Lexington Fayette Urban County Government (LFUCG)

Prescription Drug Plan
SUMMARY PLAN DESCRIPTION (SPD)

Effective January 1, 2016

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INTRODUCTION

This document is a description of the LFUCG Employee Prescription Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic prescription expenses. The Prescription Plan Manager is Baptist Health Plan (BHP) who is responsible for performing certain delegated administrative duties, including the processing of prescription claims. BHP utilizes the Express Scripts (ESI) network of pharmacies and drug formulary (see the ESI Basic Formulary and the LFUCG Formulary Addendum which are updated quarterly and obtained in the Human Resources Department).

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

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

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

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

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

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

PLAN DELIVERY SYSTEM RULES

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered prescription expenses incurred by you and your covered dependents. Benefits for prescription drug expenses are payable as shown on the LFUCG Formulary Addendum.

You are responsible for payment of:

1. The prescription drug deductible, if any;
2. The coinsurance and/or copayment;
3. The cost of medication not covered under the prescription drug benefit;
4. The cost of any quantity of medication dispensed in excess of the day supply noted in the LFUCG Formulary Addendum.

If the dispensing pharmacy's charge is less than the copayment, you will be responsible for the lesser amount. The amount paid by the Prescription Plan Manager to the dispensing pharmacy may not reflect the ultimate cost to the Prescription Plan Manager for the drug. Your copayment is made on a per prescription or refill basis and will not be adjusted if the Prescription Plan Manager or your employer receives any retrospective volume discounts or prescription drug rebates.

PRESCRIPTION DRUG COVERAGE

The LFUCG Formulary Addendum is provided to you from your employer. You may also call the toll free customer service phone number on the back of your ID card to verify whether a prescription drug is covered or not covered under the Plan.

Covered prescription drugs, medicine or medications must:

1. Be prescribed by a provider for the treatment of a sickness or bodily injury; and
2. Be dispensed by a pharmacist.

Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan. For non-qualified HSA plans, any expenses incurred under provisions of the Prescription Drug Benefit section do not apply toward your medical deductible or out-of-pocket limits. Any expenses incurred under the medical benefit do not apply toward your prescription drug out-of-pocket limits.

The Prescription Plan Manager may decline coverage of a specific medication or, if applicable, LFUCG Formulary Addendum inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

Any medications prescribed for the treatment of diagnoses excluded from coverage are not covered at any cost-sharing tier. The LFUCG Formulary Addendum does not provide information regarding the specific coverage and limitations an individual participant may have. The LFUCG Formulary Addendum applies only to outpatient medications provided to participants and does not apply to medications used in inpatient settings. If you have any specific questions regarding your coverage, you should contact the Prescription Plan Manager.

IN-NETWORK PHARMACY

You must use a Participating Pharmacy to access your prescription drug benefits. Utilization of out-of-network pharmacies which have not entered into agreement with the Plan, such as Walgreens, are not eligible for reimbursement.

For a complete list of Participating Pharmacies, visit https://www.Express Scripts.com/index.html. You may also access the website through www.BaptistHealthPlan.com and clicking on the link to Express Scripts; or access Express Scripts by logging into your account on the Secure Portal on BHP's site, https://bhp.alderaplatform.com/LogonMembers.jsp?skin=.

If you do not have internet access or would like to speak to a Customer Service representative, you may also contact Baptist Health Plan's Pharmacy Customer Service Department number listed on the back of your Prescription ID card. When a participating pharmacy is used and you do not present your I.D. card at the time of purchase, you must pay the pharmacy the full retail price and submit a completed Prescription Claim Form with the pharmacy receipt to Express Scripts.

The Prescription Claim Form may be accessed on BHP's website, https://www.BaptistHealthPlan.com/pharmacy-services/ and is located under "Additional Pharmacy Forms and Resources."

PRESCRIPTION REIMBURSEMENT OF ELIGIBLE OUT-OF-POCKET EXPENSES

If you pay out-of-pocket for a prescription at a participating pharmacy, you may return to the pharmacy within sixty (60) days, have the claim reprocessed electronically and be reimbursed for the eligible out-of-pocket expense. If you are reimbursed by the Plan for an eligible out-of-pocket prescription expense, you will be paid based on the Plan's contracted pharmacy rates, minus your applicable prescription cost share. Requests for out-of-pocket prescription reimbursement received more than six (6) months after the prescription was filled will not be eligible for reimbursement.

OUT-OF-NETWORK PHARMACY

You must use a Participating Pharmacy to access your prescription drug benefits. Utilization of Out-of-Network pharmacies which have not entered into agreement with the Plan, such as Walgreens, are not eligible for reimbursement. For a complete list of Participating Pharmacies, refer to the instructions found above in the "In-Network Pharmacy section.

PRIOR AUTHORIZATION REQUIREMENT

Due to the nature of some medications, Prior Authorization (PA) may be required before the Plan will cover the medication's cost. PAs are based on established clinical guidelines and the patient's medical history and only Practitioners or Providers may request medication PA. Prescription Drug claims exceeding $2,999.99 require PA. If your Physician has prescribed a medication that requires PA, he or she will need to contact BHP's Pharmacy Services Department by phone 877-205-6308 or by fax 859-335-3744 to obtain an approval **PRIOR** to you receiving the medication. **PA's will not be issued after the prescription has been filled.** LFUCG Formulary Addendum may be obtained from the Plan Administrator.

PAs are based on medical necessity and benefit limits and are not a guarantee of payment, payment level or participant eligibility. PA applies to all Prescription products/plans and **must** be initiated by the ordering Practitioner or Provider.

DISPENSE AS WRITTEN (DAW) 1 AND 2 PENALTY

Applicable state law requires that when there is a generic medication available for a branded medication, that the pharmacist dispense the generic product unless stated by the prescriber to dispense as written or it is requested by the patient. If a prescriber or a participant specifically requests a brand name medication when a generic medication is available, the participant will be subject to their applicable copayment and will be responsible for the applicable generic medication copayment and one hundred percent (100%) of the difference between the amount the Plan would have paid the dispensing pharmacy for the brand-name medication and the amount the Plan would have paid the dispensing pharmacy for the generic medication.

EXCEPTIONS POLICY

Prescription Drugs specifically listed as not covered will be approved ONLY when clear medical documentation from the requesting Practitioner or Provider includes evidence that the requested medication is appropriate and medically necessary. Clear medical documentation must include adequate trial and failure, contraindications, or an established allergy, of other Prescription Drugs of the same class or those used to treat your condition, which are covered by the Plan.

PRESCRIPTION DRUG OVERIDES

The Plan provides prescription drug overrides as required by applicable state law. Prescription drug overrides do not apply to any controlled medication. Only twelve (12) fills per year of a medication are allowed, regardless of override and no more than three (3) refills of a covered drug may be obtained within a ninety (90) day period.

QUANTITY LIMITS (QL)

QL's have been placed on medications to be consistent with the maximum dosages that the Food and Drug Administration (FDA) has designated to be both safe and effective. Prescriptions for which the quantity to be dispensed exceeds the FDA's maximum daily dose are excluded. QL's for brand name medications also apply to generic alternatives.

RETAIL AND SPECIALTY PHARMACY

Your Plan provisions include a retail prescription drug benefit. You will receive an identification (ID) card which includes your name, group number and your effective date.

Present your ID card at a participating pharmacy when purchasing a prescription. Prescriptions dispensed at a retail or specialty pharmacy are limited to the day supply per prescription or refill as shown in the LFUCG Formulary Addendum.

MAIL ORDER PHARMACY

Your prescription drug coverage also includes mail order pharmacy benefits, allowing participants an easy and convenient way to obtain prescription drugs. The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes

prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Baptist Health Plan/Express Scripts, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescription drugs.

Mail order prescription drugs will only be filled with the quantity prescribed by your qualified practitioner and are limited to the day supply per prescription or refill as shown on the LFUCG Formulary Addendum.

Additional mail order pharmacy information can be obtained by calling the toll-free customer service phone number on the back of your ID card or visit the Baptist Health Plan website at www.BaptistHealthPlan.com.

SPECIALTY DRUGS AND INJECTABLES

Specialty drugs and injectables may only be obtained through City Employee Pharmacy and Accredo Specialty Pharmacy Services under the Prescription Drug Benefit. You or your physician may contact the BHP Pharmacy Services Department to obtain information on this process. PA is required for certain specialty drugs including those delivered in the Physician office, clinic, or home setting.

STEP-THERAPY PROTOCOL

In order for some medications to be covered, Step-Therapy Protocol may be required. Step Therapy Protocol is an electronic PA process that takes place at the time the pharmacist files the claim. For medications that are considered "second-line" agents, the claims system will look at the participant's claims history and if a claim(s) for the required "first-line" medication(s) is found, the system will approve the claim. If "first-line" medications are not found, the system will not approve the claim and will send a message back to the pharmacy advising that the Step-Therapy Protocol has not been met. At that time, the pharmacy may contact your Physician and request that they contact the Plan for PA and review for override or fail-first protocol.

URGENT AND EMERGENT SITUATIONS

If you are out of the area and need to have a prescription filled for an urgent or emergent condition, for your convenience you may take the prescription and your BHP ID card to any participating chain pharmacy. If the pharmacist has difficulty processing the claim, he or she may contact the BHP Pharmacy Services Department at 877.205.6308.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin and other diabetic supplies when prescribed by a Physician.
4. Injectable drugs or any prescription directing administration by injection.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

DEFINITIONS

The following definitions are used in this Prescription Drug SPD:

1st Tier Medications
Typically generic medications. A generic medication is called by its chemical name; a manufacturer assigns a brand name. The price of the generic medication is usually lower than that of a brand name medication. Both generic and brand name products have the same active ingredients. Overall, the generic medication is just as safe and effective as the brand name medication. Tier 1 medications are listed on the LFUCG Formulary Addendum in lower case.

2nd Tier Medications
Typically preferred brand medications. Preferred brand medications may have generic equivalents. Once a branded medication is available as a generic product, the branded medication will move to a non-preferred 3rd Tier status and the generic medication will become the preferred 1st Tier medication unless listed otherwise in this document. Tier 2 medications are listed on the LFUCG Formulary Addendum in upper case.

3rd Tier Medications
Typically non-preferred brand medications. Non-preferred brand medications not included in the LFUCG Formulary Addendum are covered at your 3rd Tier cost-sharing amount.

Brand name medication
A drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by Baptist Health Plan/Express Scripts.

Chemical Equivalents
Multi-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and meet existing FDA physical/chemical standards.

Compound drug(s)
A drug prepared by a pharmacist using a combination of drugs in which at least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Cost share
Any prescription drug copayment, deductible, maximum out of pocket and coinsurance percentage amount that you must pay per prescription drug or refill.

Dispense as Written (DAW)
A physician directive not to substitute a product.

Generic medication
A drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Baptist Health Plan/Express Scripts.

Legend drug
Any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription."

LFUCG Formulary Addendum
A list of prescription drugs, medicines, medications and supplies specified by Baptist Health Plan/Express Scripts. This list indicates applicable dispensing limits and/or any prior authorization or step therapy requirements and is obtained from the Plan Administrator, your employer or call the customer service telephone number on your identification card for questions. Drug lists are updated quarterly and are subject to change without notice.

Mail order pharmacy
A pharmacy that provides covered mail order pharmacy services, as defined by Baptist Health Plan/Express Scripts, and delivers covered prescriptions or refills through the mail to covered persons.

Maintenance Prescription Drugs
Maintenance Prescription Drugs is defined as three (3) prescriptions for a thirty (30) day supply processed within a four (4) month period of time or one (1) prescription for a ninety (90) day supply processed within a six (6) month period of time at the same dosage.

Multi source brand
A drug sold/marketed by two or more manufacturers or labelers.

Named Fiduciary (Plan Fiduciary, Fiduciary, Claim Fiduciary)
A Named Fiduciary or Plan Fiduciary is defined under ERISA Section 3(21) as an individual that: 1) exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, 2) renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or 3) has any discretionary authority or discretionary responsibility in the administration of such plan. The Plan Administrator is the Named Plan Fiduciary of this Plan.

National Drug Code (NDC)
A national classification system for identification of drugs, similar to the Universal Product Code (UPC).

Non-participating pharmacy
A pharmacy that has NOT signed a direct agreement with Baptist Health Plan/Express Scripts or has NOT been designated by Baptist Health Plan/Express Scripts to provide covered pharmacy services, covered specialty pharmacy services or covered mail order pharmacy services, as defined by Baptist Health Plan/Express Scripts, to covered persons, including covered prescriptions or refills delivered to your home.

Off-evidence drug indications
Indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.

Off-label drug indications
Prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not

approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orphan drug
A drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

1. Affects less than 200,000 persons in the United States; or
2. Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

Over-the-Counter (OTC) drug
A drug product that does not require a Prescription Order under federal or state law.

Participating pharmacy
A pharmacy that has signed a direct agreement with Baptist Health Plan/Express Scripts or has been designated by Baptist Health Plan/Express Scripts to provide covered pharmacy services, covered specialty pharmacy services or covered mail order pharmacy services, as defined by Baptist Health Plan/Express Scripts, to covered persons, including covered prescriptions or refills delivered to your home.

Pharmacist
A person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy
A licensed establishment where prescription medications are dispensed by a pharmacist.

Plan Administrator
The participant's (your) employer.

Prescription Plan Manager
Baptist Health Plan. The Prescription Plan Manager provides services to the Plan Administrator (your employer), as defined under the Plan Management Agreement. The Prescription Plan Manager is not the Plan Administrator, Named Fiduciary, Claim Fiduciary, or the Plan Sponsor.

Plan Sponsor
The participant's (your) employer.

Plan year
A period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Prescription Drug
Any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without Prescription." Prescription Drugs require a direct order for the preparation and use of a drug, medicine or medication. The prescription

must be given verbally, electronically or in writing by a qualified Practitioner to a pharmacist for the benefit of and use by a Covered Person.

The direct order for the Prescription Drug must include:
1. The name and address of the covered person for whom the Prescription is intended;
2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. The date the Prescription was prescribed; and
4. The name, address and DEA number of the prescribing qualified Practitioner.

Prior Authorization / Precertification
The required prior approval from Baptist Health Plan for the coverage of prescription drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the covered person's diagnosis, age and sex. Certain prescription drugs, medicines or medications may require prior authorization. Refer to the LFUCG Formulary Addendum or call the customer service telephone number on your identification card to obtain a list of prescription drugs, medicines and medications that require prior authorization.

Quantity Limit
Coverage of selected drugs covered under the Plan are limited to specified values over a set period of time. These values include, but are not limited to, drug quantity, day supply, number of refills and sponsor paid dollars.

Self-administered injectable drug
An FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and is intended for use by you.

Single source brand
A drug that is available from only one source, usually the innovator that invented it. These drugs are patent protected brand name drugs for which no generic exists.

Specialty drug
A drug, medicine, medication or biological used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty drugs may:
1. Require nursing services or special programs to support patient compliance;
2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or
4. Have special handling, storage or shipping requirements.

Specialty pharmacy
A pharmacy that provides covered specialty pharmacy services, as defined by Baptist Health Plan/Express Scripts, to covered persons.

Step therapy
A type of prior authorization. Baptist Health Plan/Express Scripts may require you to follow certain steps prior to coverage of some high-cost drugs, medicines or medications. Baptist Health Plan/Express Scripts may require you to try a similar drug, medicine or medication that has been determined to be safe, effective and less costly for most people with your condition. Alternatives may include over-the-counter drugs, generic medications and brand name medications.

Therapeutic Equivalent
A medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not chemical equivalents.

Unit Dose Medications
Medications packaged in individual unit-of-use blister packs. Unit dose medications tend to be more expensive. Pharmacies providing medications to long-term care facilities are often required to dispense in unit dose packaging.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once annually you will have a choice of enrolling yourself and your eligible dependents in this Plan. You will be notified in advance when the Open Enrollment Period is to begin and how long it will last. If you decline coverage for yourself or your dependents at the time you are initially eligible for coverage, you will be able to enroll yourself and/or eligible dependents during the Open Enrollment Period.

EMPLOYEE ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. You are an employee who meets the eligibility requirements of the employer; and
2. You are a full-time or part-time permanent employee working 100 hours per month; or
3. You are a retired Police Officer or Firefighter.

Your eligibility date is the first of the month following your date of hire.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to Baptist Health Plan.

1. If your completed enrollment is received by Baptist Health Plan before your eligibility date or within thirty (30) days after your eligibility date, your coverage is effective on your eligibility date.
2. If your completed enrollment is received by Baptist Health Plan more than thirty (30) days after your eligibility date, you are a late applicant and you will not be eligible for coverage under this Plan until the next annual open enrollment period.

EMPLOYEE DELAYED EFFECTIVE DATE

If the employee is not in active status on the effective date of coverage, coverage will be effective the day the employee returns to active status. The employer must notify the Prescription Plan Manager in writing of the employee's return to active status.

DEPENDENT ELIGIBILITY

To be eligible for coverage as a dependent of a subscriber, an individual must be the lawful spouse, qualified adult (QAB) of a subscriber, a dependent child of a subscriber, or a young adult child under the age of twenty-six (26). Eligibility for coverage is not based on residency, student status, marital status, or employment.

A qualified adult dependent is defined as a person of the same or opposite sex who meets criteria established in the QAB policy administered by LFUCG. Employees must see HR and provide an Affidavit and required documentation before adding a QAB to the plan.

A "child" means a newborn child, a stepchild, a child legally placed for adoption, a legally adopted child, a child for whom legal guardianship has been awarded, or a child for whom the subscriber has a legal obligation under a divorce decree or other court order, including a qualified medical child support order, to provide health care coverage for a child. A newborn child will be covered from the moment of birth for the first thirty-one (31) days of life. To continue coverage of a newborn thereafter, the subscriber must comply with the special enrollment period requirements under this section of the SPD; otherwise coverage for the child will cease. A subscriber required by a court or administrative order to provide

health coverage for a child must submit proof of such order at the time application for the child is made. Temporary custody is not sufficient to establish eligibility under this Plan. Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

DEPENDENT EFFECTIVE DATE OF COVERAGE

WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS NOT REQUIRED

If the employee wishes to add a newborn dependent to the Plan and a change in the employee's level of coverage is not required, enrollment must be completed and submitted to the Prescription Plan Manager.

The newborn dependent will be covered on the date he or she is eligible. If the employee wishes to add a dependent (other than a newborn) to the Plan and a change in the employee's level of coverage is not required, the dependent's effective date of coverage is determined as follows:

1. If the completed enrollment is received by the Prescription Plan Manager before the dependent's eligibility date or within thirty (30) days after the dependent's eligibility date, that dependent is covered on the date he or she is eligible.
2. If the completed enrollment is received by the Prescription Plan Manager more than thirty (30) days after the dependent's eligibility date, the dependent is a late applicant and will result in denial of dependent coverage until the next annual open enrollment period.

No dependent's effective date will be prior to the covered employee's effective date of coverage. A dependent child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If your dependent child under the age of twenty-six (26) becomes an eligible employee of the employer, he or she is no longer eligible as your dependent and must make application as an eligible employee.

DEPENDENT EFFECTIVE DATE OF COVERAGE

WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS REQUIRED

If the employee wishes to add a dependent to the Plan and a change in the employee's level of coverage is required, enrollment must be completed and submitted to the Prescription Plan Manager.

The dependent's effective date of coverage is determined as follows:

1. If the completed enrollment is received by the Prescription Plan Manager before the dependent's eligibility date or within thirty (30) days after the dependent's eligibility date, that dependent is covered on the date he or she is eligible.
2. If the completed enrollment is received by the Prescription Plan Manager more than thirty (30) days after the dependent's eligibility date, the dependent is a late applicant and will result in denial of dependent coverage until the next annual open enrollment period.

No dependent's effective date will be prior to the covered employee's effective date of coverage. A dependent child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If your dependent child becomes an eligible employee of the employer, he or she is no longer eligible as your dependent and must make application as an eligible employee.

If dependent coverage is in force or applied for within thirty-one (31) days of a newborn child's date of birth, the dependent delayed effective date provision will not apply and coverage will be effective on the child's date of birth.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered employee shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee's child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

If an otherwise eligible employee named in a Qualified Medical Child Support Order (QMCSO) is not currently enrolled, and the Prescription Plan Manager determines the QMSCO is qualified and required to provide coverage to the child, the child must be covered. Since, as a condition for covering dependents, the employee must be enrolled, then both the employee and child must be permitted to enroll in the Plan.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If your employer continues to pay required contributions and does not terminate the Plan, your coverage will remain in force for:

1. No longer than the end of the month during part-time status;
2. No longer than the end of the month during an approved medical or non-medical leave of absence;
3. No longer than the end of the month during an approved military leave of absence;
4. No longer than the end of the month of a layoff;
5. No longer than the end of the month during a period of total disability.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If your coverage under the Plan was terminated after a period of layoff, total disability, approved medical or non-medical leave of absence, or approved military leave of absence (other than USERRA), and you are now returning to work, your coverage is effective immediately on the day you return to work.

If your coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, your coverage is effective immediately on the day you return to work.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you are granted a leave of absence (Leave) by the employer as required by FMLA, you may continue to be covered under the Plan for the duration of the Leave under the same conditions as other employees who are in active status and covered by the Plan. If you choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated the first of the month following the date you return to active status immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if you had been continuously covered.

An enrollee who otherwise would be ineligible due to a subscriber's inactivity at work will retain eligibility during a period of leave under FMLA. Enrollment may continue, at the subscriber's discretion, for the period of leave under the Act.

SPECIAL ENROLLMENT

If you previously declined coverage under this Plan for yourself or any eligible dependents, due to the existence of other coverage (including COBRA), and that coverage is now lost, this Plan permits you, your dependent spouse, and any eligible dependents to be enrolled for medical benefits under this Plan due to any of the following qualifying events:

1. Loss of eligibility for the coverage due to any of the following:
2. Legal separation;
3. Divorce;
4. Cessation of dependent status (such as attaining the limiting age);
5. Death;
6. Termination of employment;
7. Reduction in the number of hours of employment;
8. Any loss of eligibility after a period that is measured by reference to any of the foregoing.
9. Meeting or exceeding a lifetime limit on all benefits;
10. Plan no longer offering benefits to a class of similarly situated individuals, which includes the employee.

If you have declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, you or your dependents may have a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, you must request enrollment within sixty (60) days after the government-provided coverage ends.

In addition, if you have declined enrollment in the Plan for yourself or your dependents (including a spouse), and later become eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, you and your dependents may have a right to enroll in this Plan. However, you must request enrollment within sixty (60) days after the determination of eligibility for the state assistance.

However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

1. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.
2. COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if you stated in writing at the previous enrollment the other coverage was the reason for declining enrollment, but only if your employer requires a written waiver of coverage which includes a warning of the penalties imposed on late enrollees.

If you are a covered employee or an otherwise eligible employee, who either did not enroll or did not enroll dependents when eligible, you now have the opportunity to enroll yourself and/or any previously eligible dependents or any newly acquired dependents when due to any of the following family status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within one month from the qualifying event. You MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

In the case of a dependent's birth, enrollment is effective on the date of such birth.

In the case of a dependent's adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

Please see your employer for more details.

RETIREE COVERAGE

If you are retired Police Officer or Firefighter with at least 20 years of continuous service, you may continue coverage under the Plan with retiree benefits for you and any of your eligible dependents provided such coverage was effective at the time of your retirement. Dependents acquired through marriage after your early retirement may be added by timely enrollment. Please see your employer for more details.

SURVIVORSHIP COVERAGE

If a Police Officer or Firefighter dies while covered under this Plan, the surviving spouse and any eligible dependent children may continue coverage under this Plan as determined by the employer and dependent children reach 23 years of age, subsequent to the employee's date of death. Any dependents acquired through the remarriage of the employee's surviving spouse will be eligible as determined by the employer.

If you or any of your covered dependents no longer meet the eligibility requirements, you and your employer are responsible for notifying Baptist Health Plan of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to Baptist Health Plan.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the calendar month you enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the 'Special Provisions For Not Being in Active Status' provision;
4. The end of the calendar month you fail to be in an eligible class of persons according to the eligibility requirements of the employer;
5. For all employees, the end of the calendar month in which you terminate employment with your employer;
6. For all employees, the end of the calendar month you retire, unless you qualify for retiree coverage as determined by your employer;
7. For any benefit, the date the benefit is removed from the Plan;
8. For your dependents, the date your coverage terminates;
9. For a dependent, the end of the calendar month the dependent enters full-time military, naval or air service;
10. For a dependent, the end of the calendar month such covered person no longer meets the definition of dependent; or
11. The end of the calendar month you request termination of coverage to be effective for yourself and/or your dependents.

IF YOU OR ANY OF YOUR COVERED DEPENDENTS NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, YOU AND YOUR EMPLOYER ARE RESPONSIBLE FOR NOTIFYING THE PRESCRIPTION PLAN MANAGER OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE PRESCRIPTION PLAN MANAGER.

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Consolidated Omnibus Budget Reconciliation Act (commonly known as COBRA) requires that employers with twenty (20) or more employees in the preceding calendar year who sponsor group health and prescription plans to offer their employees and their eligible dependents the opportunity to continue their group coverage under certain circumstances.

ELIGIBILITY

A qualified beneficiary under COBRA law means an employee, employee's spouse or dependent child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the employee during the coverage period or a child placed for adoption with the employee during the coverage period.

EIGHTEEN MONTH QUALIFYING EVENTS:

- Termination (for reasons other than gross misconduct) of the employee's employment or reduction in the hours of employee's employment;
- Employer's filing of bankruptcy proceedings; the employee is entitled to the continuation of the Employer Group's existing benefits at a premium rate not to exceed one hundred two percent (102%) of the current Group rate.

THIRTY SIX MONTH QUALIFYING EVENTS:

- The death of the employee or the employee parent;
- Termination of the employee's (or employee parent's) employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment with the employer;
- Divorce or legal separation from the employee or employee parent's divorce or legal separation;
- The employee or employee parent becomes entitled to Medicare benefits.
- Loss of eligibility as a "dependent child" under the Plan;

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered employee, spouse or dependent child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for employee, spouse or dependent child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an employer eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum coverage period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a spouse due to legal separation or divorce or for a child when that child loses dependent status. Under the law, the employee or qualified beneficiary has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The qualified beneficiary must give this notice within sixty (60) days after the event occurs. (For example, an ex-spouse should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the COBRA Service Provider, who will in turn notify the qualified

beneficiary of the right to elect continuation coverage.

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first sixty (60) days of COBRA coverage, the continuation coverage period for all qualified beneficiaries may be extended eleven (11) additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the COBRA Service Provider and Plan Administrator within the initial eighteen (18) month coverage period and within sixty (60) days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the employee, the employee becoming covered by Medicare or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the COBRA Service Provider, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within sixty (60) days after Plan coverage ends, or if later, sixty (60) days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the sixty (60) day period, the right to elect coverage under the Plan will end.

A covered employee or the spouse of the covered employee may elect continuation coverage for all covered dependents, even if the covered employee or spouse of the covered employee or all covered dependents are covered under another group plan (as an employee or otherwise) prior to the election. The covered employee, his or her spouse and dependent child, however, each have an independent right to elect continuation coverage. Thus a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the sixty (60) day election period and the waiver revoked before the end of the sixty (60) day election period, coverage will be effective on the date the election of coverage is sent to the COBRA Service Provider or Plan Administrator.

On August 6, 2002, The Trade Act of 2002 (TAA), was signed in to law. Workers whose employment is adversely affected by international trade (increased import or shift in production to another country) may become eligible to receive TAA. TAA provides a second sixty (60) day COBRA election period for those who become eligible for assistance under TAA. Pursuant to the Trade Act of 1974, an individual who is either an eligible TAA recipient or an eligible alternative TAA recipient and who did not elect continuation coverage during the sixty (60) day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a sixty (60) day period that begins on the first day of the month in which he or she is determined to be TAA-eligible individual, provided such election is made not later than six (6) months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage originally lapsed.

TAA created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of sixty-five percent (65%) of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health

Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

The Plan Administrator shall require documentation evidencing eligibility of TAA benefits. The Plan need not require every available document to establish evidence of TAA. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- Eighteen (18) months for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment;
- Thirty-six (36) months for a spouse whose coverage ended due to the death of the employee or retiree, divorce, or the employee becoming entitled to Medicare at the time of the initial qualifying event;
- Thirty-six (36) months for a dependent child whose coverage ended due to the divorce of the employee parent, the employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the employee, or the child ceasing to be a dependent under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the employer filed Chapter eleven (11) bankruptcy.

DISABILITY

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional eleven (11) months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within thirty (30) days after SSA's determination.

SECOND QUALIFYING EVENT

An eighteen (18) month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying event may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within sixty (60) days after the second qualifying event occurs if you want to extend your continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The employer no longer provides group coverage to any of its employees;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group plan (as an employee or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to

any pre-existing condition, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;

NOTE: the Federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once you obtain health insurance, you will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when you move from one plan to another.

- The individual on continuation becomes entitled to Medicare benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than thirty (30) days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

Please contact your employer for more information regarding COBRA.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the employer's Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the forty-fifth (45^{th}) day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a thirty-one (31) day grace period. The employer or COBRA Service Provider must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a twelve (12) month period which is established by the Plan.

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the employer or COBRA Service Provider. This monthly premium may include the employee's share and any portion previously paid by the employer. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a two percent (2%) administration charge. However, for qualified beneficiaries who are receiving up to eleven (11) months additional coverage (beyond the first eighteen (18) months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to one hundred fifty percent (150%) of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional eleven (11) months of special coverage will pay up to one hundred two percent (102%) of the premium cost.

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the Plan Administrator or the COBRA Service Provider.

It is important for the covered person or qualified beneficiary to keep the COBRA Service Provider, Plan Administrator and Prescription Plan Manager informed of any changes in marital status, or a change of address.

PLAN CONTACT INFORMATION

Plan Administrator/Plan Sponsor
Lexington Fayette Urban County Government
200 E. Main Street
Lexington, KY 40507
Telephone: 859-258-3000

COBRA Service Provider
Conexis
6191 North State Hwy 161, Suite 500
Irving, TX 75038
Toll-Free: 1-866-475-3931

Prescription Plan Manager
Baptist Health Plan, Inc.
651 Perimeter Drive, Suite 300
Lexington, KY 40517
Toll-Free 877-205-6308
Fax 859.335.3744

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

Federal law may affect your coverage under this Plan. The Medicare as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group plan provides coverage to employees (or their spouses) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Generally, the health care plan of an employer that has at least 20 employees must operate in compliance with these rules in providing plan coverage to plan participants who have "current employment status" and are Medicare beneficiaries, age 65 and over.

Persons who have "current employment status" with an employer are generally employees who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an employer for up to 6 months; or
- Individuals who retain employment rights and have not been terminated by the employer and for whom the employer continues to provide coverage under this Plan. (For example, employees who are on an approved leave of absence).

If you are a person with "current employment status" who is age 65 and over (or the dependent spouse age 65 and over of an employee of any age), your coverage under this Plan will be provided on the same terms and conditions as are applicable to employees (or dependent spouses) who are under the age of 65. Your rights under this Plan do not change because you (or your dependent spouse) are eligible for Medicare coverage on the basis of age, as long as you have "current employment status" with your employer.

You have the option to reject plan coverage offered by your employer, as does any eligible employee. If you reject coverage under your employer's Plan, coverage is terminated and your employer is not permitted to offer you coverage that supplements Medicare covered services.

If you (or your dependent spouse) obtain Medicare coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to Medicare when you have elected coverage under this Plan and have "current employment status".

If you have any questions about how coverage under this Plan relates to Medicare coverage, please contact your employer.

If you or any of your covered dependents no longer meet the eligibility requirements, you and your employer are responsible for notifying Baptist Health Plan of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to Baptist Health Plan.

PRESCRIPTION DRUG LIMITATIONS/EXCLUSIONS

This section lists what is not covered. Participants should read this section carefully to understand what benefits are not included in the Plan. The following indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misinterpreted as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. The titles are to facilitate location of the exclusions and should not be interpreted to limit the terms of the Exclusions.

The following general exclusions pertain to all covered policyholders unless specified in Plan documentation:

1. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the LFUCG Formulary Addendum;
2. Medication products specifically listed as not covered;
3. Any medication products used for cosmetic purposes, including hair loss, are not covered;
4. Replacement of lost, stolen, misplaced, damaged, or spilled medication is not covered;
5. Weight loss medications are not covered;
6. Medications for travel prophylaxis are not covered
7. Medications obtained from out-of-network pharmacies;
8. Medications for which the quantity to be dispensed exceeds the FDA's maximum daily dose are not covered;
9. Convenience kits are not covered when active ingredient products are available individually;
10. Medications or other prescription drugs used by an outpatient to maintain a treatment plan of an addiction, dependency on drugs, alcohol, or chemicals. This includes: Medications used by an Outpatient to maintain a treatment plan of a drug addiction, drug dependency or a drug maintenance program with methadone or buprenorphine-containing products;
11. Modified food or supplements for the treatment of lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition or disease (except special formulas Medically Necessary for the treatment of certain inborn errors of metabolism or genetic conditions);
12. Non-injectable medications given in a Physician's office (this exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office);
13. Drugs used for diagnostic purposes are not covered under the Pharmacy benefit;
14. Vaccines, when recommended and/or required by a third-party entity for the purpose of sports, school (except approved well visits), camp, employment, license requirements, travel, insurance, marriage, adoption, are not covered; and
15. Human growth hormone for children born small for gestational age (It is only a Covered Service in other situations when allowed through PA).

Experimental or Investigational

Experimental medication products or any medication product used in an experimental manner, including drugs which are not FDA approved for treatment for a specified category of medical conditions are not covered, unless such use is consistent with standard medical practice and has been demonstrated as effective in published peer review medical literature as leading to improvement in health outcomes, or not included within the Plan's formulary, if any.

New Prescription Drugs

Any new FDA Approved Drug Product or Technology (such as, medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology,

such as, Pharmacies, for the first six (6) months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

Quantity Limits and Timeframes of Usage

In accordance with the FDA guidelines, the quantity dispensed and/or timeframe of use of certain covered medications may be limited. FDA approved maximum doses established for safety will determine quantity limits. For some medications, a one (1) month supply does not equal thirty (30) units. Benefits for covered prescription medications are limited to quantities that can reasonably be consumed or used within one (1) month, or as authorized under the Plan. Limits are based on clinical considerations including patient safety and appropriate use. Sample listing of these medications include narcotic analgesics, sedative/hypnotics, migraine medications and second-line antibiotics.

PRIVACY OF PROTECTED HEALTH INFORMATION

This Plan is required by law to maintain the privacy of your protected health information in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of this Plan's legal duties and privacy practices with respect to protected health information.

This Plan has policies and procedures specifically designed to protect your health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that your health information cannot be inappropriately accessed while it is stored and transmitted to Prescription Plan Manager and others that support this Plan.

In order for this Plan to operate, it may be necessary from time to time for health care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, Prescription Plan Manager and other service providers that have been engaged to assist this Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as protected health information.

A covered person will be deemed to have consented to use of protected health information about him or her for the sole purpose of health care operations by virtue of enrollment in this Plan. This Plan must obtain authorization from a covered person to use protected health information for any other purpose.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, Prescription Plan Manager, and other entities given access to protected health information, as permitted by applicable law, will safeguard protected health information to ensure that the information is not improperly disclosed.

Disclosure of protected health information is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery without authorization. Disclosure for Plan purposes to persons authorized to receive protected health information may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the employer for employment purposes, employee representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

Prescription Plan Manager will afford access to protected health information in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. Information received by Prescription Plan Manager is information received on behalf of this Plan.

Prescription Plan Manager will afford access to protected health information as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, Prescription Plan Manager has been directed that disclosure of protected health information may be made to the person(s) identified by the Plan Administrator.

Individuals who have access to protected health information in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to protected health information.

Prescription Plan Manager and other Plan service providers will be required to safeguard protected health information against improper disclosure through contractual arrangements.

CLAIM PROCEDURES

In addition, you should know that the employer / Plan Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to protected health information to police federal legal requirements about privacy.

Covered persons may have access to protected health information about them that is in the possession of this Plan, and they may make changes to correct errors. Covered persons are also entitled to an accounting of all disclosures that may be made by any person who acquires access to protected health information concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, covered persons may consent to disclosure of protected health information, as they please.

COORDINATION OF BENEFITS

All benefits provided under this Plan are subject to this coordination of benefits provision, which is applicable for the term of this Plan. If this Plan is primarily responsible for claims of covered services rendered to a covered person in accordance with this provision, the benefits of any other plans under which coverage is available to the covered person will be ignored for purposes of determining the benefits determined under this Plan. If this Plan is secondarily responsible on claims for covered services rendered to a covered person in accordance with this provision, the benefits provided for covered services under this Plan will be reduced to the extent necessary so that the sum of the reduced benefits under this SPD and the benefits determined by the other plan(s) do not exceed the total allowed amount for such covered services. "Allowable Expense" means a pharmacy expense including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person.

As used in this provision, the term "pharmacy plan" means any coverage providing benefits for covered services through: 1) individual, group, or blanket insurance coverage; 2) group practice, individual practice, and other prepayment coverage; 3) coverage under labor-management trusted plans or employee benefit organization plans; and 4) coverage under governmental programs, except Medicaid. The term "pharmacy plan" will be applied separately with respect to each coverage for benefits or services and separately with respect to that portion of any coverage which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. When a "pharmacy plan" provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both a covered service and a benefit paid. The term "benefit reserve" is defined as the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than a primary plan.

A secondary plan shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. "Claim Determination Period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide.

1. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary and any savings shall be:
   A. Recorded as a benefit reserve for the covered person; and
   B. Used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period.
2. By the end of the claim determination period, the secondary plan shall:
   A. Determine whether a benefit reserve has been recorded for the covered person;
   B. Determine whether there are any unpaid allowable expenses for that claims determination period; and
   C. Pay any unpaid allowable expenses for that claim determination period.
3. The secondary plan shall use the covered person's recorded benefit reserve, if any, to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period, at the end of which:
   A. The benefit reserve shall return to zero (0); and
   B. A new benefit reserve shall be created for each new claim determination period.

The benefits of the secondary plan shall be reduced when the sum of the benefits payable under the secondary plan, in the absence of a coordination of benefits provision, and the benefits that would be payable under the other plans, in the absence of this coordination of benefits provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period, with a reduction of benefits as follows:

1. The benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses; and
2. Each benefit is reduced in proportion and charged against any applicable benefit limit of the Plan.

In processing a claim for services rendered to a covered person covered under two or more pharmacy plans, including this SPD, the "primary-secondary" payment rule determines the provision of benefits. The first of the following requirements that describes which plan pays its benefits as primary before another plan is the requirement to use:

1. The plan has no coordination of benefits provision;
2. Nondependent or dependent. The plan that covers the person other than as a dependent is primary and the plan that covers the person as a dependent is secondary unless the person is a Medicare beneficiary, in which case the order of benefits is determined in accordance with 42 USC 1395.
3. A child, including a newborn, covered under more than one (1) plan.
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      1) The parents are married;
      2) The parents are not separated (whether or not they ever have been married); or
      3) A court decree awards joint custody without specifying that one (1) parent has the responsibility to provide health care coverage.
4. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
5. If a court decree states that one (1) parent is responsible for the child's pharmacy expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's services or expenses, but that parent's spouse does, the spouse's plan is primary.
6. If the parents are not married or are separated or divorced, and there is no court decree allocating responsibility for the child's services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:
   A. The plan of the custodial parent;
   B. The plan of the spouse of the custodial parent;
   C. The plan of the noncustodial parent; and then
   D. The plan of the spouse of the noncustodial parent.
7. Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, is primary.
8. If a person is laid off or is retired or is a dependent of such person, that plan covers after the plan covering such person as an active employee or dependent of such employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.
9. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, participant, subscriber or retiree, or as that person's dependent, is primary and the continuation coverage is secondary.
10. Longer or shorter length of coverage. If the preceding requirements do not determine the order of benefits, the plan that covered the person for the longer period of time is primary:

A. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the covered person was eligible under the second within twenty-four (24) hours after the first ended;
B. Changes during a coverage period that do not constitute the start of a new plan include:
   1) A change in scope of a plan's benefits;
   2) A change in the entity that pays, provides or administers the plan's benefits; or
   3) A change from one (1) type of plan to another.

   The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a participant of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

11. If none of the preceding requirements determines the primary plan, the allowable expenses shall be shared equally between the plans.
12. If another pharmacy plan, other than this one, contains an order of benefit determination rule, which uses gender as the determinant factor, that plan shall always be primary.

If another pharmacy plan, other than this one, does not contain coordination of benefits provisions establishing order of benefit determination rules as used in this SPD, the benefits under that other plan will be determined before the benefits under this SPD.

In order to determine the application and administration of the terms of this coordination of benefits provision, the Plan may, without the consent or notice to any person, release to or obtain from any provider of covered services, employer, insurance company, or any other organization or person any information the Plan considers necessary to implement this provision. Furthermore, any individual claiming benefits under this SPD must also provide the Plan with any information necessary to administer this provision.

Whenever any payment for covered services has been made by the Plan in an amount that exceeds the maximum benefits available for such services under this provision, the Plan reserves the right to recover such overpayments from the covered person, the provider of covered services, another pharmacy plan, or an insurance company. In the alternative, the Plan further reserves the right to deduct from any pending claim for services rendered under this SPD any amounts the covered person owes the Plan.

Whenever any payment has been made by another pharmacy plan that should have been provided under this SPD as a result of coordination of benefits, the Plan reserves the right, in its sole discretion, to reimburse such other plan for the necessary amount(s) in order to satisfy the intent of this provision. Any amounts paid will be considered to be benefits paid under this SPD, and, to the extent of such reimbursement, the Plan will be fully discharged from liability under this SPD.

MEDICARE

Any benefits covered under both this SPD and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. In the event of a conflict between federal law, state law and SPD provisions, Federal law will prevail.

Except when federal law requires the Plan to be the primary payor, the benefits under this SPD for participants age sixty-five (65) and older, or participants otherwise eligible for Medicare, do not

duplicate any benefit for which participants are entitled under Medicare, including Part B where participants shall be reimbursed by or on behalf of the participants to the Plan, to the extent the Plan has made payment for such services.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

1. The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
2. The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
3. The person receives services from a Provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
4. The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
5. The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

COORDINATION OF BENEFITS WITH MEDICARE

When an employer employs one hundred (100) or more persons, the benefits of the Plan will be payable first for a covered person who is under age sixty-five (65) and eligible for Medicare. The benefits of Medicare will be payable second.

MEDICARE PART A means the Social Security program that provides hospital insurance benefits.
MEDICARE PART B means the Social Security program that provides medical insurance benefits.

For purposes of determining benefits payable for any covered person who is a retiree or the covered spouse of a retiree and who is eligible to enroll in Medicare Part B, but does not, the Prescription Plan Manager assumes the amount payable under Medicare Part B to be the amount the covered person would have received if he or she enrolled for it. A covered person is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

OPTIONS
Federal Law allows the plan's actively working covered employees age sixty-five (65) or older and their covered spouses who are eligible for Medicare to choose one of the following options:

OPTION 1 - The benefits of the Plan will be payable first and the benefits of Medicare will be payable second.
OPTION 2 - Medicare benefits only. The covered person and his or her dependents, if any, will not be covered by the Plan.

Each covered employee and each covered spouse will be provided with the choice to elect one of these options at least one month before the covered employee or the covered spouse becomes age sixty-five (65). All new covered employees and newly covered spouses age sixty-five (65) or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a covered employee or dependent who is under age sixty-five (65).

Under Federal law, there are two categories of persons eligible for Medicare. The calculation and payments of benefits by the Plan differs for each category.

CATEGORY 1 Medicare Eligibles are actively working covered employees age sixty-five (65) or older and their age sixty-five (65) or older covered spouses, and age sixty-five (65) or older covered spouses of actively working covered employees who are under age sixty-five (65).

CATEGORY 2 Medicare Eligibles are any other covered persons entitled to Medicare, whether or not they enrolled for it. This category includes, but is not limited to, retired covered employees and their spouses or covered dependents of a covered employee other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS

For covered persons in Category 1, benefits are payable by the Plan without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the Plan. The benefits of the Plan will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not they were actually enrolled for Medicare.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or
2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

The beneficiary agrees that by accepting and in return for the payment of covered expenses by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the covered expenses it pays from any amounts received by the beneficiary from others for the bodily injuries or losses which necessitated such covered expenses. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, personal umbrella policies, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.
2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the beneficiary. This priority will apply even if the remaining portion of the amount received, after repayment is made to the Plan, is no sufficient to wholly compensate the beneficiary for their losses.
3. The right to recover amounts from others for the injuries or losses which necessitate covered expenses is jointly owned by the Plan and the beneficiary. The Plan is subrogated to the beneficiary's rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the beneficiary. This priority will apply even if the remaining portion of the amount received, after repayment is made to the Plan, is not sufficient to wholly compensate the beneficiary for their losses.
4. The beneficiary acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify responsible party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys. The beneficiary will cooperate with the Plan in any effort to recover from others for the bodily injuries and losses which necessitate covered expense payments by the Plan. The beneficiary will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the beneficiary shall be entitled to costs or attorney fees from the other for the prosecution of the claim. The Plan specifically disclaims any obligation to contribute toward the costs and attorney fees incurred by the beneficiary in obtaining a settlement or judgment on their claims.
5. By accepting payment of covered expenses (whether the payment of such covered expenses is made to the beneficiary or made on behalf of the beneficiary to any provider) from the Plan, the beneficiary agrees that as to any amounts received from others, he/she will serve as a constructive trustee over such amount. Failure to hold such amounts in trust will be deemed a breach of the beneficiary's fiduciary duty to the Plan. Only those amounts received by the beneficiary that are in excess of the amounts paid in benefits by the Plan shall be retained by the beneficiary. No court costs or attorneys' fees may be deducted from the Plan's recovery without our express written consent, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claims.
6. The beneficiary shall notify the Plan in writing within thirty (30) days of her/his intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered person, consults an attorney, or brings an action against a third (3rd) party (including an insurance company). The beneficiary will also forward copies to the Plan of police reports or other documents received in connection with the accident or incident resulting in payment of benefits by the Plan. The beneficiary shall not settle or take any action that would

otherwise compromise any claim against a potentially liable third party without notifying the Plan in writing within thirty (30) days in advance of the action to be taken, and the Plan agrees in writing to such action. The cost of legal representation of the beneficiary shall not be assumed by the Plan, and the Plan shall not be responsible for payment of any legal fees for the beneficiary unless the Plan has agreed to do so in writing.

7. 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 for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any insurance coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. 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, the covered person; the covered person's representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.
8. The Plan also has the right to file suit on behalf of the beneficiary against any third party, corporation, or organization that may be deemed responsible or liable for the condition giving rise to the payment of benefits by the Plan; however, the Plan is not obligated in any way to pursue this right independently or on your behalf.
9. The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical 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 beneficiary's failure to cooperate or otherwise comply with the terms of this provision will entitle the Plan to withhold, retract or deduct benefits due the beneficiary under the SPD or the institution of court proceedings against the covered person.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the Prescription Plan Manager and when asked, assist the Prescription Plan Manager by:

- Authorizing the release of medical information including the names of all providers from whom you received medical attention;
- Obtaining medical information and/or records from any provider as requested by the Prescription Plan Manager;
- Providing information regarding the circumstances of your sickness or bodily injury;
- Providing information about other insurance coverage and benefits, including information related to any bodily injury or sickness for which another party may be liable to pay compensation or benefits; and
- Providing information the Prescription Plan Manager requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a bodily injury or sickness for which the information is sought, until the necessary information is satisfactorily provided.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the Prescription Plan Manager in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the Prescription Plan Manager that you may have a claim, providing the Prescription Plan Manager relevant information, and signing and delivering such documents as the Prescription Plan Manager reasonably request to secure the Plan's recovery rights. You agree to obtain the Plan's consent before releasing any party from liability for payment of medical expenses. You agree to provide the Prescription Plan Manager with a copy of any summons, complaint or any other process serviced in any lawsuit in which you seek to recover compensation for your bodily injury or sickness and its treatment.

You will do whatever is necessary to enable the Prescription Plan Manager to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

You agree that you will not attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering or other element of damages not related to medical expenses. The Plan's recovery rights apply to any and all settlements or judgments, regardless of how designated and regardless of whether liability for payment is admitted by any responsible party. The Plan's recovery rights apply even if the settlement or judgment does not identify the covered expenses paid by the Plan.

Failure of the covered person to provide the Prescription Plan Manager such notice or cooperation, or any action by the covered person resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the covered person being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the covered person owes the Plan until such time as cooperation is provided and the prejudice ceases.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

JURISDICTION

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

INITIAL PRESCRIPTION CLAIMS DETERMINATIONS

Prescription claims will be first submitted to and initially determined by the Prescription Plan Manager.

CLAIM DETERMINATION TIMEFRAMES

The period of time for a claim determination begins when a claim is received by the Prescription Plan Manager, in accordance with the following claims procedures. After submission of a claim by a participant, the Prescription Plan Manager will notify the participant within a reasonable time, as follows:

Pre-Service Claim/Authorization Determination

The Prescription Plan Manager will notify you of the determination with respect to your claim within a reasonable period of time, but not later than fifteen (15) days after the Prescription Plan Manager receives the claim, unless the Prescription Plan Manager determines that special circumstances require an extension of time for processing the claim. If the Prescription Plan Manager determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial fifteen (15) day period. In no event will the extension exceed a period of fifteen (15) days from the end of the initial fifteen (15) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Prescription Plan Manager expects to render the claim determination. If the Prescription Plan Manager requires such an extension because you have not provided all the necessary information for the Prescription Plan Manager to decide the claim, you will have forty-five (45) days from the time you receive the extension notice to provide the necessary information.

Urgent Care Eligibility Determination

If you or a dependent is in need of urgent care, as determined by the Plan based on the available medical information, but the eligibility of the individual needing the care is in dispute, the Prescription Plan Manager will notify you of the initial eligibility decision as soon as possible, but not later than twenty-four (24) hours after receipt of the eligibility claim by the Prescription Plan Manager. Urgent care claims must be decided as soon as possible, taking into consideration the medical needs of you or a dependent, but in not circumstances later than seventy-two (72) hours after the Prescription Plan Manager receives the claim. If a claim is submitted that does not contain the information necessary to determine eligibility for the Plan, the Prescription Plan Manager will provide a notice to you as soon as possible, but not more than twenty-four (24) hours after receipt of the claim by the Prescription Plan Manager. The notice will describe the specific information necessary to complete the claim. You will have forty-eight (48) hours to provide the necessary information to Company.

Urgent Care Claim Determination

The Prescription Plan Manager will first determine whether a claim is an urgent care claim. This determination will be made on the basis of information furnished by or on behalf of a participant. In making this determination, the Prescription Plan Manager will defer to the judgment of a physician with knowledge of the participant's condition. Accordingly, the Prescription Plan Manager may require a participant or the participant's physician to clarify the medical urgency and circumstances that support the urgent care claim for expedited decision-making.

The Prescription Plan Manager will notify the participant of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to the participant's situation, but not later than seventy-two (72) hours after receipt of the urgent care claim.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the Prescription Plan Manager as soon as possible, but not more than twenty-four (24) hours after receipt of the urgent care claim. The notice will describe the specific information necessary to complete the claim.

1. The claimant will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than forty-eight (48) hours.
2. The Prescription Plan Manager will notify the participant of the Plan's urgent care claim determination as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:
   A. The Prescription Plan Manager's receipt of the specified information; or
   B. The end of the period afforded the participant to provide the specified additional information.

Concurrent Care Determination

The Prescription Plan Manager will notify a claimant of a concurrent care decision that involves a reduction in or termination of benefits that have been pre-authorized. The Prescription Plan Manager will provide the notice sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse determination.

A request by a claimant to extend a course of treatment beyond the period of time or number of treatments that is a service involving urgent care will be decided by the Prescription Plan Manager as soon as possible, taking into account the medical situation. The Prescription Plan Manager will notify a claimant of the benefit determination, whether adverse or not within twenty-four (24) hours after receipt of the request, provided that the request is submitted to the Prescription Plan Manager at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claim Determination

The Prescription Plan Manager will notify you of the determination with respect to your claim within a reasonable period of time, but not later than thirty (30) days after the Prescription Plan Manager receives the claim, unless the Prescription Plan Manager determines that special circumstances require an extension of time for processing the claim. If the Prescription Plan Manager determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial thirty (30) day period. In no event will the extension exceed a period of fifteen (15) days from the end of the initial thirty (30) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Prescription Plan Manager expects to render the claim determination. If Prescription Plan Manager requires such an extension because you have not provided all the necessary information for the Prescription Plan Manager to decide the claim, you will have forty-five (45) days from the time you receive the extension notice to provide the necessary information.

INITIAL DENIAL NOTICES

The Prescription Plan Manager will provide you with written or electronic notification of any adverse claim determination. In the case of an urgent care claim the notice may be provided orally; however, written or electronic notification will be furnished no later than three (3) days after the oral notification
The notification will set forth:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the determination is based, including any internal Plan rule, protocol or similar criterion;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's claim appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") following an adverse claim determination on appeal; and
5. In case of a claim involving urgent care, a description of the expedited review process applicable to an urgent care claim.

A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request. If the adverse claim determination is based on medical necessity, experimental, investigational or for research purposes, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse claim determination of an urgent care claim, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.

APPEALS FOR ADVERSE PRESCRIPTION CLAIMS DETERMINATIONS

Your Plan Sponsor has provided in the Prescription Plan for you to have a mandatory first (or one) level appeal and a *voluntary* second level appeal to address covered persons' complaints and appeals.

Appeals of adverse Prescription claims determinations will be submitted to the Prescription Plan Manager to process for the Plan Administrator (or his designee) to review and decide the appeal. You (or your authorized representative) have one hundred eighty (180) days following receipt of notification of an adverse claim determination within which to appeal the determination. In connection with your appeal you may submit written comments, documents, records and other information relating to your claim. Upon request you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The determination regarding your appeal will take into account all comments, documents, records and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial claim determination.

You must complete your Plan Sponsor's mandatory first level appeal process prior to initiating a lawsuit under ERISA Section 501(a). You are not required to complete the mandatory first level or the voluntary second level appeal prior to submitting a request for an Independent External Review.

Appeals of adverse claims determinations will be decided by the Plan Administrator promptly. Appeals decisions will not defer to the initial adverse claim determination, and will not be made by the Prescription Plan Manager or subordinate of the Prescription Plan Manager that made the initial adverse claim determination. The appeal determination made by the Plan Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

You may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the adverse claims denial being appealed was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational or for research purposes or not medically necessary, or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the Prescription Plan Manager or subordinate of the Prescription Plan Manager or otherwise the same individual who made the initial adverse claim determination.

HOW TO FILE AN APPEAL

A request for an internal appeal must be submitted in writing within one-hundred-eighty (180) calendar days of receipt of an adverse benefit determination. To initiate an internal appeal, please forward to the Prescription Plan Manager for processing and submission to the Plan Administrator to determine the appeal, the following information:

1. The initial denial letter,
2. The number of prescription claims in question,
3. The date(s) of service,

4. A summary of any previous communication you have had with the Plan, providers or Prescription Plan Manager regarding the prescription claim denial, and
5. Any additional pertinent medical information.

The foregoing information should be sent to the Prescription Plan Manager at the following address:

Appeals Coordinator
Baptist Health Plan
651 Perimeter Drive, Suite 300
Lexington, KY 40517

EXPEDITED APPEALS/URGENT CARE APPEALS

You may request an expedited appeal of an adverse claim determination that involves urgent care. A request for an expedited appeal may be submitted orally or in writing. In such case of oral requests for expedited appeals of an adverse claim determination involving claims for urgent care, the Prescription Plan Manager will provide all necessary information to the Plan Administrator regarding the claim on appeal by telephone, facsimile or other available similarly expeditious method, to the extent permitted by applicable law.

You will be notified of the decision on your expedited internal appeal as soon as possible, taking into account medical requirements, but no later than seventy-two (72) hours for each appeal after the Prescription Plan Manager receives your request for review. If oral notification is given, written notification will follow in hard copy or electronic format within the next three (3) days.

For urgent care claims only, the decision made upon completion of the appeal shall be final and binding on all parties.

An expedited appeal process is available if the claimant is hospitalized, or in the opinion of the treating provider, a review under a standard time frame could, in the absence of immediate medical attention; result in any of the following: (a) place the health of the claimant or, with respect to a pregnant woman, the health of the claimant or the unborn child in serious jeopardy; (b) cause serious impairment to bodily functions or serious dysfunction of a bodily organ or part; (c) subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim; or (d) as related to a recommended or requested service determined to be experimental or investigational, cause the service to be significantly less effective if not promptly initiated.

An expedited appeal determination may be requested orally by contacting the Prescription Plan Manager's Appeals Coordinator at 859.269.4475 or 800.787.2680, but must be followed up with a written request from the claimant's provider to the Appeals Coordinator, Baptist Health Plan, 651 Perimeter Drive, Suite 300, Lexington, KY 40517. If the above criteria are met, the claimant may qualify to proceed with an expedited external review at the same time as an expedited internal appeal.

PRE-SERVICE DETERMINATION

If an appeal involves a pre-service determination (which may include a concurrent care claim reduction or termination), you will be notified of the decision on your appeal within a reasonable period that is appropriate for the claimant's medical condition, but no later than thirty (30) days after the Prescription Plan Manager receives your request for review.

POST-SERVICE DETERMINATION

If your claim involves a post-service determination, you will be notified of the decision on your appeal within sixty (60) days after the Prescription Plan Manager receives your request for review.

APPEAL DENIAL NOTICES

In making its decision with respect to your appeal, the Plan Administrator will not afford deference to the initial adverse determination of your claim. Further, the decision on review will be made by a representative of the Plan Administrator who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual, nor the Prescription Plan Manager. The Prescription Plan Manager will provide you with written or electronic notification of the Plan Administrator's determination with respect to your appeal.

Notice of a benefit determination on appeal will be provided to you by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above and include the following:

1. The specific reason or reasons for the adverse determination;
2. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
3. Reference to the specific Plan provisions on which the determination is based, including any internal Plan rule, protocol or similar criterion;
4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
5. A description of the Plan's claim appeal procedures and the time limits applicable to such procedures,
6. In case of a claim involving urgent care, a description of the expedited review process applicable to an urgent care claim.
7. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") following an adverse claim determination on appeal;

VOLUNTARY SECOND LEVEL APPEALS

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed in "How to File an Appeal." Voluntary appeals must be submitted within sixty (60) calendar days of the denial of the first level appeal. *You are not required to complete a voluntary second level appeal prior to submitting a request for an External Review by an Independent External Review Entity.*

EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ENTITY (IRE)

A request for an external review of an adverse claim determination or denial of coverage by an independent review entity (IRE) may be made by a participant within one-hundred twenty (120) calendar days after exhausting the internal appeal process, if the following conditions are met:

1. The Prescription Plan Manager has rendered an adverse claim determination for lack of medical necessity, or due to the experimental or investigational nature of the requested drug;
2. The participant has completed the Plan's internal appeal process and the Plan Administrator has upheld the adverse claim determination, or has failed to timely decide the appeal or notify the participant of the appeal decision; and

3. The participant was eligible on the date of service, or if a prospective denial, the participant was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed prescription drug was requested.

The participant will, however, be responsible for a $25 filing fee to be paid to the IRE. Please do not send this fee to the Plan or to the Prescription Plan Manager. An external review shall not be afforded if:

1. The subject matter (drug or service) of your adverse claim determination and appeal has previously undergone external review under the Plan's external review process and the IRE found in favor of the Plan; and
2. No relevant new clinical information has been submitted to the Plan since the IRE found in the Plan's favor.

Written requests for external review shall be submitted to the Prescription Plan Manager. As part of the written request, the covered participant must complete an **Independent Review Entity (IRE) Authorization for the Use and Disclosure of Protected Health Information (PHI)** ***form to obtain all necessary medical records from both Baptist Health Plan and any provider utilized for review purposes regarding the decision to deny, limit, reduce, or terminate coverage.***

The Plan will be responsible for the cost of the external review with the exception of the $25 filing fee. External reviews will be assigned to IREs on a rotating basis such that the same IRE is not utilized for two (2) consecutive reviews. The IRE will send a written decision to the participant within twenty-one (21) calendar days of receiving the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the participant and the Plan agree to the extension.

The Prescription Plan Manager has five (5) days from receipt to complete a preliminary review to confirm if:

1. The claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
2. The adverse benefit determination or the final internal adverse benefit determination did not relate to the claimant's failure to meet the requirements for eligibility under the Plan; and
3. The claimant has exhausted the Plan's final internal appeal process or is otherwise not required to exhaust the process before requesting external review.

The Prescription Plan Manager will send out an acknowledgement Notice to you within one (1) day after the preliminary review has been completed.

1. If your request for external appeal review is incomplete, the Notice will describe the information or materials needed to make the request complete. You must perfect the request for external appeal review with complete information within forty-eight (48) hours or within the original one hundred twenty (120) calendar day filing period, whichever is later.
2. If the request is not eligible for external review, the Notice will include the reasons it was not eligible and your right to contact the Employee Benefits Security Administration regarding such matters.

The Prescription Plan Manager must assign the file to an Independent Review Entity (IRE). External review will be assigned in a rotating basis such that the same IRE is not utilized for two (2) consecutive reviews.

The IRE will send acknowledgement to you that they have been assigned to review your appeal and may offer you the opportunity to present additional information.

The IRE will review the following types of information and documents received on a timely basis without regard to any previous decisions or conclusions:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating provider;
4. The terms of the claimant's Plan to ensure that the IRE's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRE's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRE will issue written notice of the final external review decision, as described below, to both you and the Prescription Plan Manager within twenty-one (21) calendar days of receiving the request for external review. An extension of up to fourteen (14) calendar days may be allowed if you and the Plan are in agreement.

EXPEDITED EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ENTITY (IRE)

An expedited external review may be requested orally and followed up by an abbreviated written request by contacting the Prescription Plan Manager. You may be eligible for an expedited external review of your appeal if you are hospitalized, or in the opinion of the treating provider, an external review of the appeal under a standard time frame could, in the absence of immediate medical attention; result in any of the following:

1. Place the health of the participant, or, with respect to a pregnant woman, the health of the participant or the unborn child in serious jeopardy;
2. Cause serious impairment to bodily functions or serious dysfunction of a bodily organ or part;
3. Subject the participant to be in severe pain that cannot be adequately managed without the care or treatment that is subject of the adverse claim determination; or
4. As related to a recommended or requested prescription drug determined to be experimental or investigational, cause the subject prescription drug or drug therapy to be significantly less effective if not promptly initiated.

If the above criteria are met, you may qualify to proceed with an expedited external review at the same time as an expedited internal appeal.

In the case of an expedited external review, the IRE will make a decision within twenty-four (24) hours from receiving all of the information required from the Plan. An extension of up to twenty-four (24) hours may be allowed if the participant and the Plan agree to such extension.

EXTERNAL REVIEW DETERMINATION NOTICE

The determination notice is binding on all parties and will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim including the date or dates of service, the health care provider, the

claim amount (if applicable), the diagnosis code and its corresponding meaning (upon request), the treatment code and its corresponding meaning (upon request), and the reason for the previous denial;
2. The date the IRE received the assignment to conduct the external review and the date of the IRE decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considering in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or established under the Public Health Services Act section 2793.

If the determination is favorable and:
1. It is a pre-service appeal, the Plan will issue the necessary authorization for the service;
   A. It is a post-service appeal, the Plan will promptly process the claim for benefits;
2. If services were rendered by a participating provider, any benefit payment due will be made to the provider directly.

You are responsible for any applicable copayment, coinsurance and/or deductible amount in accordance with the Summary of Benefits.

After a final external review decision, the IRE must maintain records of claims and notices associated with the external review process for six (6) years. An IRE must make such records available for examination by the claimant, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

OTHER RESOURCES TO HELP YOU

For questions about your appeal rights, appeals' notice, or for assistance, you can contact the Employee Benefits Security Administration at 866.444-EBSA (3272). Additionally, a consumer assistance program may be able to assist you by contacting the Kentucky Department of Insurance at P.O. Box 517, Frankfort, KY 40602, 877.587.7222, http://insurance.ky.gov. For plans governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following this review.

EXHAUSTION

Upon completion of the appeals process under this section, a participant will have exhausted his or her administrative remedies under the Plan. If the Plan fails to complete a claim determination or appeal within the time limits set forth above, the participant may treat the claim or appeal as having been denied, and the participant may proceed to the next level in the review process. After exhaustion, a participant may pursue any other legal remedies available to him or her which may include bringing a civil action under ERISA § 502(a) for judicial review of the Plan's determinations. Additional information may be available from a local U.S. Department of Labor Office.

PLAN ADMINISTRATOR DISCRETION

Initial eligibility verification, benefits, and claims determinations will be made by the Prescription Plan Manager. When making such initial determinations, the Prescription Plan Manager does not have authority or discretion to deviate from or otherwise interpret the terms and provisions of the Plan including this summary plan description, or to make any decision with respect to appeals (including expedited appeals) of coverage denials or adverse benefit determinations. Only the Plan Administrator has full and complete discretion and final decision-making authority to determine eligibility for benefits, to construe the terms of the Plan, and to decide any matter presented through the claims and appeals procedures. In the event of a denial of coverage or adverse benefit determination, benefits under the Plan will be paid to a participant only if the Plan Administrator decides in his or her discretion that the participant is entitled to them. Any final determination by the Plan Administrator will be binding upon all parties. If challenged in court, such determination shall not be overturned unless proven to be arbitrary and capricious based upon the evidence considered by the Plan Administrator at the time of the determination.

SCOPE OF PLAN AUTHORITY WITH RESPECT TO CLAIMS

The Plan through the Plan Administrator has full and complete discretionary authority to interpret the terms of the Plan and to finally decide any matters presented as part of the claims procedure. A denial of benefits may be challenged in court only after the claims and claim appeal procedures have been exhausted. If challenged in court, determinations by Plan Administrator shall not be subject to an initial redetermination of the claim but to review only and shall not be overturned unless proven to be arbitrary and capricious based upon the evidence considered by Plan Administrator at the time of the determination.

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

You and the Plan Administrator may also have the right to other voluntary alternative dispute resolution options, such as mediation. To find out more information, contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

If the Plan Administrator fails to follow the claims procedures as outlined above, you have the right to bring a civil action in court. In the case of a medical claim (other than a claim based on eligibility) you have the right to go directly to the external review process.

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Lexington Fayette Urban County Government Employee Plan

   Common Name of Plan: Lexington Fayette Urban County Government

2. Plan Sponsor and Employer: Lexington Fayette Urban County Government
   200 E. Main Street
   Lexington, KY 40507
   Telephone: 859-258-3000

3. Plan Administrator, Named Fiduciary and Claim Fiduciary:

   Lexington Fayette Urban County Government
   200 E. Main Street
   Lexington, KY 40507
   Telephone: 859-258-3000

4. Employer Identification Number: 61-0858140.

   The Plan number assigned for government reporting purposes is: 516

5. The Plan provides prescription drug benefits for participating employees and their enrolled dependents.

   Plan benefits described in this SPD are effective January 1, 2016.

   The Plan year is January 1 through December 31 of each year.
   The fiscal year is July 1 through June 30 of each year.

6. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

   Janet Graham, Commissioner of Law
   200 E. Main Street
   Lexington, KY 40507

7. The Prescription Plan Manager is responsible for performing certain delegated administrative duties, including the processing of prescription claims and handling prescription drug appeals.

   Baptist Health Plan
   651 Perimeter Drive, Suite 300
   Lexington, KY 40517
   Telephone: Refer to your ID card

   The Prescription Plan Manager through its medical directors may from time to time act as a consultant to the Plan Administrator for purposes of coordinating pharmacy services available

under the Plan to maximize Plan benefits. However, the Prescription Plan Manager does not make decisions of any kind with respect to your prescription benefits, or determine whether a prescription you or your provider may request is a covered expense for which benefits are available under the Plan. **Only the Plan Administrator has authority** to determine coverage of a requested prescription by the Plan.

8. This is a self-insured and self-administered prescription benefit Plan. The cost of the Plan is paid with contributions shared by the employer and employee. Benefits under the Plan are provided from general assets of the employer and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see your employer for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

9. Each employee of the employer who participates in the Plan receives a Summary Plan Description (SPD), which is this SPD. This SPD will be provided to employees by the employer. It contains information regarding eligibility requirements, termination provisions, and a description of the benefits provided and other Plan information.

10. The Plan benefits and/or contributions may be modified or amended from time to time and at any time may be terminated by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

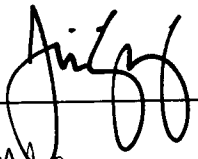
11. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating employees and their dependents covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

12. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

13. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

SIGNATURE PAGE

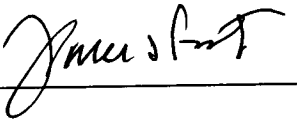
LEXINGTON FAYETTE URBAN COUNTY GOVERNMENT

By: 

Title: Mayor

Date: 3-Dec-2015

BAPTIST HEALTH PLAN, INC. PRESCRIPTION PLAN MANAGER

By: 

Title: President

Date: 5.9.16

SUMMARY OF BENEFITS ADDENDUM – 1/1/16

LFUCG PPO 1 and 2 Plan	On-Site Retail Pharmacy 30-day Supply	In-Network Retail Pharmacy 30-Day Supply	Express Scripts Home Delivery 90-Day Supply
Generic Drugs	$3	$10	$20
Preferred Brand-Name Drugs	$15	$30	$60
Non-Preferred Brand-Name Drugs	$30	$60	$120
Note: PPO Plans have a Separate Prescription Max out of Pocket: Single $2,000/Family $4,000			

LFUCG HSA 1 Plan	On-Site Retail Pharmacy 30-day Supply	In-Network Retail Pharmacy 30-Day Supply	Express Scripts Home Delivery 90-Day Supply
Generic Drugs	All Prescriptions are subject to Deductible & Coinsurance Deductible: Single $2,600/Family $5,200 Coinsurance after Deductible: 0%		
Preferred Brand-Name Drugs			
Non-Preferred Brand-Name Drugs			
Note: HSA 1 Plan has a Max out of Pocket That is Combined with Medical Claims: Single $2,600/Family $5,200			

LFUCG HSA 2 Plan	On-Site Retail Pharmacy 30-day Supply	In-Network Retail Pharmacy 30-Day Supply	Express Scripts Home Delivery 90-Day Supply
Generic Drugs	All Prescriptions are subject to Deductible & Coinsurance Deductible: Single $2,600/Family $5,200 Coinsurance after Deductible: 20%		
Preferred Brand-Name Drugs			
Non-Preferred Brand-Name Drugs			
Note: HSA 2 Plan has a Max out of Pocket That is Combined with Medical Claims: Single $5,000/Family $10,000			

Out-of-Network Pharmacies are not covered for any Prescription Plan.
You must use a Participating Pharmacy to access your Prescription benefits.