if the following conditions are satisfied:

(i) The Employee is a Program Participant or is eligible to enroll in the Program but for a failure to enroll during a previous enrollment period;

(ii) A person becomes a Dependent of the Employee (through marriage, birth, adoption or placement for adoption or guardianship); and

(iii) The Employee enrolls the Dependent within a period of 60 days from the date of the marriage, birth, adoption or placement for adoption or guardianship. The coverage of the Dependent enrolled within the 60-day period will be effective, in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received; in the case of a Dependent's birth, as of the date of birth; or in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption, or date of guardianship.

(c) **Loss of Medicaid Eligibility**—Employees may enroll themselves or Dependents in the Program upon loss of eligibility for health coverage under Medicaid. Employees can request Special Enrollment Rights for themselves and Dependents within 60 days after the date of termination of coverage. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received by the Plan Administrator or its delegate.

(d) **Eligibility for State Premium Assistance**—Employees or Dependents who become eligible for a State premium assistance subsidy under the Program from Medicaid or CHIP can request a Special Enrollment Right for themselves and Dependents within 60 days after the date on which eligibility for premium assistance has been determined. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received by the Plan Administrator or its delegate.

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4.4 CHANGE IN STATUS OR OTHER EVENT

An Employee or Dependent may be eligible to enroll in the Program if such enrollment is due to a change in status or other event which permits a change in election to the corresponding Medical Plan during the Plan Year and for which the Plan Administrator, in its sole discretion, on a uniform and consistent basis, determines is permitted.

4.5 COVERAGE EFFECTIVE DATES

(a) **Effective Date of Employee Coverage**—A new Employee will be covered under this Program coincident with the first day of coverage under the Medical Plan. Employees who enroll during the regular Open Enrollment Period will be covered under this Program on the first day of the Plan Year following that Open Enrollment Period.

(b) **Effective Date of Dependent Coverage**—Dependents who satisfy the eligibility and enrollment requirements of the Program will have coverage effective (i) for new Employees, on the date that the Employee is covered; (ii) for new Dependents, on the date specified under a Dependent Special Enrollment Right; or (iii) on the first day of the Plan Year following enrollment during an Open Enrollment Period.

4.6 TERMINATION OF COVERAGE

(a) **Termination of Employee Coverage**. Subject to any COBRA rights, an Employee's coverage under the Program will terminate upon the earliest of the following:

(i) The date the Medical Plan is terminated;

(ii) The date that the benefits under this Program are terminated;

(iii) Termination of participation in the Medical Plan;

(iv) The last day of the calendar month in which the Plan Participant ceases to be an Eligible Employee, including the death or termination of employment of the Plan Participant or ceasing to be a member of an Eligible Class;

(v) The end of the period for which the required contribution was last made, if the charge for the next period is not paid when due; and

(vi) The date determined by the Plan Administrator or its delegate in cases of fraud or an intentional misrepresentation of a material fact regarding coverage eligibility. In the event of a retroactive termination of coverage, 30-days written notice of rescission must be provided.

(b) **Termination of Dependent Coverage**—Subject to any COBRA rights, a Dependent's coverage will terminate on the earliest of the following:

(i) The date the Medical Plan is terminated;

(ii) The date that the benefits under this Program are terminated;

(iii) Termination of participation in the Medical Plan;

(iv) The last day of the calendar month in which the Plan Participant ceases to be an Eligible Employee, including the death or termination of employment of the Plan Participant or ceasing to be a member of an Eligible Class;

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(v) The end of the period for which the required contribution was last made, if the charge for the next period is not paid when due;

(vi) The date determined by the Plan Administrator or its delegate in cases of fraud or an intentional misrepresentation of a material fact regarding coverage eligibility. In the event of a retroactive termination of coverage, 30-day notice of rescission must be provided.

4.7 EXTENSIONS OF COVERAGE

(a) **Disabled or Handicapped Dependent Children**—An already covered Dependent child who attains age 26 (which would otherwise terminate their status as a "Dependent") will continue as a Dependent eligible for coverage if the child satisfies the requirements for coverage of disabled or handicapped dependent children under the terms and conditions of the Medical Plan. A newly eligible Employee who has a Dependent child who was disabled or handicapped prior to attaining age 26 is subject to the eligibility rules of the Medical Plan.

(b) **Family and Medical Leave**—This Program shall at all times comply with the Family and Medical Leave Act.

During any leave of absence taken under the Family and Medical Leave Act, coverage will continue under this Program on the same conditions as coverage would have been provided if the Plan Participant had been continuously employed during the entire leave period.

If Program coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Program when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated. For example, other waiting periods will not be imposed unless they were in effect for the Employee and/or Dependents when Program coverage terminated.

(c) **Rehiring Terminated Employees**—An Employee who is terminated from employment and then rehired at a later date will be eligible for coverage at the same time and in the same manner as eligibility for the Medical Plan.

(d) **Employees on Military Leave**—Employees going into or returning from uniformed service may elect to continue Program coverage under USERRA. USERRA applies to persons who perform duty, voluntarily or involuntarily, in the "uniformed services" which include the Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service commissioned corps, as well as the reserve components of each of these services. Federal training or service in the Army National Guard and Air National Guard also gives rise to rights under USERRA. In addition, under the Public Health Security and Bioterrorism Response Act of 2002, certain disaster response work (and authorized training for such work) is considered "service in the uniformed services." The following rules apply:

(i) The maximum period of coverage that an eligible person may elect shall be the lesser of:

- The 24-month period beginning on the date on which the person's absence begins; or
- The period of the uniformed services leave.

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

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

These rights apply only to Employees and their Dependents covered under the Program before leaving for uniformed service.

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ARTICLE V. BENEFIT COVERAGE

5.1 COINSURANCE

Except for specified Prescription Drugs, the coinsurance percentages described below apply after the deductible amount has been paid.†

PROVIDER CATEGORY			
PRESCRIPTION DRUG BENEFIT	**Participating ESI Pharmacy 30-Day Supply Non-Maintenance**	**Non-Participating Pharmacy**	**Home Delivery Pharmacy/ Retail Maintenance (Non-Injectable) 90-Day Supply**
Generic	20%*	40%**	20%*
Brand –Formulary	20%*	40%**	20%*
Brand –Non-Formulary	20%*	40%**	20%*
Contraceptives	$0	Not Covered	$0
Aspirin, Folic Acid	$0	Not Covered	$0
Smoking Cessation Products	$0	Not Covered	$0

* If the cost of the Prescription Drug is less than the coinsurance, Program Participants will pay the actual cost.

** If a prescription order is filled at a Participating Pharmacy without presentation of the ID Card or if a prescription order is filled at a Non-Participating Pharmacy, the Program Participant may have to pay for the entire cost of the Prescription Drug and then file a claim with Express Scripts, Inc. for reimbursement. (See details below.) For Non-Participating Pharmacies, the Plan pays 60% of the allowable charges after the deductible amount has been satisfied. The Program Participant pays the balance of billed charges plus the difference in cost between the pharmacy's billed charge and the allowable charge.

† If participating in a high deductible health plan, Program Participants will be responsible for 100% of the cost until the deductible amount is satisfied. Please note that certain preventive drugs are covered at 100% without the need to satisfy the deductible amount. Once the deductible amount is satisfied, the out-of-pocket cost of a Covered Prescription for Network Pharmacies will be 20% until the annual out of pocket amount for Network Pharmacies has been satisfied. Thereafter, the Program will pay 100% of the cost of a Covered Prescription for Network Pharmacies for the remainder of the Plan Year.

RESTRICTED GENERIC PROGRAM: If a Brand Name drug is requested when a medically appropriate Generic Prescription Drug is available, and the prescribing Physician has allowed the substitution, the Program Participant will pay the difference between the cost of the Brand Name drug and the Generic Prescription Drug, plus the applicable coinsurance. If the Program Participant's Physician recommends a Brand Name drug because it is medically appropriate, then only the Brand Name coinsurance will be charged.

5.2 EXPRESS SCRIPTS, INC. RETAIL PRESCRIPTION BENEFIT PROGRAM

Program Participants may purchase Prescription Drugs, on an outpatient basis, through Express Scripts, Inc. Retail Prescription Benefit Program which utilizes Participating Pharmacies.

Program Participants may utilize any of the Express Scripts, Inc. Participating Pharmacies to obtain Prescription Drugs. In order to do so, the ID Card along with the Covered Prescription (as described below) must be made available to any Participating Pharmacy. Through the Express Scripts' Program system, the pharmacist will electronically verify eligibility and any early refills.

If injectable drugs (other than Insulin) or specialty drugs are being purchased, Program Participants may purchase a 30-day supply through participating Accredo retail pharmacies.

If a Program Participant fills a prescription order at a Participating Pharmacy without presenting their ID Card, or a Prescription Drug is purchased at a Non-Participating Pharmacy, the individual may have to pay for the entire cost of the drug and then file a claim

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with Express Scripts, Inc. for reimbursement. In order to be reimbursed, the Prescription Drug must be a Covered Prescription and the claim must include the drug name, dosage, quantity, the patient's name and address, and the Employee's name and Social Security Number. Claim forms may be obtained from the Express Scripts, Inc. website. Program Participants will be reimbursed by Express Scripts, Inc. at 100% of the cost of the drug, less the Employee's portion of the cost, if any. Claims should be submitted to:

Express Scripts
P.O. Box 66773
St. Louis, MO 63166-6733
Attn: Claims Department

Prescription Drugs covered under the Medical Plan are not covered under this Program.

5.3 PRESCRIPTION DRUG PROGRAMS

(a) **Home Delivery Pharmacy**. The ESI Home Delivery Pharmacy is available for individuals who take maintenance medications (such as heart medication or high blood pressure medications). The Home Delivery Pharmacy is the most efficient way to purchase maintenance drugs.

Except for injectable Insulin, covered contraceptives and bee sting kits, injectable drugs cannot be purchased through the Home Delivery Pharmacy.

(b) **Accredo Exclusive Specialty Drug Program.** The Accredo Exclusive Specialty Drug Program provides specialty drugs such as injectables or drugs for cancer, multiple sclerosis or rheumatoid arthritis, for example. After no more than one fill at a retail Pharmacy, specialty drugs should be obtained through the Accredo Exclusive Specialty Drug Program. Program Participants who are eligible for this program will be contacted directly by Accredo with a letter advising them of the necessary steps to participation. Program Participants may also contact Accredo at (844) 520-2674 for more information about the program and how to get started or visit Accredo.com.

(c) **Keenan Pharmacy Care Management (KPCM)**— KPCM provides an independent, unbiased layer of clinical management by engaging Physicians and Program Participants directly to ensure that the best possible drug therapies are chosen, based on their clinical effectiveness and overall cost to Program Participants and the Program. KPCM may recommend modifications to a Prescription Drug order and, if approved by the prescribing Physician and Program Participant, a new Prescription Drug order is issued.

All specialty prescriptions require prior authorization review through the Keenan Pharmacy Care Management Program. Physicians should contact US-Rx Care at 844.744.4410

Covered Prescription:

A Covered Prescription is a Prescription Drug that meets all of the following requirements:

- It is prescribed for the Program Participant;
- It is filled while the Program Participant is covered under the Program;
- The Prescription Drug is not excluded under the Program or the Prescription Drug order filled does not exceed quantity limits and other requirements of the Program; and

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- It is for a Legend Drug or a compound containing at least one legend drug, or for insulin, or for any drug or medication which, in accordance with Federal or State laws, may not be dispensed without the written prescription of a Physician.

Covered Prescription Drugs are indicated in the Formulary. Please visit: www.express-scripts.com to access the Formulary or contact Express Scripts for coverage determinations or request a paper copy.

5.4 DISPENSING LIMITS

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each prescription order are consistent with clinical dosing guidelines as recommended by the Food & Drug Administration. Please visit: www.express-scripts.com to review quantity limits and other dispensing limits of the Program or contact Express Scripts for a determination on dispensing limits or to obtain paper copy of the Formulary.

5.5 PRESCRIPTION EXCLUSIONS

There are Prescription Drugs that are not covered under the Program. Please review the Formulary for a complete list of Covered Prescriptions. If a Prescription Drug is not on the Formulary or is identified as not covered, the Program will not cover such Prescription Drug and the Program Participant will be responsible for the entire cost. Please visit: www.express-scripts.com for access to the Formulary or contact Express Scripts to request a paper copy. Please call Express Scripts at (800) 925-9145 with questions regarding exclusions and **limitations.**

Common Excluded Products Are Noted Below		
Abortifacients	Allergens	Depigmentation
Diagnostic, Testing and Imaging Supplies	Durable Medical Equipment	Hair Growth Agents
Homeopathic Meds and Medical Foods	Impotence Injectable and non-Injectable	Injectable Cosmetics
Photo-Aged Skin Products	Serums, Toxoids	Weight Management Products
Yohimbine		
**All over-the-counter products & drugs and over-the-counter equivalents are not covered.		
***Certain Injectable or other medications are not covered.		

Limitation:

No payment will be made for expenses incurred:

- While receiving in-patient hospital services, or
- While receiving services that are similar to in-patient hospital services such as nursing home, clinic coverage, etc.

5.6 PRESCRIPTION RESTRICTIONS – PRIOR AUTHORIZATION

Some Prescription Drugs will need to be authorized prior to their purchase. Please visit Express-Scripts.com or call ESI to identify drugs that require prior authorization.

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In order to receive a Prescription Drug that needs to be approved in advance, the prescribing Physician must contact Express Scripts. Only the prescribing Physician (or sometimes a pharmacist) can give Express Scripts the information needed to determine if the Prescription Drug order can be covered. Express Scripts' prior authorization phone lines are open 24 hours/day, 7 days per week. Express Scripts Coverage Review Department can be contacted at (800) 753-2851.

The prescribing Physician or pharmacist will be asked questions about patient's specific condition. If the information provided meets the Program's requirements, you will pay the Program's coinsurance at the Pharmacy.

The need for prior authorization may be eliminated in two ways:

- The prescribing Physician can be asked if another medication that's covered by the Program can be prescribed; or
- The Program Participant can simply pay full price for the Prescription Drug at the Pharmacy.

If a Prescription Drug order needs to be filled immediately:

- Talk with your pharmacist about filling a small supply of the Prescription Drug right away (full price may have to be paid);
- Then, ask the pharmacist to contact the prescribing Physician. The Physician needs to call the Express Scripts prior authorization department to find out if the Prescription Drug can be covered by the Program. Only the prescribing Physician (or in some cases, your pharmacist) can provide the information needed for this authorization.

There are some instances in which the request for prior authorization will be denied. For example, this Program doesn't cover certain drugs. A Program Participant or authorized representative may want to file an appeal to have the Prescription Drug covered. Contact Express Scripts at the number on the back of the ID Card. A description of the appeals process can be found at Article VI.

5.7 PREVENTIVE MEDICINES AND DRUGS

The Affordable Care Act provides for recommended medicines and drugs, as described in Appendix B, at no cost to the Program Participant. Please contact the Pharmacy Benefit Manager for information about the administration of this important benefit**.** For updates on Preventive Medicines and Drugs, please visit: www.healthcare.gov.

5.8 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUM

The deductible amount is the amount that must be paid by a Program Participant before the Program begins to cover a portion of the cost of Prescription Drugs. For families, expenses accumulate for each family member toward the family deductible. The entire family deductible must be satisfied before the Program begins to cover a portion of the cost of Prescription Drugs.

Prescription Drug coinsurance for purchases from Participating and non-Participating Pharmacies, including the Home Delivery Pharmacy and Accredo Exclusive Specialty Drug Program count toward this Program's and the Medical Plan's deductible amount and out-of-pocket maximum, which are for medical and Prescription Drug expenses combined.

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Once the eligible combined out-of-pocket Medical Plan and Prescription Drug expenses satisfy the out-of-pocket maximum, the Program will cover 100% of eligible Prescription Drug expenses.

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ARTICLE VI. CLAIMS AND APPEALS PROCEDURES

A claim is a request for a benefit determination which is made in accordance with the Program's procedures described in this Article. A claim may be submitted by a Program Participant or authorized representative. The claim must be received by the Pharmacy Benefit Manager within 12 months of the date the Prescription Drug order was filled so the claim review and benefit determination process can begin.

6.1 INCOMPLETE CLAIM FORM

All attempts will be made to process claims. However, if an incomplete claim form is submitted so that it is impossible to process a claim, then, within 15 days (and sooner if reasonably possible) the individual will be notified of the information needed to complete the claim request. The individual will then have 45 days from receipt of the notice within which to provide the information. Otherwise, the claim will be denied.

6.2 WHEN A PRE-PURCHASE CLAIM OR AUTHORIZATION SHOULD BE FILED

The Pharmacy Benefit Manager must notify the claimant about the Program's benefit determination (whether adverse or not), within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days, after it receives a request for benefits. If the Pharmacy Benefit Manager needs more than 15 days to determine benefits, due to reasons beyond its control, it must notify the claimant or authorized representative within that 15-day period that it needs more time to determine benefits. In any case, even with an extension, the Pharmacy Benefit Manager cannot take more than 30 days to determine benefits.

If the Program Participant's request for benefits is denied in whole or in part, such person will receive a written notice of the denial within the time frame stated above after the Pharmacy Benefit Manager has all the information it needs to process the request for benefits, if the information is received within the time frames.

6.3 NOTIFICATION OF APPROVAL OR DENIAL OF AN AFTER-PURCHASE CLAIM

After-Purchase claims should be filed with the Pharmacy Benefit Manager within 365 days of the date of purchase. Benefits are based on the Program's provisions at the time the charges are incurred. The Plan Sponsor or its designee reserve the right to deny claims that are filed after 365 days from the date of purchase unless it can be demonstrated that (i) it was not reasonably possible to submit the claim within the 365-day period, and (ii) such claim was submitted by the end of the Plan Year following the Plan Year in which the claim was incurred.

The time requirements do not apply if the Pharmacy Benefit Manager determines that the patient was not legally capable of submitting the claim on time.

These claims procedures address the period within which benefit determinations must be decided, not paid. Benefit payments will be made within reasonable periods of time following approval of the claim.

Denials of After-Purchase claims will be issued within 30 days of submission of the claim, subject to the limitations described in section 1 above. The Pharmacy Benefit Manager may take an additional 15 days to process the claim upon notice.

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The Pharmacy Benefit Manager shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall be set forth in a culturally and linguistically appropriate manner, calculated to be understood by the claimant:

- Information sufficient to identify the claim involved (including the date of purchase, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The specific reason or reasons for the adverse benefit determination;
- A description of the Program's standard, if any, that was used in denying the claim;
- Reference to the specific Program's provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Program's review procedures and the time limits applicable to such procedures;
- Whichever of the following applies:
  - (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request, or
  - (ii) If the adverse benefit determination is based on whether such Prescription Drug was Medically Necessary or Experimental and/or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- A statement of the claimant's right to bring a civil action following an external review; and
- Information regarding how to initiate a review of the determination.

6.4 APPEALS

If a claim is denied in whole or in part, a Program Participant or authorized representative may begin the appeals process as described in the notice of denial.

Appeal Rights

If a Program Participant desires to appeal the Pharmacy Benefit Manager's denial of a prior authorization request, or denial of all or part of an after-purchase claim, the Program Participant or authorized representative will have 180 days from the date of receipt of the notice of decision to file an appeal. The Plan Participant or authorized representative may do so by submitting the appeal, along with Physician supporting documentation, if any, to the address and in the form described on the explanation of benefits denying all or a portion of the claim.

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As previously noted, certain criteria were relied upon by Express Scripts in determining whether to approve the claim request. The Program Participant, prescribing Physician or authorized representative may request a copy of the applicable criteria free of charge.

Express Scripts understands the importance of Program Participant involvement in decisions affecting an individual's health care. The decision to continue with the requested medication is between the Program Participant and prescribing Physician. If there are additional questions regarding prescription drug benefits, please call the toll-free number on the Program identification card or the contact information below.

ADMINISTRATIVE & CLINICAL APPEALS

ADMINISTRATIVE APPEAL		CLINICAL APPEAL	
1st Level Appeals Handled by:	Express Scripts	**1st Level Appeals Handled by:**	Express Scripts
Mail To:	EXPRESS SCRIPTS	**Mail To:**	EXPRESS SCRIPTS
Address:	PO BOX 66587	**Address:**	PO BOX 66588
City, State, Zip:	ST. LOUIS, MO 63166-6587	**City, State, Zip:**	ST. LOUIS, MO 63166-6588
Attention:	ATTN: ADMINISTRATIVE APPEALS DEPARTMENT	**Attention:**	ATTN: CLINICAL APPEALS DEPARTMENT
Phone #:	(800) 946-3979	**Phone #:**	(800) 753-2851
2nd Level Appeals Handled by:	Express Scripts	**2nd Level Appeals Handled by:**	Express Scripts
Mail To:	EXPRESS SCRIPTS	**Mail To:**	EXPRESS SCRIPTS
Address:	PO BOX 66587	**Address:**	PO BOX 66588
City, State, Zip:	ST. LOUIS, MO 63166-6587	**City, State, Zip:**	ST. LOUIS, MO 63166-6588
Attention:	ATTN: ADMINISTRATIVE APPEALS DEPARTMENT	**Attention:**	ATTN: CLINICAL APPEALS DEPARTMENT
Phone #:	(800) 946-3979	**Phone #:**	(800) 753-2851
Urgent Appeals Handled by:	Express Scripts	**Urgent Appeals Handled by:**	Express Scripts
Mail To:	EXPRESS SCRIPTS	**Mail To:**	EXPRESS SCRIPTS
Address:	PO BOX 66587	**Address:**	PO BOX 66588
City, State, Zip:	ST. LOUIS, MO 63166-6587	**City, State, Zip:**	ST. LOUIS, MO 63166-6588
Attention:	ATTN: ADMINISTRATIVE APPEALS DEPARTMENT	**Attention:**	ATTN: CLINICAL APPEALS DEPARTMENT
Phone #:	(800) 946-3979	**Phone #:**	(800) 753-2851

If the request involves urgent care, the Program Participant or authorized representative or prescribing Physician may submit the appeal orally by calling the phone number provided on the Program identification card or number indicated above. The Pharmacy Benefit Manager must notify the Program Participant, prescribing Physician or authorized representative of its determination as soon as possible but not later than 72 hours after the Program receives a request for determination.

The following is a summary of other appeal rights:

(a) The appeal must be submitted within 180 days from the date of receipt a notice of adverse benefit determination that denies benefits for all or part of the claim (or, if additional

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information is being requested as described in the second paragraph below, then within 180 days following the last day on which additional information is permitted to be submitted before the request is denied.)

(b) Individuals will be allowed an opportunity to submit written comments, documents or other information relating to the claim, and upon request and free of charge, afforded reasonable access to and copies of all documents and other information relevant to the claim.

(c) Upon receipt of the appeal request, it will be reviewed in accordance with the claims procedures described herein and under the ACA.

(i) Non-Urgent Care Request. If a request is not designated by the prescribing Physician as being for urgent care, in general, notification of the determination on appeal must be made not later than 30 days after receipt by the Program of the request for review on appeal.

(ii) Urgent Care Request. If a request is designated as urgent care (as determined by the pre-Physician), you must be notified of the determination not later than 72 hours after receipt of your request for review on appeal.

Standard Appeal Procedures

(a) Applicable medical records, including client-specific applicable Program language, will be forwarded to a reviewer for each case review.

(b) All documentation regarding any previous appeal, specific Program language, and any other relevant information the reviewer needs to properly evaluate each claim will also be forwarded. The reviewer will notify the claimant in writing; inform them of the right to submit additional records for review; and provide the name and telephone number of a contact person to answer questions related to the appeal process.

(c) The reviewer selected to conduct the review will review the documentation within a reasonable period of time within sixty (60) days after receiving the case.

(d) Should additional information be needed, the reviewer may contact the patient's Physician to request the additional information.

(e) The reviewer will review available medical records, will review any additional information obtained from patient's Physician, and will write a rationale in support of their final decision.

(f) The final decision of the reviewer may affirm Express Scripts' determination in full (Deny Coverage), may reverse Express Scripts determination in full (Approve Coverage), or may affirm Express Scripts determination in part and reverse it in part (Modify Coverage).

(g) A letter will be sent by the reviewer to the Program Participant with a copy to Express Scripts, the patient, and/or the attending Physician. The letter will include the final internal appeal decision, the reasons for the final decision, discussion, references to the Program provisions on which the decision is based, and a statement indicating that this is the final internal appeal decision. In addition to the letter, Express Scripts will receive a copy of the actual case review done by the reviewer.

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Independent External Appeals Process

Program Participants may request an independent external review of a final internal adverse benefit determination. The external review is subject to the following procedures and deadlines:

(a) A request for an external review must be submitted within the four (4) month period after receipt of the notice of denial.

(b) A preliminary review determination will be made within five (5) business days following receipt of the external review request.

(c) Notification of the preliminary review determination will occur within one (1) business day after completion of the preliminary review.

(d) In the event it is determined that the request for external review is incomplete, the remainder of the four-month filing period is available to perfect the request or, if later, 48 hours following receipt of notice.

(e) The independent reviewer will provide notice (of acceptance for review, and deadline for submissions of additional information) in a timely manner.

(f) The reviewer will be provided with documents and information considered in making its benefits determination within five (5) business days of assignment to the reviewer.

(g) Additional information must be submitted within ten (10) business days following receipt of notice from the reviewer.

(h) The reviewer shall forward to the Program or Express Scripts, Inc. any additional information submitted by you within one (1) business day of receipt.

(i) In the event the Program reverses its denial, it must provide notice to the claimant and reviewer within one (1) business day of receipt.

(j) The reviewer must render a decision within 45 days of receipt of the request for review.

Expedited External Review

External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the patient or would jeopardize their ability to regain maximum function. For an expedited review, the reviewer must provide notice of the final external review decision as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the reviewer receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that non-written notice, the reviewer will provide written confirmation of the decision.

Right to Bring Suit

Following a continued denial of the request for coverage after exhaustion of the mandatory appeals process described in the Program and, if filed timely, the external review, a Program Participant may have a right to bring a civil action provided that such action is filed within one year of the date of receipt of the denial on the appeal.

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ARTICLE VII. COORDINATION OF BENEFITS WITH OTHER SOURCES OF PAYMENT

7.1 COORDINATION OF PRESCRIPTION DRUG BENEFITS

There is no coordination of benefits between this Program and any other medical or prescription drug plan.

7.2 EFFECTS OF MEDICARE

Medicare requires that the Plan Sponsor offer to active Employees and their covered Dependents, who are age 65 and over (or under age 65 and eligible for Medicare due to total disability), the same health benefits as are available to all other Employees and Dependents. Medicare further provides that an Employee may choose to be covered under the Program when they enroll in the Medical Plan. If so, Medicare will then become the secondary provider of coverage. The Program will determine what benefits are covered; the remainder of the expenses may then be submitted to Medicare by the individual for reimbursement.

If the Employee declines to participate in the Medical Plan and this Program, Medicare becomes the primary (and only) payor.

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ARTICLE VIII. INFORMATION CONCERNING CONTINUATION COVERAGE UNDER COBRA

You are required to follow the procedures described below with regard to notification of the Plan Administrator or its delegate of a COBRA-related event in order for you or other covered individuals to be eligible for continuation coverage of benefits under the Program. For specific details regarding your rights and responsibilities under COBRA, you may refer to your Medical Plan document, request details from the Plan Sponsor and read the information below.

8.1 NOTICE RESPONSIBILITIES

It is the responsibility of Program Participants to provide the following Notices as they relate to COBRA Continuation Coverage:

- Notice of Divorce or Separation: Notice of the occurrence of a Qualifying Event that is a divorce or legal separation from your spouse or domestic partner.
- Notice of Child's Loss of Dependent Status: Notice of a Qualifying Event that is a child's loss of Dependent status under the Program (e.g., a Dependent child reaching the maximum age limit).
- Notice of a Second Qualifying Event: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
- Notice Regarding Disability: Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.
- Notice Regarding Address Changes: It is important that the Plan Administrator be kept informed of the current addresses of all Program Participants or beneficiaries who are or may become Qualified Beneficiaries.

8.2 NOTIFICATION PROCEDURES

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

- Form or Means of Notification – Notification of the qualifying event must be provided to the Plan Administrator or its designee by completing the appropriate form prescribed by the Plan Administrator including any new addresses.

Notification must include the reason for the loss of coverage (such as divorce or other loss of dependent eligibility).

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8.3 Delivery of Notification

Notification must be received by the Plan Administrator or its delegate. Upon receipt, the COBRA Administrator will be notified.

8.4 Time Requirements for Notification

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the date of the Qualifying Event. If Notice is not received within the 60-day period, COBRA Continuation Coverage will not be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the date of the determination. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Program will not reject an incomplete Notice as long as the Notice identifies the Program, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Program is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Program for more complete information within a reasonable period of time following the request.

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ARTICLE IX. HIPAA STANDARDS OF PRIVACY

The HIPAA Standards of Privacy of the Medical Plan apply to this Program unless the Medical Plan is a fully-insured group health plan in which case the provisions of this Article IX shall apply to this Program. The provisions of this Article comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

9.1 DEFINITIONS

Business Associate—a person who, on behalf of the Plan: (i) performs a function that involves the use or disclosure of Protected Health Information, including claims processing, data analysis, utilization review, quality assurance, patient safety activities listed at 42 C.F.R. §3.20, billing, benefit management, practice management, and repricing; or (ii) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services that involve the disclosure of Protected Health Information from the Plan, or from another Business Associate of the Plan, to the person.

Business Associate includes (i) a health information organization, e-prescribing gateway, or other person that provides data transmission services with respect to Protected Health Information to the Plan and that requires access on a routine basis to such Protected Health Information; (ii) a person that offers a personal health record to one or more individuals on behalf of the Plan; (iii) patient safety organizations and (iv) a subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the Business Associate.

Business Associate does not include (i) a Health Care Provider, with respect to disclosures by a Plan to the Health Care Provider concerning the treatment of the individual; (ii) the Plan Administrator, with respect to disclosures by the Plan to the Plan Sponsor, to the extent that the requirements of the "Disclosure To Plan Sponsor," Section 15.3, apply and are met; (iii) a government agency, with respect to determining eligibility for, or enrollment in, a government health plan that provides public benefits and is administered by another government agency, or collecting Protected Health Information for such purposes, to the extent such activities are authorized by law; or (iv) a Covered Entity participating in an organized health care arrangement that performs a function or activity as described in this definition for or on behalf of such organized health care arrangement, or that provides a service as described in this definition to or for such organized health care arrangement by virtue of such activities or services.

Breach—the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under this Article or the HHS Regulations which compromises the security of privacy of the protected health information.

The term "Breach" does not include any of the following:

(a) Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of the Plan, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HHS Regulations.

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(b) Any inadvertent disclosure by a person who is authorized to have access to Protected Health Information of the Plan to another person authorized to have access to Protected Health Information of the Plan, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HHS Regulations.

(c) A disclosure of Protected Health Information where the Plan has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Covered Entity—a health plan, health care clearinghouses and Health Care Providers who electronically transmit any Health Information in connection with transactions for which HHS as adopted standards.

Health Information—any information, including genetic information, whether oral or recorded, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual.

Health Care Operations—any of the following activities of the Plan: (i) conducting quality assessment and improvement activities; (ii) reviewing the competence or qualifications of Health Care Providers; (iii) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits (including stop-loss insurance); (iv) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (v) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan; and (vi) business management and general administrative activities of the Plan, including compliance with the requirements of this Article, and the provision of data analyses for the Plan Sponsor. However, the Plan will not use genetic information for underwriting purposes.

HHS Regulations—those regulations regarding security and privacy of Protected Health Information, as set forth in 45 C.F.R. Subtitle A, Subchapter C, as amended from time to time, and any subsequent laws and regulations relating to such subject matter.

Individually Identifiable Health Information—Health Information that either identifies the individual or provides a reasonable basis to believe it can be used to identify the individual.

Limited Data Set—Protected Health Information that excludes the direct identifiers of the individual or of relatives, employers, or household members of the individual.

Payment—the activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care, including: (i) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; (ii) billing, claims management, collection activities, and obtaining payment under a contract for reinsurance; (iii) review of health care services with respect to Medical Necessity, coverage under the Plan, appropriateness of care, or justification of charges; (iv) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (v) disclosure to consumer reporting agencies of Protected Health Information relating to collection of premiums or reimbursement.

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Protected Health Information—Individually Identifiable Health Information other than employment records held by the Plan in its role as employer, education records covered by the Family Educational Rights and Privacy Act, as amended (20 U.S.C. 1232g), records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

Summary Health Information—information, which may be Individually Identifiable Health Information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan, but excludes the identifying information described at HHS Regulations § 164.514(b)(2)(i), except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of five digit zip code.

Treatment—the provision, coordination, or management of health care and related services by one or more Health Care Providers, including the coordination or management of health care by a Health Care Provider with a third-party; consultation between Health Care Providers relating to a patient; or the referral of a patient for health care from one Health Care Provider to another.

Unsecured Protected Health Information—Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified on the Department of Health and Human Services Website.

9.2 DISCLOSURES TO BUSINESS ASSOCIATES

The Plan may disclose Protected Health Information to a Business Associate and may allow a Business Associate to create, receive, maintain, or transmit electronic Protected Health Information on its behalf, only if the Plan obtains satisfactory assurances, in accordance with provisions of this Article that the Business Associate will appropriately safeguard the information.

There shall be a contract between the Plan and a Business Associate. Such contract must:

(a) Establish the permitted and required uses and disclosures of Protected Health Information by the Business Associate. The contract may not authorize the Business Associate to use or further disclose the information in a manner that would violate the requirements of subpart E of the HHS Regulations (45 C.F.R. §§164.500 to 164.534) if done by the Plan, except that:

(i) the contract may permit the Business Associate to use and disclose Protected Health Information for the proper management and administration of the Business Associate; and

(ii) the contract may permit the Business Associate to provide data aggregation services relating to the Health Care Operations of the Covered Entity.

(b) Provide that the Business Associate will:

(i) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

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(ii) With respect to electronic Protected Health Information: (i) comply with the applicable requirements of 45 C.F.R. §§164.302 to 164.318 (including security standards, administrative safeguards, physical safeguards, technical safeguards, organizational requirements, and policies and procedures and documentation requirements; (ii) ensure that any subcontractors that create, receive, maintain, or transmit electronic Protected Health Information on behalf of the Business Associate agree to comply with the applicable requirements of 45 C.F.R. §§164.302 to 164.318 by entering into an appropriate contract or other arrangement; and (iii) report to the Plan any security incident of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. §164.410;

(iii) Report to the Plan any use or disclosure of the information not provided for by its contract of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. §164.410;

(iv) Ensure that any subcontractors that create or receive Protected Health Information on behalf of the Business Associate agree to the same restrictions and conditions that apply to the Business Associate with respect to such information in accordance with 45 C.F.R. §164.502(e)(1)(ii);

(v) Make available Protected Health Information in accordance with 45 C.F.R. §164.524;

(vi) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(viii) To the extent the Business Associate is to carry out the Plan's obligation under subpart E of the HHS Regulations (45 C.F.R. §§164.500 to 164.534), comply with the requirements of subpart E of the HHS Regulations that apply to the Plan in the performance of such obligation;

(ix) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by, the Business Associate on behalf of the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with subpart E of the HHS Regulations (45 C.F.R.§§ 164.500 to 164.534); and

(x) At termination of the contract, if feasible, return or destroy all Protected Health Information received from, or created or received by, the Business Associate on behalf of the Plan that the Business Associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

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(c) Authorize termination of the contract by the Plan, if the Plan determines that the Business Associate has violated a material term of the contract.

(d) If the Plan knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligation under the contract or other arrangement, the Plan shall take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful, terminate the contract or arrangement, if feasible.

9.3 DISCLOSURES TO PLAN SPONSOR

Subject to the paragraph below, the Plan may disclose the following to the Plan Sponsor:

(a) Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan;

(b) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan Sponsor; and

(c) Information in accordance with an authorization described below.

The Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Administrator that the Plan documents incorporate the following provisions and that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents;
- Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available Protected Health Information in accordance with the Access, Amendment and Accounting provisions described below;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HHS Regulations;
- If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation required in the paragraph below is established.

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There shall be adequate separation between the Plan and the Plan Sponsor. Those persons under the control of the Plan Sponsor to be given access to Protected Health Information shall be set forth in the Plan's written policies or procedures. In the event no such persons are identified in such policies or procedures, such persons shall consist of the Employees of the Plan Sponsor's Human Resources Department, and any other person who receives Protected Health Information relating to Payment under, or Health Care Operation of, or other matters pertaining to the Plan in the ordinary course of business. The access to and use of Protected Health Information by such persons shall be restricted to the Plan administration functions that the Plan Sponsor performs for the Plan. The Plan Sponsor will provide an effective mechanism for resolving any noncompliance with the terms of this paragraph.

9.4 DISCLOSURES FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Except with respect to uses or disclosures that require an authorization as described below, the Plan may use or disclose Protected Health Information: (i) for the Plan's Payment or Health Care Operations; (ii) for Treatment activities of a Health Care Provider; (iii) to another Covered Entity or a Health Care Provider for the Payment activities of the entity that receives the information; or (iv) to another Covered Entity for Health Care Operations activities of the entity that receives the information if the disclosure is for health care fraud and abuse detection or compliance or for assessment or review of Health Care Providers.

9.5 DISCLOSURES REQUIRING AN AUTHORIZATION

Except as otherwise permitted or required by this Article, the Plan may not use or disclose Protected Health Information without an authorization that is valid under the disclosure provisions described herein.

The Plan must obtain an authorization for any use or disclosure of (i) psychotherapy notes (except to the extent set forth in HHS Regulation §164.508(a)(2)), or (ii) Protected Health Information for marketing (except to the extent set for in HHS Regulation §164.508(a)(3)). The Plan must obtain an authorization for any disclosure of Protected Health Information for which the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the Protected Health Information (except to the extent set forth in HHS Regulation §164.508(a)(4)).

The Plan will not use or disclose Protected Health Information for marketing and will not sell Protected Health Information without a written authorization.

A written authorization is also required for any other use or disclosure not described in this Article.

A valid authorization under this provision must contain at least the following elements: (i) a specific and meaningful description of the information to be used or disclosed; (ii) the identification of the persons authorized to make the requested use or disclosure; (iii) the identification of the persons to whom the Plan may make the requested use or disclosure; (iv) a description of each purpose of the requested use or disclosure; (v) an expiration date or an expiration event for the use or disclosure; and (vi) signature of the individual, date and, if applicable, title. An authorization for use or disclosure of Protected Health Information may not be combined with any other document to create a compound authorization (except to the extent set for in HHS Regulation §164.508(b)(3)).

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The authorization must contain statements adequate to place the individual on notice of all of the following: (i) the individual's right to revoke the authorization in writing, and the exceptions to the right to revoke; (ii) whether Treatment, Payment, enrollment or eligibility for benefits is conditioned on the individual signing the authorization; and (iii) the potential for the information disclosed to be subject to redisclosure by the recipient.

9.6 DISCLOSURES ALLOWING INDIVIDUAL TO AGREE OR OBJECT

The Plan may use or disclose Protected Health Information for the reasons listed below, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. The Plan may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this paragraph.

The Plan may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the Protected Health Information directly relevant to such person's involvement with the individual's care or Payment related to the individual's health care.

The Plan may use or disclose Protected Health Information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death.

If the individual is deceased, the Plan may disclose Protected Health Information of the individual to a family member, other relative, a close personal friend of the individual, or any other person identified by the individual who was involved in the individual's care or Payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Plan.

9.7 DISCLOSURES NOT REQUIRING AUTHORIZATION OR AGREEMENT

The Plan may use or disclose Protected Health Information without the written authorization of the individual or the opportunity for the individual to agree or object, in the following situations, subject to the applicable requirements of HHS Regulations §164.512: (i) as required by law; (ii) for public health activities; (iii) regarding victims of abuse, neglect or domestic violence; (iv) for health oversight activities; (v) for judicial and administrative proceedings; (vi) for law enforcement purposes; (vii) regarding decedents; (viii) for cadaveric organ, eye or tissue donation purposes; (ix) for research purposes; (x) to avert a serious threat to health or safety; (xi) for specialized government functions; or (xii) for Workers' Compensation.

9.8 OTHER REQUIREMENTS

When using or disclosing Protected Health Information or when requesting Protected Health Information from another Covered Entity, the Plan must make reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, except with respect to: (i) disclosures to or requests by a Health Care Provider for Treatment; (ii) uses or disclosures made to the individual to which they relate; (iii) uses or disclosures made pursuant to an authorization under the Disclosure provisions above and (iv) uses and disclosures that are required by law.

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The Plan must identify: (i) those persons in its workforce who need access to Protected Health Information to carry out their duties; and (ii) for each such person, the categories of Protected Health Information to which access is needed and any conditions appropriate to such access. The Plan must make reasonable efforts to limit access to Protected Health Information consistent with the preceding sentence.

The Plan may use or disclose a Limited Data Set only for the purposes of research, public health, or Health Care Operations. The Plan may use or disclose a Limited Data Set only if the Plan obtains satisfactory assurance, in the form of a data use agreement that meets the requirements of HHS Regulation §164.514(e)(4), that the Limited Data Set recipient will only use or disclose the Protected Health Information limited purposes. If the Plan knows of a pattern of activity or practice of the Limited Data Set recipient that constitutes a material breach or violation of the data use agreement, the Plan must take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps are unsuccessful: (i) discontinue disclosure of Protected Health Information to the recipient; and (ii) report the problem to the Secretary of Health and Human Services.

9.9 NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices can be obtained through the Medical Plan.

9.10 ACCESS OF INDIVIDUALS TO PROTECTED HEALTH INFORMATION

Except as otherwise provided in HHS Regulation §164.524, an individual has a right of access to inspect and obtain a copy of Protected Health Information about the individual. The Plan must act on a request for access no later than 30 days after receipt of the request (60 days if the Protected Health Information is not accessible to the Plan on-site). The Plan may extend the time for such actions by no more than 30 days, provided that the Plan, within the time limit set forth above, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request. If the individual requests a copy of the Protected Health Information, the Plan may impose a reasonable, cost-base fee.

If the Plan denies access, in whole or in part, to Protected Health Information, the Plan must provide a timely, written denial to the individual in plain language that explains: (i) the basis for the denial; (ii) if applicable, a statement of the individual's review rights; and (iii) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services.

If the individual has requested a review of a denial that is subject to review under HHS Regulation §164.524, the Plan must promptly refer the request to a licensed health care professional, who was not directly involved in the denial, to review the decision to deny access. The designated reviewing official must determine, with a reasonable period of time, whether or not to deny the access requested. The Plan must promptly provide written notice to the individual of the determination of the designated reviewing official.

9.11 AMENDMENT OF PROTECTED HEALTH INFORMATION

An individual may submit a written request that the Plan amend the Protected Health Information maintained by the Plan. The Plan must act on the individual's request no later than 60 days after receipt of the request. If the Plan is unable to act on the request within such 60-day period, the Plan may extend the time for such action by no more than 30 days, provided

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that the Plan, within such 60-day period, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request.

If the Plan accepts the requested amendment, in whole or in part, the Plan must timely inform the individual that the amendment is accepted and obtain the individual's identification of an agreement to have the Plan notify the relevant persons with which the amendment needs to be shared. The Plan must make reasonable efforts to inform and provide the amendment within a reasonable time to: (i) persons identified by the individual as having received Protected Health Information needing the amendment; and (ii) persons, including Business Associates, that the Plan knows have the Protected Health Information and that may have relied, or could foreseeably rely, on such information to the detriment of the individual.

If the Plan denies the requested amendment, in whole or in part, the Plan must provide the individual with a timely, written denial that explains: (i) the basis for the denial; (ii) the individual's right to submit a written statement disagreeing with the denial; (iii) a statement that, if the individual does not submit a statement of disagreement, the individual may request that the Plan provide the individual's request for amendment and the denial with any future disclosures of the Protected Health Information; and (iv) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services. The Plan may prepare a written rebuttal to the individual's statement of disagreement. Whenever such a rebuttal is prepared, the Plan must provide a copy to the individual who submitted the statement of disagreement. The Plan must, as appropriate, identify the Protected Health Information that is the subject of the disputed amendment and append or otherwise link the individual's request for an amendment, the Plan's denial of the request, the individual's statement of disagreement, if any, and the Plan's rebuttal, if any, to the information. The Plan must include such material, or an accurate summary, with any subsequent disclosure of the Protected Health Information to which the disagreement relates.

9.12 ACCOUNTING OF DISCLOSURES

An individual has a right to receive an accounting of disclosures of Protected Health Information made by the Plan in the six years prior to the date on which the accounting is requested, except for disclosures: (i) to carry out Treatment, Payment and Health Care Operations as provided above; (ii) to the individual; (iii) pursuant to an authorization described above; (iv) to persons involved in the individual's care or for other notification purposes as provided above; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (v) as part of a Limited Data Set as provided above.

The Plan must provide an individual who submits a request for an accounting with a written accounting of disclosures by the Plan or Business Associates of the Plan that includes the following for each disclosure: (i) the date of the disclosure; (ii) the name of the person who received the Protected Health Information and, if known, the address of such person; (iii) a brief description of the Protected Health Information disclosed; and (iv) a brief statement of the purpose of the disclosure.

The Plan must act on the individual's request for an accounting within the time limits described above. The Plan must provide the first accounting to an individual in any 12-month period without charge. The Plan may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12-month period, provided that the Plan informs the individual in advance of the fee and provides the individual with an opportunity

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to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

9.13 ADMINISTRATIVE REQUIREMENTS

The Plan must designate a privacy official who is responsible for the development and implementation of the policies and procedures of the Plan with respect to privacy of Protected Health Information. The Plan must also designate a contact person or office that is responsible for receiving complaints under this Article and who is able to provide further information about matters covered by the notice described above. These designations must be documented by the Plan.

The Plan must train all members of its workforce on the policies and procedures with respect to Protected Health Information required by this Article, as necessary and appropriate for the members of the workforce to carry out their function within the Plan. The Plan must document such training.

The Plan must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information.

The Plan must provide a process for individuals to make complaints concerning the Plan's policies and procedures required by this Article or its compliance with such policies and procedures or the requirements of this Article. The Plan must document all complaints received, and their disposition, it any.

The Plan must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the Plan or the requirements of this Article. The Plan must document the sanctions imposed.

The Plan must mitigate, to the extent practicable, any harmful effect that is known to the Plan of a use or disclosure of Protected Health Information in violation of its policies and procedures or the requirements of this Article by the Plan or its Business Associates.

The Plan may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for the exercise by the person of any right under this Article or the HHS Regulations.

The Plan may not require individuals to waive their rights under this Article as a condition of the provision of Treatment, Payment, enrollment in the Plan, or eligibility for benefits.

The Plan must implement and document policies and procedures with respect to Protected Health Information that are designed to comply with the requirements of this Article. The Plan must retain the documentation required by this Article for six years from the date of its creation or the date when it last was in effect, whichever is later.

The Plan shall change its policies and procedures as necessary and appropriate to comply with changes in the law, including the standards, requirements, and implementation specifications of the HHS Regulations.

9.14 SECURITY RULE COMPLIANCE

In order to comply with the requirements of the HIPAA Security Rule as issued by the HHS, the Plan Administrator shall:

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(a) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained or transmitted to or by the Plan Administrator on behalf of the Plan;

(b) Implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the Plan's electronic Protected Health Information;

(c) Ensure that adequate separation of the Plan and the Plan Sponsor is supported by reasonable and appropriate security measures;

(d) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information, agree to implement reasonable and appropriate safeguards to protect electronic Protected Health Information;

(e) Report to the Plan any security incident of which it becomes aware that may threaten the integrity and confidentiality of electronic Protected Health Information; and

(f) Make its policies and procedures and documentation relating to Security Rule safeguards available to HHS for purposes of determining the Plan's compliance therewith.

9.15 BREACH NOTIFICATION

The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Plan to have been, accessed, acquired, used, or disclosed as a result of such Breach.

A Breach shall be treated as discovered by the Plan as of the first day on which such Breach is known to the Plan, or, by exercising reasonable diligence would have been known to the Plan. The Plan shall be deemed to have knowledge of a Breach if such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is a workforce member or agent of the Plan.

Except for the notices to the Secretary of Health and Human Services, as provided in subparagraph (d), below, the Plan shall provide the notification required by this Section without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach.

(a) The notification required by this Section shall be written in plain language and shall include, to the extent possible:

- A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
- A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
- Any steps individuals should take to protect themselves from potential harm resulting from the Breach;
- A brief description of what the Plan is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and

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- Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.

(b) The notification required by this Section shall be provided in the following form:

- Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available;
- If the Plan knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of the HHS Regulations), written notification by first-class mail to either the next of kin or personal representative of the individual;
- In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under subparagraph (a), a substitute form of notice reasonably calculated to reach the individual shall be provided. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual;
- In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means;
- In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall: (i) be in the form of either a conspicuous posting for a period of 90 days on the home page of the website of the Plan, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the Breach likely reside; and (ii) include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's Unsecured Protected Health Information may be included in the Breach; or
- In any case deemed by the Plan to require urgency because of possible imminent misuse of Unsecured Protected Health Information, the Plan may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under this paragraph.

(c) For a Breach of Unsecured Protected Health Information involving more than 500 residents of a state or jurisdiction, the Plan shall, following the discovery of the Breach, notify prominent media outlets serving the state or jurisdiction. Such notification shall be made without unreasonable delay and in no case later than 60 calendar days after discovery of the Breach, and shall be written in plain language and shall include the information described above and meet the requirements set forth in subparagraph (d).

(d) The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify the Secretary of Health and Human Services:

- For Breaches of Unsecured Protected Health Information involving 500 or more individuals, the Plan shall, except as provided in the subparagraph below, provide

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the notification required by the subparagraphs above contemporaneously with the notice required by the provisions of this Section and in the manner specified on Department of Health and Human Services website; and

- For Breaches of Unsecured Protected Health Information involving less than 500 individuals, the Plan shall maintain a log or other documentation of such Breaches and, not later than 60 days after the end of each Plan Year, provide the notification required by the subparagraph for Breaches occurring during the preceding Plan Year, in the manner specified on the Department of Health and Human Services website.

(e) If a law enforcement official states to the Plan that a notification, notice, or posting required under this Section would impede a criminal investigation or cause damage to national security, the Plan shall:

- If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; and
- If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and not longer than 30 days from the date of the oral statement, unless a written statement as described above, is submitted during that time.

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ARTICLE X. GENERAL PROVISIONS

This Program plan document/summary description constitutes the entire Program.

10.1 AMENDMENT

The Program may be amended, modified, restated, or terminated at any time by the Plan Sponsor by duly adopted resolution of its governing body or written action of such governing body's duly authorized delegate.

10.2 EFFECTIVE DATE

The original Effective Date of the Program is the same as the Medical Plan.

10.3 APPLICABLE LAW

The Program shall be construed in accordance with ERISA or the Public Health Service Act, as the case may be, and the laws of the relevant State, as applicable. All provisions herein shall be administered according to, and their validity shall be determined under the relevant laws of the applicable State to the extent that such laws are not inconsistent with or preempted by Federal law.

10.4 INDEPENDENT MEDICAL EXAMINATION

The Program, at its own expense, shall have the right and opportunity to require the examination of the Participant whose condition is the basis of a claim when and as often as may be reasonably required during the pendency of a claim.

10.5 RECOVERY

Whenever payments have been made by the Pharmacy Benefit Manager, at any time, for a Covered Prescription in a total amount in excess of the maximum amount of payment necessary, the Pharmacy Benefit Manager shall have the right to recover these payments, to the extent of the excess, from the individual to whom, or from whom, or with respect to whom, these payments have been made.

10.6 CHANGES TO THIS PROGRAM DOCUMENT

The Program constitutes the entire agreement between the Plan Sponsor and Program Participant with respect to prescription drug benefits, and any statement made by the Plan Sponsor or by a Program Participant shall, in absence of fraud, be considered a representation and not a warranty. No change in the Program or waiver of any of its provisions shall be valid unless approved in writing by the Plan Sponsor.

10.7 INDEMNIFICATION

Except as provided under ERISA, if applicable and relevant State law, no board member, officer or Employee of the Plan Sponsor shall incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Program and shall be indemnified and held harmless by the Plan Sponsor from and against any such personal liability, including all expenses reasonably incurred in their defense if the Plan Sponsor fails to provide such defense.

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The Plan Sponsor may purchase insurance to cover the potential liability of board members, officers and Employees serving in a fiduciary capacity with respect to the Program and, at its expense, may insure itself against loss by misdeeds or omissions of Program fiduciaries. The Plan Sponsor may also purchase insurance to cover the exposure of its directors, officers and Employees by reason of such right or recourse.

10.8 PROGRAM TERMINATION

The Plan Sponsor may terminate the Program at any time. Upon termination, the rights of Program Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Program will be communicated to all Employees.

10.9 BENEFITS NOT SUBJECT TO ALIENATION

No benefit payment under the Program shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due, or to become due, to any Program Participant, the Plan Administrator may, in its sole discretion, terminate the interest of such Program Participant or former Program Participant in such payment to or for the benefit of such individual, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

Notwithstanding the above, Program benefits may be assigned to providers of pharmacy benefits under this Program.

10.10 NOT AN EMPLOYMENT CONTRACT

Nothing contained in the Program shall be construed as a contract of employment between the Employer and any Employee, or as conferring any right upon any Employee to be continued in employment with the Employer or as a limitation on the right of the Employer to discharge any Employee.

10.11 WORKERS' COMPENSATION

The Program is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

10.12 PROGRAM CONTRIBUTIONS

The Program is financed by contributions from the Employer and its Program Participants. Contributions collected by the Employer shall be deposited with the Program. The amount of the contributions by the Program Participants shall be determined by the Plan Administrator, based on a periodic review of Program costs.

Such contributions shall be used only in accordance with the Program and no part of the principal or income, if any, shall be diverted to purposes other than for the exclusive purpose of providing benefits to eligible Program Participants and defraying reasonable expenses of administering the Program in accordance with the provisions of the Program documents.

10.13 ASSIGNMENT

No benefit payment under the Program shall be subject in any way to alienation, sale, transfer, pledge, assignment, attachment, garnishment, execution or encumbrance of any kind, and any

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attempt to accomplish the same shall be void and shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against the Program or Plan Sponsor for the payment of any claims. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due, or to become due, to any Program Participant, the Plan Administrator may, in its sole discretion, terminate the interest of such Program Participant or former Program Participant in such payment, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

Nothing contained in the Program shall be construed to make the Program or the Plan Sponsor liable to any third party to whom a Program Participant may be liable for medical care, prescription drugs, medications, treatment, or services.

10.14 BOOKS AND RECORDS

The Plan Sponsor shall maintain records which show at all times the names of all Program Participants, if any, the date each Program Participant became covered under the Program, and all such other information as may be required to administer the Program.

10.15 LEGAL ACTION

Until the Plan Administrator has issued its final decision on a claim, no legal action can be brought to recover under the Program. No such action may be brought at all unless it is brought within two years from the deadline for filing a claim.

Notwithstanding the above, a claimant must comply with the procedures and time limits set forth in Article VI in order to make a claim with respect to the Program.

10.16 CONFORMITY WITH GOVERNING LAW

If any provision of the Program is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

10.17 SEVERABILITY

In the event that any section of this Program is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Program. The sections and sub-sections of the Program document/summary description shall be fully severable. The Program shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Program

10.18 PAYMENT OF FEES

Expenses required or permitted by law and otherwise to be paid by the Program, and all other fees required by the Affordable Care Act, are payable by the Program from Program assets.

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ARTICLE XI. SUMMARY INFORMATION

PROGRAM INFORMATION SUMMARY

Program Name:	KPPC Pharmacy Benefit Program
Plan Year:	Calendar Year
Pharmacy Benefit Manager:	Express Scripts, Inc.
Customer Service Telephone:	See number on Identification Card
Prior Authorization Telephone:	(800) 753-2851
Website:	www.Express-Scripts.com
Name of Plan Sponsor and Contact Information:	Lakeside Industries, Inc. 6505 – 226th Place SE, Suite 200 Issaquah, WA 98027
Plan Administrator:	The Plan Sponsor is also the Plan Administrator
For language assistance:	Contact the Plan Administrator during normal business hours or Express Scripts at any time.

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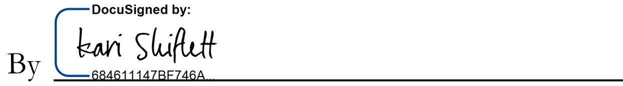
SIGNATURE PAGE

BY THIS AGREEMENT,

IN WITNESS WHEREOF, this instrument is executed for the Plan Sponsor on or as of the day and year first below written.

PLAN SPONSOR

By 

Dated 8/19/2020

Its HR Director

Witness ____________________ Dated ____________________

LAKESIDE KPPC SPD_C2-20200811

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APPENDIX A

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following List of States is current as of January 31, 2020. Contact your State for more information on eligibility –

- **ALABAMA - MEDICAID**
Website: http://myalhipp.com
Phone: 1-855-692-5447

- **ALASKA - MEDICAID**
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

- **ARKANSAS - MEDICAID**
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

- **CALIFORNIA - MEDICAID**
Website:
www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

- **COLORADO - HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)**
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

- **FLORIDA - MEDICAID**
Website: http://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

- **GEORGIA - MEDICAID**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, ext. 2131

- **INDIANA - MEDICAID**
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov./fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

- **IOWA – MEDICAID AND CHIP (HAWKI)**
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

- **KANSAS - MEDICAID**
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

- **KENTUCKY - MEDICAID**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

- **LOUISIANA - MEDICAID**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

- **MAINE - MEDICAID**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

- **MASSACHUSETTS - MEDICAID AND CHIP**
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

- **MINNESOTA - MEDICAID**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under Eligibility tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

- **MISSOURI - MEDICAID**
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

- **MONTANA - MEDICAID**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

- **NEBRASKA - MEDICAID**
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

- **NEVADA - MEDICAID**
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

- **NEW HAMPSHIRE - MEDICAID**
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free for the HIPP program: 1-800-852-3345, ext. 5218

- **NEW JERSEY - MEDICAID AND CHIP**
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

- **NEW YORK - MEDICAID**
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

- **NORTH CAROLINA - MEDICAID**
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

- **NORTH DAKOTA - MEDICAID**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

- **OKLAHOMA - MEDICAID AND CHIP**
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

- **OREGON - MEDICAID**
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

- **PENNSYLVANIA - MEDICAID**
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

- **RHODE ISLAND – MEDICAID AND CHIP**
Website: http://www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

- **SOUTH CAROLINA - MEDICAID**
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

- **SOUTH DAKOTA - MEDICAID**
Website: http://dss.sd.gov
Phone: 1-888-828-0059

- **TEXAS - MEDICAID**
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

- **UTAH - MEDICAID AND CHIP**
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

- **VERMONT - MEDICAID**
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

- **VIRGINIA - MEDICAID AND CHIP**
Medicaid Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

- **WASHINGTON - MEDICAID**
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

- **WEST VIRGINIA - MEDICAID**
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

- **WISCONSIN - MEDICAID AND CHIP**
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

- **WYOMING - MEDICAID**
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

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APPENDIX B

PREVENTIVE CARE SERVICES

Preventive Care Services are based on recommendations of the U.S. Preventive Task Force, Centers for Disease Control and Prevention and the Health Resources and Services Administration. The extent and timing of such services are based on guidance from these organizations. The frequency, type of Prescription Drug (Brand Name or Generic Prescription Drug) and availability is based on reasonable medical management techniques. More information on Preventive Care Services for adults, women including pregnant women and children can be found at https://www.healthcare.gov/what-are-my-preventive-care-benefits/. The specific recommendations of the U.S. Preventive Services Task Force can be found at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

Preventive Prescription Drugs are available without cost sharing only if purchased from a Participating Pharmacy or the Home Delivery Pharmacy, in either case a prescription order must be used.

TOPIC	DESCRIPTION
Anemia	Iron supplements for children ages 6 to 12 months at risk for anemia.
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years
Breast cancer preventive medication	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
Contraceptive methods and counseling	All Food and Drug Administration approved Prescription Drugs.
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.

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TOPIC	DESCRIPTION
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Tobacco use counseling and interventions: nonpregnant adults	U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.

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APPENDIX C

ERISA

It is the intention of the Plan Sponsor to establish a program of benefits constituting an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974 and any amendments thereto.

1. STATEMENT OF RIGHTS

Program Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Program Participant shall be entitled to:

Receive Information About Their Program and Benefits. This includes the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Program, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Program, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and receive a summary of a Program's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

- The right to continue health care coverage for self, spouse or dependents if there is a loss of coverage under a Plan as a result of a qualifying event. The Employee or their dependents may have to pay for such coverage. See the COBRA Continuation Coverage section for additional details about these rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program Participants, ERISA imposes duties upon the people who are responsible for the operation of the Program (the fiduciaries). Fiduciaries have a duty to operate the Program prudently and in the interest of Program Participants and beneficiaries. No one, including the Employer, may fire a Program Participant or discriminate against them to prevent their obtaining a welfare benefit or exercising rights under ERISA.

Enforce Their Rights

If an individual's claim for a welfare benefit is denied in whole or in part, they must receive a written explanation of the reason for the denial. They have the right to have the Plan Administrator review and reconsider their claim.

Under ERISA there are steps a Program Participant can take to enforce the above rights. For instance, if they request materials from the Program and do not receive them within 30 days,

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they may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay them up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If they have a claim for benefits which is denied or ignored, in whole or in part, they may file suit in a State or Federal court. In addition, if they disagree with the Program's decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), they may file suit in Federal court.

If it should happen that Program fiduciaries misuse the Program's money, or if they are discriminated against for asserting their rights, they 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. If they are successful, the court may order the person sued to pay these costs and fees. If they lose, the court may order them to pay these costs and fees, for example, if it finds their claim is frivolous.

Assistance with Their Questions

If a Program Participant has any questions about a Plan, they should contact the Plan Administrator. If they have any questions about this statement or about their rights under ERISA, they should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in their telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Program Participant may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. TYPE OF ADMINISTRATION

The Program is a self-funded Pharmacy Benefit Program and the administration is provided through a prescription benefit manager. The Program is not insured.

3. FUNDING

The Plan Sponsor shares the cost of Employee and Dependent coverage under this Program with the covered Employees. The level of any Employee contribution is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contribution.

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4. PLAN INFORMATION SUMMARY

Summary Plan Description

The Program is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor.

Name of Plan Administrator/Sponsor:	Lakeside Industries, Inc.
Federal Employer ID Number	91-0751657
Street Address of Plan Sponsor:	6505 – 226th Place SE, Suite 200 Issaquah, WA 98027
Telephone:	(425) 313-2625
Plan Name:	KPPC Pharmacy Benefit Program
Plan Year:	Calendar Year
Plan Number:	501
Type of Administration/ Pharmacy Benefit Manager:	Express Scripts, Inc. Customer Service: (844) 823-5227
Agent for Service of Legal Process:	President Lakeside Industries of Washington 6505 – 226th PL SE, Ste 200 Issaquah, WA 98027 (206) 313-2604
Type of Plan:	An employee welfare benefit plan that is a group health plan.