# SANDUSKY CITY SCHOOL DISTRICT
# HEALTH BENEFIT PLAN

# PRESCRIPTION DRUG SUMMARY

March 1, 2021

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# INTRODUCTION

This Summary contains general information about the prescription drug benefits available to you as a Covered Person in the Health Benefit Plan of the Sandusky City School District (the "Plan"). The prescription drug benefits described in this Summary are administered by OptumRx and are separate from any prescription drug benefits that are available under your medical plan administered by Medical Mutual.

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

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

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

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 This Summary may be modified by riders and amendments or superseded and replaced by a new summary.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

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

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

## SCHEDULE OF BENEFITS

Benefit Period: Calendar Year
Dependent Age Limit: The end of the month of the 26th birthday

The below Schedule of Benefits corresponds to the prescription drug benefit package available through the Sandusky City School District (the "District") and shows your financial responsibility for prescription drug benefits under the Plan. After you have paid the amounts indicated in the Schedule of Benefits, the Plan covers the remaining liability for the covered charge, subject to benefit maximums. The covered charge is the maximum amount that can be considered for prescription drug benefit payment by the Plan. Out-of-pocket maximum(s) and deductibles that may apply will renew each benefit period. Utilization management programs are subject to change from time to time.

| **Cost Sharing**<br>**For Covered Services, you pay the following portion, based on the Allowed Amount** | | | |
|---|---|---|---|
| | **Retail (up to a 30 days supply)** | **Retail (Rx filled a 3rd time within a 180-day period)** | **Home Delivery (90 days supply)** |
| **Generic** | $15.00 | $30.00 | $30.00 |
| **Formulary** | $50.00 | $50.00 | $50.00 |
| **Non-Formulary** | $100.00 | $100.00 | $100.00 |
| **Utilization Management** | | | |
| **Step Therapy** | Yes | | |
| **Prior Authorization** | Yes | | |
| **Drug Quantity Management** | Yes | | |
| **Exclusive Specialty** | Yes | | |
| **Dispense as Written** | Yes | | |
| **Home Delivery/Retail Program** | CVS90 Saver | | |

For Prescription Drugs received from non-Network Pharmacies, you pay the entire amount at the Pharmacy and file a claim form with OptumRx. OptumRx will reimburse you for 75% of the Allowed Amount, minus the Prescription Drug Copayment, as indicated. You may be responsible for any amount in excess of the Prescription Drug Covered Charges. If the Prescription Drug is not available from a Network Pharmacy, you will not be subject to this reduced reimbursement.

Coverage is provided for Contracting Home Delivery Pharmacies only. Services received from any Non-Contracting Home Delivery Pharmacy are excluded.

## ELIGIBILITY

### Enrolling for Coverage

Eligible Employees and other eligible individuals may enroll for individual prescription drug coverage or they may enroll themselves and their Eligible Dependents in family prescription drug coverage, as permitted by the Plan. Under individual coverage, only the Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered. Coverage

will not begin until your enrollment has been approved by the Plan and you have been given an effective date.

**Covered Person**

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

**Card Holder**

A Card Holder is an Eligible Employee or other eligible individual who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or other legally mandated continuation of coverage.

**Eligible Employees**

An Eligible Employee is:

An employee of the District who meets the eligibility requirements of the District including working the required number of hours that the District requires for eligibility. Any applicable waiting period must be satisfied, but will not exceed 90 days.

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

**Eligible Dependents**

An Eligible Dependent is:

- the Card Holder's spouse, provided you are not legally separated;
- the Card Holder's or spouse's:
    - natural children;
    - children placed for adoption and legally adopted children;
    - children for whom either the Card Holder or Card Holder's spouse is the legal guardian or custodian; or
    - any children who, by court order, must be provided health care coverage by the Card Holder or Card Holder's spouse.
- the Card Holder's stepchildren, provided the natural parent remains married to the Card Holder and resides in the household.

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

**Child Support Order**

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. The Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Plan will promptly notify affected Card Holders if a medical child support order is received. The Plan will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Plan will determine whether the order is acceptable and notify each affected Card Holder of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

**Effective Date**

Coverage starts at 12:01 a.m. on your effective date. Your effective date is determined by the Plan. No benefits will be provided for services, supplies or charges incurred before your effective date. The District will have rules regarding when your coverage becomes effective, including any applicable waiting periods. The District will notify you of the date your group coverage will become effective at the time you enroll for coverage.

## CHANGES IN COVERAGE

**HIPAA Special Enrollment Rights**

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

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

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

## TERMINATION OF COVERAGE

### How and When Your Coverage Stops

Your coverage as described in this Summary stops:

- When the Card Holder fails to make the required contributions.
- On the date a Covered Person enrolled as a spouse under the Plan stops being an Eligible Dependent.
- At the end of the month during which a Covered Person enrolled as a child under the Plan stops being an Eligible Dependent.
- At the end of the month during which the Card Holder becomes ineligible.
- On the day a final decree of legal separation, divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.
- Immediately upon notice if:
    - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
    - a Covered Person intentionally misrepresents a material fact provided to the District or OptumRx or commits fraud or forgery. If your coverage is rescinded, you will be given 30 days' advance written notice, during which time you may request a review of the decision.

## RESCISSION OF COVERAGE

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

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

## CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

### Introduction

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

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

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

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

**When is COBRA continuation coverage available?**

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

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

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

**How is COBRA continuation coverage provided?**

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

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

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

***Disability extension of 18-month period of COBRA continuation coverage***

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the

second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

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

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act (ACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

**Keep your Plan informed of address changes**

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

**Plan Contact Information**

If you have any questions, please contact the benefits office of the District.

## HOW YOUR PRESCRIPTION DRUG PLAN WORKS

**Your ID Card**

When you first enroll in the prescription drug coverage, you will receive prescription drug identification cards from OptumRx. If you elect more than coverage for yourself, you will receive two cards in your name. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling OptumRx at 1-855-896-9779. In an emergency, you are able to print a temporary identification card from OptumRx's website, www.optumrx.com. It is important to remember to use your prescription drug plan ID card at the pharmacy rather than your medical plan insurance card.

**When You Need to Fill a Prescription**

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

If the patient or the doctor requests a brand-name medication when a generic equivalent is available, you will be responsible for your generic drug copayment plus the difference in price between the brand-name medication and its generic equivalent. This will apply even if the doctor writes "dispense as written" (DAW) on the prescription. If you order a brand-name medication that has a generic equivalent, the difference in cost between the brand-name medication and the generic medication will not apply towards the deductible or out-of-pocket maximum.

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

**Website and Mobile App**

The OptumRx website (www.optumrx.com) provides a personalized online experience when you log in. The home page displays a wide range of resources, including easy-order medicine refills and renewals, order status with drug name, shipping details and prescription and prior authorization expiration dates,

and provides the member with the opportunity to transfer eligible prescriptions to home delivery. Many self-service features let members immediately take care of multiple tasks, such as paying a bill, verifying their shipping address, updating payment information, submitting a retail claim for reimbursement and managing preferences.

The OptumRx mobile application (app) will help you make better decisions for healthier outcomes – anytime, anywhere. Features include: quick access to popular actions, home delivery refills, bill pay, dose reminders, alerts, drug interactions, find a pharmacy, and a number of other functions. To download the OptumRx mobile app, members should search for "OptumRx" in their mobile device's app store and download it for free.

**Retail Pharmacies**

OptumRx has contracted with thousands of retail pharmacies, including most major drug stores. These retail pharmacies in the OptumRx Broad Network are referred to as "participating pharmacies." To locate a participating pharmacy close to your home or other location, you can call OptumRx at 1-855-896-9779 or check OptumRx's website at www.optumrx.com.

A number of vaccines (e.g., flu vaccine) are covered within the OptumRx's retail Pharmacy Vaccination Program. There are a few ways to locate a participating pharmacy including going to www.optumrx.com and clicking "Locate a Pharmacy" to search for in-network pharmacies convenient for you, calling the number on your OptumRx member ID card to find a participating pharmacy near you, or contacting your network pharmacy in advance to inquire about vaccine availability and current vaccination schedules. Also, present your member ID card to the pharmacist at the time of service.

**OptumRx Pharmacy for Home Delivery**

OptumRx offers the OptumRx Home Delivery Pharmacy to fill your long-term non-specialty prescriptions (also known as maintenance medications) through home delivery. You will also have the convenience of having your medications delivered right to you. Please call 1-855-896-9779 or visit www.optumrx.com for more information.

**CVS90 Saver**

Under this program, members are required to fill their maintenance medications at either OptumRx Home Delivery Pharmacy or CVS; otherwise, the members incur a copay penalty of 2x the appropriate retail copayment. Members have 3 grace fills, so starting with the 4$^{th}$ fill members must fill their maintenance drugs at OptumRx Home Delivery Pharmacy or CVS to avoid the copay penalty.

**Covered Medications**

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

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

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

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

**Preventive Drugs Covered at 100%**

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

**The Formulary and Changes to It**

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

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

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

- A drug may be moved to a higher or lower cost-sharing formulary tier.
- Additional drugs may be excluded from the formulary.

- A restriction may be added on coverage for a formulary-covered drug (e.g., prior authorization).
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug.

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

**OptumRx Specialty Pharmacy Services**

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

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

**Limitations**

If you are uncertain whether the drug that your physician has prescribed is covered by the Plan, please call OptumRx at 1-855-896-9779 to confirm. If you want to know if a specific drug is covered under the Plan, go to "Prescriptions" and then select the "Price a Medication" application on the OptumRx website, www.optumrx.com. That application will indicate whether a drug is covered, what it will cost and if any limitations or exclusions apply. For more information about limitations and exclusions, visit www.optumrx.com.

**Supply Limits**

Some prescription drugs are subject to supply limits based on OptumRx's criteria. Supply limits, which are subject to periodic review and modification by OptumRx, may restrict the amount dispensed per prescription order or refill and/or the amount dispensed for each month's supply. Limits are based on manufacturer suggested prescribing guidelines and may change from time to time. This does not affect the day supply limits which are part of the plan design and would only change if the plan design is changed. You may obtain information on maximum dispensing limits by either visiting www.optumrx.com or by contacting OptumRx at 1-855-896-9779.

**Quantity Management**

To help promote safe and effective drug therapy consistent with plan limits, certain covered medications may have quantity restrictions. These quantity restrictions are based on product labeling or clinical guidelines and are subject to periodic review and change. Examples include drugs used for hormone

supplementation, multiple sclerosis and oncology drugs. Visit www.optumrx.com for details on drugs with quantity restrictions or call OptumRx Member Services at 1-855-896-9779. Extended days' supply, for special instances like out of the country vacations, can only be approved by, and at the discretion of, the Plan.

**Prior Authorization**

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

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

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

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

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

**Step Therapy Requirements**

Step therapy is a program designed to help you save money by using the most cost effective treatments if you have certain conditions that require maintenance medications. It requires that you try a first line alternative, often a generic medication, to treat your condition. Then, based on your physician's review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization as described in the "Prior Authorization" section fall into this step therapy program. Please contact OptumRx Member Services at 1-855-896-9779 or visit www.optumrx.com for more specific information on the program.

**Drug Coverage Provided by Your Medical Plan**

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

## COORDINATION OF BENEFITS

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

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

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

For all mail order claims and retail claims (except as noted below), a COB claim must be submitted by you after the primary plan has processed the charges and delivered to you an explanation of benefits or receipt. You must utilize the Prescription Reimbursement Request Form found on the OptumRx website or available by contacting OptumRx customer service. The Prescription Reimbursement Request Form must be submitted along with the primary plan's receipt/documentation as noted on the Form. The COB reimbursement formula used by the Plan is: discounted network price (i.e., what the claim would have cost if processed as primary under the Plan) minus the copayment. Major/big box retail store pharmacies may be willing to process COB claims at the retail store if you provide them with your primary and secondary coverage information.

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

## OPTUMRX REVIEWS AND APPEALS OVERVIEW

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

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

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

**How to Request an Initial Coverage Review**

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing pharmacist may call the OptumRx Prior Authorization Department at 1-800-711-4555 or the prescriber may submit a completed coverage review form by faxing it to the number provided on the form. Forms may be obtained online at www.optumrx.com. Home delivery coverage review requests are automatically initiated by the OptumRx Home Delivery Pharmacy as part of filling the prescription.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one where, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-800-711-4555.

**Denial Process**

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

**How to Request Appeals After Coverage Review Has Been Denied**

**Mandatory Level 1 Appeal**

Upon receipt of an Adverse Benefit Determination notice, a Covered Person or Authorized Representative can request a level 1 appeal with OptumRx within 180 days from receipt of an Adverse Benefit Determination notice. You must complete this mandatory internal appeal before any additional action is taken, except under certain circumstances as described below. To initiate an appeal, a Covered Person or Authorized Representative should call OptumRx Member Services at 1-855-896-9779 or submit an appeal by mail to: OptumRx Appeals, 3515 Harbor Blvd., Mailstop 106-0286, Costa Mesa CA 92626. If an appeal is initiated by mail, the following information must be submitted:

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

Alternatively, the prescriber or dispensing pharmacist may call the OptumRx Prior Authorization Department at 1-800-711-4555 to initiate an appeal on behalf of a Covered Person.

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

If your claim is denied at the mandatory level 1 appeal, you may be eligible for either the external review process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the external review process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment. Prior to requesting an external review (but not after requesting an external review), you may request an additional voluntary internal review process. Alternatively, you may request an external review directly after receiving an Adverse Benefit Determination at the mandatory level 1 appeal. The external review process and the voluntary internal review process are described below.

**External Review Process**

**Contact Information for Filing an External Review**

To initiate an external review, a Covered Person or Authorized Representative should call OptumRx Member Services at 1-855-896-9779 or submit a request by mail to: OptumRx Appeals, 3515 Harbor Blvd., Mailstop 106-0286, Costa Mesa CA 92626. If an external review is initiated by mail, the following information must be submitted:

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

Alternatively, the prescriber or dispensing pharmacist may call the OptumRx Prior Authorization Department at 1-800-711-4555 to initiate an external review on behalf of a Covered Person.

**Understanding the External Review Process**

Under Chapter 3922 of the Ohio Revised Code, all Health Plan Issuers must provide a process that allows a person covered under a Health Benefit Plan or a person applying for Health Benefit Plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by OptumRx to deny a requested medication or payment because such medication is not covered, excluded, or limited under the Plan, or the Covered Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny Plan coverage or to rescind coverage.

**Opportunity for External Review**

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of medications denied in order to qualify for an external review. However, a Covered Person must generally exhaust the mandatory level 1 appeal process before seeking an external review. Exceptions to this requirement will be included in the Adverse Benefit Determination notice.

**External Review by an IRO**

A Covered Person is entitled to an external review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information
- The Adverse Benefit Determination indicates the requested medication is experimental or investigational, the requested medication is not explicitly excluded in the Plan, and the treating physician certifies at least one of the following:
    - Standard medications have not been effective in improving the condition of the Covered Person
    - Standard medications are not medically appropriate for the Covered Person
    - No available standard medication covered by OptumRx is more beneficial than the requested medication.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- A Covered Person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if the medication is delayed until after the time frame of an expedited internal appeal, and the Covered Person has filed a request for an expedited internal appeal.
- A Covered Person's treating physician certifies that the final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if the medication is delayed until after the time frame of a standard external review.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of experimental or investigational medication and the Covered Person's treating physician certifies in writing that the recommended medication would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final Adverse Benefit Determinations (meaning the medication has already been provided to the Covered Person).

**External Review by the Ohio Department of Insurance**

A Covered Person is entitled to an external review by the Ohio Department of Insurance in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The Adverse Benefit Determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND OptumRx's decision has already been upheld through an external review by an IRO.

**Request for External Review**

Regardless of whether the external review case is to be reviewed by an IRO or the Ohio Department of Insurance, a Covered Person or Authorized Representative must request an external review through OptumRx within 180 days from receipt of the Adverse Benefit Determination notice after the mandatory level 1 appeal, if you do not request a voluntary internal review. If you do request a voluntary internal review, the request for external review must be made within 180 days from your receipt of the Adverse Benefit Determination notice after the voluntary internal review.

All requests must be in writing, including by electronic means, except for a request for an expedited external review. Expedited external reviews may be requested orally. A Covered Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete and the Adverse Benefit Determination is eligible for external review, OptumRx will initiate the external review and notify the Covered Person in writing, or immediately in the case of an expedited review, that the request is complete and the Adverse Benefit Determination is eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. OptumRx will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, OptumRx will inform the Covered Person in writing and specify what information is needed to make the request complete. If OptumRx determines that the Adverse Benefit Determination is not eligible for external review, OptumRx must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by OptumRx and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

**IRO Assignment**

When OptumRx initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review. An IRO that has a conflict of interest with OptumRx or the Covered Person, or other conflict, will not be selected to conduct the review.

**Reconsideration by OptumRx**

If you submit information to the IRO or the Ohio Department of Insurance to consider, the IRO or Ohio Department of Insurance will forward a copy of the information to OptumRx. Upon receipt of the information, OptumRx may reconsider its Adverse Benefit Determination and provide coverage for the medication in question. Reconsideration by OptumRx will not delay or terminate an external review. If

OptumRx reverses an Adverse Benefit Determination, OptumRx will notify you in writing and the IRO will terminate the external review.

**IRO Review and Decision**

The IRO must consider all documents and information considered by OptumRx in making the Adverse Benefit Determination, any information submitted by a Covered Person and other information such as the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by OptumRx of a request for a standard review or within 72 hours of receipt by OptumRx of a request for an expedited review. This notice will be sent to the Covered Person, OptumRx and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the IRO was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the IRO's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involve a medication that is stated to be experimental or investigational also include the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

**Binding Nature of External Review Decision**

An external review decision is binding on OptumRx except to the extent OptumRx has other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to OptumRx.

**If You Have Questions About Your Rights or Need Assistance**

You may contact OptumRx at the Customer Service telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800-686-1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

**Voluntary Internal Review Process**

If your mandatory level 1 appeal is denied and your claim does not qualify for an external review, you have the option of a voluntary internal review by OptumRx.

**Contact Information for Filing a Voluntary Internal Review**

To initiate a voluntary internal review, a Covered Person or Authorized Representative should call OptumRx Member Services at 1-855-896-9779 or submit a request by mail to: OptumRx Appeals, 3515 Harbor Blvd., Mailstop 106-0286, Costa Mesa CA 92626. If a voluntary internal review is initiated by mail, the following information must be submitted:

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

Alternatively, the prescriber or dispensing pharmacist may call the OptumRx Prior Authorization Department at 1-800-711-4555 to initiate a voluntary internal review on behalf of a Covered Person.

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

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

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

**Alternative Options**

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

## SUBROGATION AND RIGHT OF RECOVERY

These subrogation and right of recovery provisions shall apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that the Plan may have to recover medical and/or prescription drug expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to any payment you receive, or have a right to receive, including, but not limited to, any payment or right to payment from any and all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical and/or prescription drug claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

**Subrogation**

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

**Reimbursement**

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any recovery you receive for your injury, illness or condition.

**Constructive Trust**

By accepting benefits from the Plan (whether the payment of such benefits is made to you or made on your behalf to any provider), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

**Lien Rights**

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery by you whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

**Assignment**

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

**First-Priority Claim**

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

**Applicability to All Settlements and Judgments**

All terms of these subrogation and reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical and/or prescription drug benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical and/or prescription drug expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

**Cooperation**

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due

to your injury, illness or condition. You must not settle or compromise any claim unless the Plan or its representative is notified in writing at least 30 days prior to such settlement or compromise and the Plan or its representative agrees to such settlement or compromise in writing. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall promptly provide all information requested by the Plan, its representative, or the Claims Administrator, including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation, including, but not limited to, any police report, notices, or other papers received in connection with the injury, illness or condition. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or reimbursement interest or prejudice the Plan's ability to enforce these subrogation and reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

**Future Benefits**

If you fail to cooperate with and reimburse the Plan, the Plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

**Interpretation**

In the event that any claim is made that any part of these subrogation and reimbursement provisions is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan and/or its representative shall have the sole authority and discretion to resolve all disputes regarding the interpretation of these provisions.

**Jurisdiction**

By accepting benefits from the Plan, you agree that any court proceeding with respect to these subrogation and reimbursement provisions may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees incurred by the Plan in successfully enforcing in any court proceeding the Plan's subrogation and/or reimbursement rights against you.

**Discretionary Authority**

The Plan shall have discretionary authority to interpret and construe the terms and conditions of these subrogation and reimbursement provisions and make any determination or construction which is not arbitrary and capricious. The Plan's determination will be final and conclusive.