

**CAREMARK RX, INC.**

**FLEXIBLE BENEFIT PLAN  
(OUT-OF-AREA PLAN)**

**JANUARY 1, 2007**

*Flexible Benefit Plan (Out-Of-Area Plan)  
Effective January 1, 2007*

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## INTRODUCTION

Caremark Rx, Inc. (“Caremark”) has prepared this document to help you understand your benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions which require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section.

As used in this document, the word *year* refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.

Any amount you or your eligible dependents have accumulated toward the benefit maximum amounts of any previous Caremark Rx, Inc. plan will be counted toward the benefit maximum amounts of this plan. In addition, any time accumulated toward satisfaction of a waiting period under the previous plan will be counted toward satisfaction of the waiting period of this plan.

Caremark Rx, Inc. intends the plan to be permanent, but since future conditions affecting your *employer* cannot be anticipated or foreseen, Caremark Rx, Inc. reserves the right to amend, modify or terminate the plan in any manner, at any time, which may result in the termination or modification of your coverage. If the plan is terminated, any plan assets will be used to pay for eligible expenses incurred prior to the plan’s termination, and such expenses will be paid as provided under the terms of the plan prior to its termination.

Benefits described in this document are effective January 1, 2007.

## **ELIGIBILITY AND PARTICIPATION**

### **Who Is Eligible**

You are eligible to participate in this plan if you are a regular employee on the U.S. payroll of an included business unit for at least 1 complete calendar month and your standard hours to work are at least 20 hours per week. You are not eligible if you are a member of a collective bargaining unit (unless it is part of your bargaining agreement), or if you are a temporary employee. COBRA eligible individuals are also eligible to enroll in the medical plans. Eligibility for *Medicaid* or the receipt of *Medicaid* benefits will not be taken into account in determining eligibility.

Your eligible dependents may also participate. Eligible dependents include: your lawful spouse as defined by applicable state law; your domestic partner; your unmarried, dependent children to age 19 (including natural children, stepchildren and children who, before reaching the age of 18, have been legally adopted by you); your dependent children from age 19 to age 25, if enrolled as a full-time student; and your dependent, *incapacitated* children (only if *incapacitated* prior to age 19).

You may not participate in this plan as an employee and as a dependent, and your dependents may not participate in this plan as a dependent of more than one employee.

If your *employer* determines that your separated or divorced spouse or any state child support or *Medicaid* agency has obtained a legal qualified medical child support order (QMCSO), through a court order or an administrative process established under state law, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that you provide health coverage for your child(ren) and you do not enroll the child(ren), your *employer* must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or *Medicaid* agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your *employer* that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). The *plan administrator* has discretion to adopt procedures to determine if a child support order satisfies the requirements of a QMCSO. If you are not enrolled for coverage, you will be required to enroll along with the child and your share of the cost of such coverage will be withheld from your pay.

### **Who Pays For Your Benefits**

Caremark shares the cost of providing benefits for you and your dependents. From time to time, Caremark may adjust the amount of contributions required for coverage. In addition, the deductibles, coinsurance and co-payments may also change periodically. You will be notified of any changes in the cost of plan coverage before they take effect.

### **General Enrollment Requirements And Election Information**

You must enroll within the time frame specified on your Personal Report. If you also desire dependent coverage, you must enroll your eligible dependents at this time. You must enroll via the Caremark Employee Self Service website.

## **General Enrollment Requirements And Election Information** (continued)

If you enroll a domestic partner, you will be required to complete a Domestic Partner Affidavit Form and return it to the Caremark Benefits Center within 31 days of your enrollment. If you enroll a dependent child between the ages of 19 and 25, you are required to validate full-time student status during your enrollment process. If you enroll an *incapacitated* dependent child, you are required to complete an Incapacitated Child Form and return it to the Caremark Benefits Center within 31 days of your enrollment. You will be required to obtain and provide your *employer* with a birth date and Social Security number for each covered dependent.

If you do not have eligible dependents, including newborns, at the time of your initial enrollment and acquire them at a later date, you may enroll them within 31 days of the date you acquire them by contacting the Caremark Benefits Center. If your newborn child is properly enrolled, coverage will begin on the date of the child's birth.

You are allowed to change your enrollment elections during a *plan year* if you have a change in status. If you have a qualifying change in your status, you may change your enrollment decision within 31 days of the change in status by calling the Caremark Benefits Center at 1-888-769-1717 and following the applicable instructions. Your change will only be accepted if it is reported to the Caremark Benefits Center. Your change in enrollment election must be consistent with your change in status. In other words, you may only change your election if the change in status causes you, your spouse or your child to gain or lose eligibility for coverage under this or another plan, and the election change must correspond with the effect on coverage. If you decide to change from one plan option to another, you will only be able to do so during the annual enrollment period.

A qualifying change in status includes: marriage; divorce; legal separation; annulment of marriage; death of spouse or child; birth; adoption; dissolution of domestic partnership; termination or commencement of employment by you, your spouse or your child; a reduction or increase in hours of employment for you, your spouse or your child (defined as a switch between part-time and full-time, a strike, lockout, or commencement or return from an unpaid leave of absence); a change in dependent status for your child; a change in residence that affects your plan eligibility; a significant change in cost or a significant curtailment of health coverage for you, your spouse or your child; a special enrollment event under the Health Insurance Portability and Accountability Act (HIPAA) for you, your spouse or your child; you or the plan receives a QMCSO; or you, your spouse or your child becomes entitled to either *Medicaid* or *Medicare*.

## **When Coverage Begins**

### Newly Eligible Employees

Newly eligible employees must satisfy a waiting period before benefits can become effective. If you are a newly eligible employee, your benefits will become effective on the first day of the month following 1 complete calendar month of "benefits eligible" employment. For example, if your hire date is February 1, your benefits become effective March 1; if your hire date is February 2, your benefits become effective April 1.

### Employees Changing From Benefits Ineligible To Benefits Eligible

If you are an employee changing from "benefits ineligible" to "benefits eligible" status, your benefits will become effective on the first day of the month following 1 complete calendar month of "benefits eligible" employment. This 1-month waiting period begins on the date you become "benefits eligible" or the date you have a change in status.

## **When Coverage Begins** (continued)

### Dependents

Coverage for your dependents begins the later of when your coverage begins or the first day a dependent is legally acquired, if properly enrolled.

### **Special Enrollments**

If you decline coverage under this plan for yourself or your dependents because of other health plan coverage, you may be required to provide written notice to the plan that you are declining coverage due to the existence of other coverage. If such other health plan coverage is subsequently terminated due to: (a) a loss of eligibility for such coverage (loss of eligibility does not include a loss due to: failure to pay premiums when due; failure to exhaust COBRA continuation coverage, if elected; or causes such as making a fraudulent claim or misrepresentation); or (b) termination of any company contributions for such coverage, then you and/or your eligible dependents may enroll in the plan. To enroll, you must call the Caremark Benefits Center within 31 days of the loss of the other coverage or termination of company contributions and follow the applicable instructions.

In addition, if you acquire a new dependent as a result of marriage, birth or adoption, you and/or your eligible dependents may enroll in this plan. To enroll, you must call the Caremark Benefits Center and complete and return any required forms within 31 days of the date of the marriage, birth or adoption and follow the applicable instructions.

Newborns and adopted children are covered retroactive to the date of birth or adoption if enrolled within 31 days of the status change.

### **Late Enrollments**

If you or your dependents are not enrolled within the time frame specified on your Personal Report or within 31 days of a special enrollment date, you may enroll for coverage only during the annual enrollment period.

### **HIPAA Certificate Of Creditable Coverage**

If you leave this plan a HIPAA Certificate of Creditable Coverage will be provided showing your coverage. (If you or your dependents elect COBRA coverage as noted in that section a second Certificate of Creditable Coverage will be provided when the COBRA coverage terminates.) The plan must also give you the certificate at any other time you request it while you are covered or up to 24 months after your coverage ends. You should contact Coventry Health Care for assistance in requesting and obtaining a certificate of coverage. If you become covered by a plan that has a pre-existing condition exclusion, you may use the certificate to show your new plan how long you had coverage under this plan.

## **When Coverage Ends**

Your coverage ends the earliest of the end of the month in which your employment with Caremark ends, the end of the month in which you are no longer eligible to participate in this plan or the date the plan ends.

Coverage for your dependents ends the earliest of the end of the month in which your coverage ends, the date a dependent no longer meets the eligibility requirements or the date the plan ends.

## **Special Situations, Extensions Of Coverage**

### Family Medical Leave Act (FMLA)

If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), eligibility may continue for the duration of the leave if you pay any required contributions toward the cost of the coverage. Your *employer* has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your *employer* will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA. Coverage continued under this provision is in addition to coverage continued under Optional Continuation of Coverage (COBRA).

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), coverage for you and your eligible dependents will be automatically reinstated on the date you return to *active employment* if you and your dependents are otherwise eligible under the plan. Any waiting periods will not apply. However, all accumulated annual and *lifetime* maximums will apply.

### Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you were covered under this plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed service leave, whichever is shortest, if you pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage continued under Optional Continuation of Coverage (COBRA).

Whether or not you elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act, coverage will be reinstated on the first day you return to *active employment* with Caremark if you are released under honorable conditions and you return to employment: on the first full business day following completion of your military service for a leave of 30 days or less; within 14 days of completing your military service for a leave of 31 to 180 days; or within 90 days of completing your military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an *illness* or *injury* determined by the VA to be service connected will be allowed).

## **Special Situations, Extensions Of Coverage** (continued)

When coverage under this plan is reinstated, all provisions and limitations of this plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this plan. The eligibility waiting period will be waived. (This waiver of limitations does not provide coverage for any *illness* or *injury* caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your *employer*.)

## **Reinstatement Of Coverage**

If you are a benefits eligible employee who terminates employment for any reason and are rehired in a benefits eligible status within 6 months, coverage may be reinstated on the first day of the month following your rehire. You will be required to make new elections. All accumulated annual and *lifetime* maximums will apply.

If you are a benefits eligible employee rehired in a benefits eligible status after 6 months from your termination date, you must satisfy the waiting period and make new elections.

## **PROVIDER NETWORKS**

Caremark Rx, Inc. has selected Coventry Health Care to provide services for its health care plan.

The plan uses a *preferred provider organization (PPO)*, whose name appears on your plan identification card. A *PPO* is a group of *health care providers* that has agreed to provide medical care services at a contracted rate through the *PPO*. Because the contracted rate results in savings to both you and the plan, you are reimbursed at a higher level if you use *PPO* providers. *PPO* providers are also referred to as a “network” or “network providers.” The terms “non-network” or “out-of-network” refer to *health care providers* that do not participate in the *PPO*.

Network providers include *hospitals, physicians, outpatient* facilities and other ancillary *health care providers*. The *PPO* directory lists *hospitals* and *physicians* that are available through the network. This free directory will be provided to you in an electronic format upon your enrollment in the plan. Network providers can be found in two ways: 1) by calling Coventry Health Care toll-free at 1-800-272-8931, any time, day or night; and 2) via the Internet, by logging on to [www.mycoventryhealth.com](http://www.mycoventryhealth.com). Enter the login ID: **CMB**.

When seeking health care, please note that the plan is structured so that you have the lowest out-of-pocket cost for your health care coverage when network providers are used. You have the flexibility of seeking care directly from any type of network provider, including specialists. For most visits, simply choose the network *physician* preferred and make an appointment when care is needed. You may also seek care from a non-network provider. However, it is important to note that when using a non-network provider, the plan’s coinsurance may be reduced as outlined on the Schedule of Medical Benefits, which will increase the amount you must pay. The final choice of *health care providers* is always up to you. Some plan benefits may be offered only through the network. Please refer to the Health Care Management Services section of this plan to determine if you need to give prior notification of services before seeing your provider.

Providers in the network will maintain traditional *health care provider/patient* relationships with you and/or your dependent(s) for the provision of *hospital* and other medical services. Such relationships include the right of providers in the network to commence or terminate treatment in accordance with generally accepted principles of medical practice and treatment. Nothing contained in this plan will require a provider in the network to commence or continue medical treatment for you or your dependent(s), and nothing contained in this plan will require you or your dependent(s) to commence or continue medical treatment with a particular provider in the network. Further, nothing in this plan will limit or otherwise restrict a *physician’s* medical judgment with respect to his/her ultimate responsibility for patient care in the providing of medical services to you and/or your dependent(s).

## **HEALTH CARE MANAGEMENT SERVICES**

### **What Is Health Care Management?**

Caremark desires to provide you and your family with a health care benefit plan that financially protects you from significant health care expenses while helping you obtain quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Caremark has contracted with Coventry Health Care to identify and assist individuals with conditions requiring extensive or long-term care. The program is not intended to diagnose or treat medical conditions, guarantee benefits, make payments or validate eligibility for plan coverage. The program focuses on making recommendations regarding the appropriateness and *medical necessity* of specified health services. The final medical decisions regarding treatment are always made between you and your treating *physician*.

Health care management services include a number of components explained in more detail below. These components include: prior notification and certification requirements for *inpatient* services, certain *outpatient* imaging services and *mental/nervous disorders*; case management services for serious or extended *illnesses*; voluntary maternity services; round-the-clock support; and the Coventry Transplant Network.

### **Prior Notification Requirements**

You are required to call Coventry Health Care's Member Services toll-free number (1-800-272-8931) for the following:

- All *inpatient* admissions (other than maternity), including any elective admission to a *hospital*.
- Before an *inpatient* admission for back *surgery*.
- All bariatric *surgery*, prior to selecting a Bariatric Surgery Network surgeon or scheduling any pre-surgical evaluations or testing.
- Within 48 hours (2 calendar days) of any emergency admission.
- Before receiving *inpatient* treatment for chemical dependency/substance abuse or a *mental/ nervous disorder*.
- Prior to receiving your 4th visit for *outpatient* treatment for chemical dependency/substance abuse or a *mental/nervous disorder*. However, you should contact Coventry Health Care prior to the first visit for assistance with locating network providers.
- When a maternity stay extends beyond 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery.
- All human organ and tissue transplants prior to selecting a transplant facility or scheduling a pre-transplant evaluation.
- For the following *outpatient* services: CT scans, MRIs, MRAs, PET scans and more than 2 ultrasounds per pregnancy.

## **Prior Notification Requirements** (continued)

You may call at any time, day or night. When you call Coventry Health Care, it will be necessary to provide your name, the patient's name, the name of the *physician* and *hospital* or facility, the reason for the hospitalization and any other information needed to complete the review, as determined by Coventry Health Care. You will be advised if certification of *medical necessity* is required for the proposed services. If so, the certification process described in the following section will be started immediately. It is your responsibility to obtain the cooperation of the *physician* in the program.

## **Certification And Non-Certification**

Coventry Health Care may review a proposed service and evaluate whether it is *medically necessary*. If it is determined to be *medically necessary*, you and your providers will receive a Notice of Certification. If Coventry Health Care does not recommend that the proposed services are *medically necessary*, you and your *physician* will receive a Notice of Clinical Non-Certification. The notice will describe why the proposed services were non-certified and will describe how to appeal the non-certification (See the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section).

Depending on the proposed service and the health of the participant, Coventry Health Care will respond in a timely and appropriate manner. Requests for certification fall into one of two categories. Based on the categorization of the request, Coventry Health Care will respond orally or in writing within the prescribed times. The categories of requests for certification are:

### Request For Certification Involving Urgent Care

This involves a request for certification of proposed services to which the application of the time periods for making non-urgent care certifications: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a *physician* with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

### Request For Certification Involving Non-Urgent Care

This comprises a request for certification of proposed services which do not involve urgent care.

After you or your *health care provider* have made a request for certification which does or does not involve urgent care, Coventry Health Care may provide a Notice of Certification, a Notice of Clinical Non-Certification, or ask that you or your *authorized representative* provide additional information. The time periods for these actions to be completed by either you or Coventry Health Care are as follows:

**Certification And Non-Certification** (continued)

<b><u>REQUEST INVOLVING URGENT CARE</u></b>	<b><u>RESPONSE TIME</u></b>
Coventry Health Care to request additional information .....	24 hours from your initial request for certification
Coventry Health Care to notify you of failure to follow certification procedures.....	24 hours from your initial request for certification
You or your authorized representative to provide Coventry Health Care with additional information .....	48 hours from time request is made by Coventry Health Care
Coventry Health Care to provide Notice of Certification or Notice of Clinical Non-Certification .....	72 hours from your initial request for certification

<b><u>REQUEST INVOLVING NON-URGENT CARE</u></b>	<b><u>RESPONSE TIME</u></b>
Coventry Health Care to request additional information .....	15 days from your initial request for certification
Coventry Health Care to request an additional 15 days when matters beyond its control have delayed its ability to review the request.....	15 days from your initial request for certification
Coventry Health Care to notify you of failure to follow certification procedures.....	5 days from your initial request for certification
You or your authorized representative to provide Coventry Health Care with additional information .....	45 days from date request is made by Coventry Health Care
Coventry Health Care to provide Notice of Certification or Notice of Clinical Non-Certification.....	15 days from your initial request for certification

The time periods above are not cumulative, but instead run concurrently. However, if Coventry Health Care requests additional information, the time periods above for providing the Notice of Certification or Notice of Clinical Non-Certification will be delayed. When the requested information is received by Coventry Health Care, the time period to provide the appropriate notice will resume as of the date the information was first requested by Coventry Health Care.

For example, if Coventry Health Care requested additional information on the 5<sup>th</sup> day after receipt of a certification request for non-urgent services, Coventry Health Care has the remaining 10 days in the original 15-day period to provide the appropriate notice after receiving the information it requested from you. Regardless of any delays in this process, the decision whether to receive a proposed health care service is always yours, in consultation with your *physician*.

## **Certification And Non-Certification** (continued)

If you or your dependent are hospitalized or receive other health care services without meeting the notification requirements, notification may be made during the *hospital* confinement or delivery of other services. If the confinement or other service is determined to be *medically necessary*, the preceding days of *hospital* confinement or other service will not be penalized. Remaining days of *hospital* confinement or other services, if certified, will not be penalized if the confinement or other service is deemed *medically necessary*.

If services are proposed to extend beyond the period for which certification is given, Coventry Health Care will initiate further *medical necessity* review prior to the receipt of additional services. If you, your dependent or the *physician* request services beyond the period for which certification is given, an extension request should be made no later than 24 hours before the end of the period. Coventry Health Care will review the request and provide an oral or written Notice of Certification or Notice of Clinical Non-Certification within 24 hours of receipt of the request if it is a request involving urgent care, or if it is a reduction or termination of services previously certified.

If Coventry Health Care does not receive adequate information to properly evaluate whether the proposed services are *medically necessary*, you and your *physician* will receive a Notice of Additional Information Needed. This notice will describe what information is needed. You must submit the information requested as soon as possible, but no later than 45 days upon receipt or a notice will be issued showing a non-recommendation based on a lack of information provided. You may choose to resubmit the request for certification with the requested information. Also, please see the “How To Appeal A Denial Of Benefits Or Clinical Non-Certification” section if a Notice of Clinical Non-Certification is issued.

- The decision whether to receive a proposed health care service is always yours, in consultation with your *physician*, and will be at your expense if not covered under this plan.
- Prior to payment of benefits, Coventry Health Care may retrospectively review for *medical necessity* any services provided but not previously certified or reviewed. This will apply even if you or your dependent has made a request for certification, but Coventry Health Care did not provide a Notice of Certification or a Notice of Clinical Non-Certification because the necessary information was not provided. However, you will not be penalized for failure to follow required notification procedures.
- Certification is not a guarantee that benefits are payable by this plan. Also, certification does not substitute for filing a claim with the plan, if necessary. Payment of benefits is subject to all plan provisions, limitations and exclusions. In addition, verification of coverage does not fulfill certification requirements nor does it guarantee payment of benefits. If you are uncertain about whether certification is required for proposed services, please call Coventry Health Care at 1-800-272-8931.

## **Reduced Benefits For Failure To Follow Required Notification Procedures**

If you follow the notification and certification requirements outlined above, your benefits will be unaffected, and you and the plan avoid expenses related to unnecessary health care. However, if you do not follow the procedures required by this plan, the plan's payment will be reduced by \$400 for all related covered *hospital* expenses, after any applicable deductible. For *outpatient* imaging services (e.g., MRI, MRA), the plan's payment will be reduced by \$400 for all related covered expenses, after any applicable deductible. For bariatric *surgery* and *outpatient* treatment of a *mental/nervous disorder* or substance abuse, expenses will be denied if you do not follow the procedures required by this plan. This will not apply to situations where a *medical emergency* results in your inability to follow the notification and certification requirements prior to receiving care. You, your dependent or the *physician* should provide notification as soon thereafter as possible.

The penalty assessed when you do not follow the notification and certification procedures required by the plan does not apply toward your out-of-pocket maximum.

## **Case Management**

If you or your dependent have a serious or extended care *illness* or *injury*, a case manager may assist in identifying and coordinating appropriate and cost-effective medical care alternatives. The case manager may also coordinate communication among you and all *health care providers* involved in your or your dependent's care.

Plan benefits may be modified by the *plan administrator* to permit a method of treatment not expressly provided for, but not prohibited by law, rules or public policy, if the *plan administrator* determines that such modification is *medically necessary* and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The modified benefits will be coordinated with you and your treating *physician*. The intent of the modified benefits is to provide you with maximum coverage under the plan. The *plan administrator* also reserves the right to limit payment for services to those amounts which would have been charged had the services been provided in the safest and most cost-effective setting available.

## **Specialized Maternity Program**

The primary objective of the specialized maternity program is to identify high-risk pregnancies to promote positive outcomes for the mother and baby, and to assist in coordinating cost-effective care. You are encouraged to call Coventry Health Care's Member Services toll-free number at 1-800-272-8931 during the first trimester of your pregnancy; however, you may call at any time during your pregnancy. When you call, a *nurse* will ask you questions about your general health and medical history. This information may be provided to your *physician* or *practitioner* and will help determine whether a Coventry Health Care *nurse* can provide you with additional support during and/or after your pregnancy.

If appropriate, a case manager will follow your case, recommend specialists and/or facilities when applicable, and coordinate communication among you and all *health care providers* involved in your care.

The specialized maternity program is an optional service provided for your benefit. The plan's coinsurance will not be reduced if you choose not to participate.

## **Round-The-Clock Support**

You may call Coventry Health Care Member Services at the toll-free number (1-800-272-8931) at any time, day or night, to: initiate the certification or notification process; obtain assistance in locating network providers; obtain general health care information; or have your questions about health care issues answered. A *nurse* will provide you with information about your condition, self-care and, if necessary, suggest the names of network providers from whom you may seek health care.

This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. This service is not meant to replace *physician* care. If you require medical care, please be sure to see your *physician* or *practitioner*.

## **Lab Savings Program**

The Lab Savings Program is a voluntary program that provides maximum benefits for covered lab services. This program provides covered *outpatient* laboratory services at no out-of-pocket cost to you when Quest Diagnostics Inc. performs the testing. If your *physician* draws the blood and forwards to Quest, the *physician's* charges for the office visit and blood draw fall under the normal plan provisions (*physician* office visit, for example).

To obtain 100 percent laboratory benefit coverage Quest Diagnostics must process all lab testing. You will have to inform your *physician* or *practitioner* that you want Quest Diagnostics used for the lab processing. If your *physician/practitioner* doesn't use a Quest Diagnostics service facility, you can request a prescription for the lab tests and go to a Quest facility. You can locate the nearest Quest facility by calling 1-800-272-8931, or visiting our Web site at [www.mycoventryhealth.com](http://www.mycoventryhealth.com).

## **Bariatric Surgery Benefits**

Bariatric *surgery* is provided as a benefit to qualified participants who suffer from the diagnosed condition of *morbid obesity* and meet the minimum qualifications for coverage. You may be required to complete certain pre-surgical evaluations such as psychological, nutritional, cardiac or exercise evaluations, as determined by your bariatric surgeon, to establish whether you are a good candidate for this *surgery*. Only those surgical procedures that are covered and certified as *medically necessary* will be eligible under the plan. You are required to follow the plan's pre-certification procedures (see Prior Notification Requirements) or benefits will be denied. Prior to selecting a surgeon, you must call Coventry Health Care for assistance with locating Bariatric Surgery Network providers and to determine if you meet the initial criteria for surgical care.

Please note that not every surgeon who participates in the national network also participates in the Bariatric Surgery Network. If you choose a surgeon who is not participating in the Bariatric Surgery Network, benefits will be denied. The plan does not reimburse travel and lodging, so you will be responsible for all non-medical expenses related to your care. In most cases, you will need to schedule a 5-day stay in the area following your release from the *hospital* for follow-up visits with your surgeon.

### Post-Surgical Care

The goal for weight loss *surgery* is to allow individuals to live a higher quality, healthier and longer life. The *surgery* itself, however, is only a tool to help you achieve this goal. Success requires a commitment to follow the recommended dietary, exercise and lifestyle changes. Your bariatric center will offer support groups and other programs that will help you succeed following the *surgery*. Any covered medical services after your *surgery*, including complications from the *surgery*, for up to 1 year following the date of *surgery*, will be considered part of the original *surgery* and subject to the lifetime benefit maximum as outlined on the Schedule of Bariatric Surgery Benefits.

**ACCORDANT HEALTH MANAGEMENT**  
**(Formerly CarePatterns)**

The Accordant Health Management Programs (800-227-3728) offer comprehensive support to you and your doctor through individualized participant education and counseling, as well as ongoing monitoring of your health by trained clinical educators for the following diseases:

- Asthma
- Pediatric Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Musculoskeletal Pain
- Headache
- Heart Failure
- Depression
- Hypertension
- Peptic Ulcer

You will be contacted and welcomed to the program by Accordant Health Management Services staff if you are identified as a potential candidate for this benefit. Participants have the option of “opting out” if they choose not to participate.

Two new programs will be available to Caremark employees on an “opt-in” basis beginning in 2007. This means the programs are available to employees who are interested and determine they would like to participate. The programs are:

- Weight Management – Modest weight loss can improve blood pressure, blood sugar, cholesterol levels and overall health. This new program is a web-based program which allows participants to create individualized goals, menus and exercise plans in addition to providing educational support as needed for individuals who are interested in losing weight. Participants have access to Accordant Health Management nursing staff as needed.
- Tobacco Cessation Program – This structured program provides telephone counseling and web-based support by trained tobacco addiction counselors to participants who are interested in improving their health through the elimination of tobacco products. The program include over-the-counter nicotine replacement products for a limited time period.

## **COVENTRY TRANSPLANT NETWORK**

### **What Is The Coventry Transplant Network?**

Caremark provides you and your family with a human organ and tissue transplant benefit that helps you obtain quality care and financially protects you from significant health care expenses. The Coventry Transplant Network (CTN) provides transplant services through a special network of transplant facilities. It is designed to help you obtain the transplant services that are appropriate for you and eligible for reimbursement under this plan. It includes case management and may include some services not otherwise covered by this plan. The medical professionals who conduct the program focus their review on the appropriateness of the proposed transplant procedures. Only those procedures that are covered and certified as *medically necessary* will be eligible under the plan.

Please note that because transplantation is a highly specialized area, not all network *hospitals* are part of the Coventry Transplant Network. To receive the Coventry Transplant Network benefits and maximums, this must be your primary plan for payment of benefits. When this plan is secondary, expenses will be denied.

### **Required Review Procedures**

To enroll for the Coventry Transplant Network benefits, you are required to call Coventry Health Care Member Services at 1-800-272-8931 as soon as the possibility of a transplant is discussed with your *physician*. When you call, it will be necessary to provide the program with all information needed to complete the review. This call will also satisfy the prior notification requirements as outlined in the Health Care Management Services section of this plan. In order to receive benefits, you must choose one facility within the special network of transplant facilities. Transplant-related services must be received at the facility you choose in order to be covered under the Coventry Transplant Network benefit. All transplant benefits, including pre-transplant evaluation expenses (even if the transplant does not occur), will be provided by the plan as outlined on the Schedule of Transplant Benefits.

### **Reduced Benefits For Failure To Follow Required Review Procedures**

When the required review procedures for the Coventry Transplant Network are followed and you use one of the designated transplant facilities, your benefits will be unaffected, and you and the plan avoid unnecessary expenses. However, if a transplant procedure is not performed at a Coventry Transplant Network facility, no coverage will be provided for the transplant, including any organ donor costs or travel, lodging and meal expenses.

## **Covered Transplants**

When all of the provisions of the Coventry Transplant Network are satisfied, the plan will provide benefits as outlined on the Schedule of Transplant Benefits. The types of transplants may include:

- Allogenic bone marrow/peripheral stem cell transplantation.
- Autologous bone marrow/peripheral stem cell transplantation.
- Heart transplantation.
- Heart/lung transplantation.
- Lung transplantation.
- Liver transplantation.
- Kidney transplantation.
- Kidney/pancreas transplantation.
- Pancreas transplantation.
- Intestinal/small bowel transplantation.

## **Covered Transplant Services**

- Pre-transplant evaluation.
- Acquisition/procurement of organ(s), stem cells or bone marrow.
- Transplant procedures and associated hospitalization.
- Transplant-related follow-up care provided by the designated transplant facility for the duration of the transplant contract.
- Pharmacy supplies and services provided by the Coventry Transplant Network facility for immunosuppressant and other transplant-related medications while hospitalized.
- Donor expenses, if not covered under any other plan.
- Transplant-related services provided by the Coventry Transplant Network facility that are associated with the transplant events listed above, including laboratory and other diagnostic services.
- *Physician* services related to the transplant events listed above.

### **Covered Transplant Services (continued)**

- Travel and lodging expenses if the recipient plus one other person (both parents, if recipient is under age 19), and the living donor (if applicable) live greater than 50 miles one way from the designated facility. Air travel is recommended when the recipient plus one other person (both parents, if recipient is under age 19) and the living donor (if applicable) live greater than 150 miles one way from the designated facility. Eligible auto mileage will be reimbursed as determined by the IRS. Car rentals are not covered. Your case manager may be able to assist you with travel arrangements.
- The recipient may be approved for travel to the approved facility where the transplant was performed for all transplant-related services required for 12 months following discharge of the recipient from the facility.

### **Transplant Services Not Covered**

- Services, supplies, drugs and aftercare for, or related to, artificial or non-human organ implants or transplants.
- Services that are considered *investigational/experimental* or not *medically necessary*.
- Expenses for services which are specifically excluded under the Medical Expenses Not Covered section of this plan, unless a part of a treatment plan approved through the Health Care Management Services case management program.

## **GENERAL INFORMATION ABOUT YOUR MEDICAL BENEFITS**

All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood.

### *Medical Necessity*

Generally speaking, most medical insurance plans are governed by rules regarding what is considered *medically necessary*. In most cases, if a treatment is not considered *medically necessary*, as defined by the plan, the treatment will be denied. It is important for all plan participants to understand the definition of *medically necessary/medical necessity*, so that they may make the best decisions regarding their treatment plan. In addition, the treatment must not be *investigational/experimental*.

### *Usual And Customary Charges (U&C)*

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the plan for any purpose. *U&C* does not apply to network providers.

### *Health Care Providers*

The plan provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital or specialized treatment facility* as those terms are specifically defined in the Definitions section.

### *Custodial Care*

The plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

### *Benefit Year*

The word *year*, as used in this document, refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*.

## **Deductibles**

A deductible is the amount of covered expenses each covered individual must pay during each *year* before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *year*.

The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits.

## **Co-Payments**

Co-payments (sometimes referred to as co-pays) are the first-dollar amounts you must pay for certain covered services under the plan which are usually paid at the time the service is performed (i.e. *physician* office visits or emergency room visits). These co-payments do not apply to your annual deductible or out-of-pocket maximum.

The co-payment amounts are shown on the Schedule of Medical Benefits.

## **Coinsurance**

Coinsurance represents the portion of covered expenses paid by the plan and by you after you have satisfied any applicable deductible. For non-network providers, these percentages apply only to covered expenses which do not exceed *usual and customary charges*. You are responsible for all remaining covered and non-covered expenses, including any amount which exceeds the *usual and customary charge* for covered expenses.

Use of the term “coinsurance” in this plan document does not imply that Coventry insures the plan. The plan is offered by Caremark Rx, Inc. on a self-insured basis, and Caremark Rx, Inc. is solely responsible for all plan payments. Coventry acts as the *contract administrator* and is not financially responsible for any benefits under the plan.

The coinsurance percentages are shown on the Schedule of Medical Benefits.

## **Out-Of-Pocket Maximums**

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a *year*, excluding the deductible, before the plan’s coinsurance increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches the annual out-of-pocket maximum, the plan will pay 100% of additional covered expenses for that individual during the remainder of that *year*.

The family out-of-pocket maximum applies collectively to all covered persons in the same family. When the annual family out-of-pocket maximum is reached, the plan will pay 100% of covered expenses for any covered family member during the remainder of that *year*.

However, expenses for services which do not apply to the out-of-pocket maximum will never be paid at 100%.

The annual individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits.

## **Benefit Maximums**

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.

The benefit maximums applicable to this plan are shown on the Schedule of Medical Benefits.

## COVERED MEDICAL EXPENSES

When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Medical Benefits for the services and supplies listed in this section. This list is intended to give you a general description of expenses for services and supplies covered by the plan.

### **Hospital Services**

- Semi-private room and board expenses.
- Private room and board expenses, limited to the cost of a semi-private room, unless a private room is *medically necessary* or if a semi-private room is not available.
- *Intensive care unit* and coronary care unit charges.
- Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.
- Well-baby nursery, *physician* and initial exam expenses (including screening for hearing) during the initial *hospital* confinement of a newborn. Charges for the newborn will be considered separately from the mother's expenses.
- *Hospital* confinement expenses for dental services if hospitalization is necessary to safeguard the health of the patient.
- *Outpatient hospital* services.

### **Emergency Services**

- Treatment in a *hospital* emergency room or other emergency care facility for a condition that can be classified as a *medical emergency* or *accidental injury*.
- Ground or air transportation provided by a professional ambulance service to and from a *hospital* or emergency care facility which is equipped to treat a condition that can be classified as a *medical emergency*.

### **Specialized Treatment Facilities**

- An *ambulatory surgical facility*.
- A *birthing center*.
- A *rehabilitation facility*.
- A *skilled nursing facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- An *urgent care facility*.
- A *hospice facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.

## Specialized Treatment Facilities (continued)

- A *mental/nervous treatment facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- A *substance abuse treatment facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- A *psychiatric day treatment facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- A chemical dependency/substance abuse day treatment facility. Benefits are limited as outlined on the Schedule of Medical Benefits.
- A *residential treatment facility*. Benefits are limited as outlined on the Schedule of Medical Benefits.

## Surgical Services

- Surgeon's expenses for the performance of a surgical procedure.
- Assistant surgeon's expenses. When using non-network providers, the amount eligible for consideration is not to exceed 20% of the *usual and customary charge* of the surgical procedure.
- Two or more surgical procedures performed during the same session. When using non-network providers, the amount eligible for consideration is the sum of *usual and customary charges* for the largest amount billed for one procedure plus 50% of the sum of *usual and customary charges* billed for all other procedures performed.
- Anesthetic services when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.
- *Reconstructive surgery* when needed to correct damage caused by an *accidental injury* or a birth defect resulting in the malformation or absence of a body part.
- Breast reconstruction following a total or partial mastectomy. Benefits include prostheses and reconstruction of the non-diseased breast to restore symmetry.
- Expenses for or related to the *medically necessary* removal of breast or other prosthetic implants.
- Surgical reproductive sterilization.
- Human organ and tissue transplants. For a list of covered transplants, refer to the Coventry Transplant Network section of this plan.
- Surgical treatment of *morbid obesity*. Benefits are limited as outlined on the Schedule of Bariatric Surgery Benefits.
- Surgical treatment for the correction of infertility. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Surgical impregnation procedures. Benefits are limited as outlined on the Schedule of Medical Benefits.

## **Surgical Services** (continued)

- Surgical treatment of temporomandibular joint dysfunction (TMJ). Benefits are limited as outlined on the Schedule of Medical Benefits.
- Circumcision.
- *Outpatient surgery.*
- Penile prosthetic implants.
- Podiatry *surgery.*
- Repair of cleft palate. Benefits include all services to repair the cleft and the associated congenital abnormalities, including, but not limited to: alveolar ridge closure; multistage repair of the cleft palate; appliances for palatal expansion in preparation for bone graft *surgery*; Orthognathic *surgery*, if the functional impairment results from the cleft palate; orthodontia expenses; and *reconstructive surgery* of the lip. Dental implants are excluded. You are encouraged to notify Coventry Health Care prior to beginning treatment.

## **Mental/Nervous And Substance Abuse Services**—Benefits are limited as outlined on the Schedule of Medical Benefits.

- *Inpatient* treatment of a *mental/nervous disorder* and/or substance abuse.
- *Outpatient* treatment of a *mental/nervous disorder* and/or substance abuse.
- *Partial hospitalization.*
- *Intensive outpatient treatment.*
- Counseling of or related to eating disorders.
- Counseling of or related to attention deficit disorder (ADD or ADHD).

## **Medical Services**

- *Physician* home and office visits.
- *Inpatient physician* visits.
- *Second surgical opinions.*
- *Third surgical opinions.*
- Dental services received after an *accidental injury* to teeth. This includes replacement of teeth and any related x-rays. Treatment must begin within 90 days of the *accident*. An *accidental injury* does not include damage caused by biting or chewing. Benefits are limited as outlined on the Schedule of Medical Benefits.

## Medical Services (continued)

- Pregnancy-related care for all covered females. Pursuant to federal law, the plan does not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *physician* or *practitioner*, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, the plan does not, under federal law, require that a *physician* or *practitioner* obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).
- Termination of pregnancy, only through surgical procedures.
- Selective or non-selective reduction of multiple pregnancy.
- Radiation therapy. However, there is no coverage provided for high-dose radiotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition, except as specified in the Coventry Transplant Network section of this plan.
- Chemotherapy. However, there is no coverage provided for high-dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition, except as specified in the Coventry Transplant Network section of this plan.
- *Chiropractic services*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Physical therapy from a qualified *practitioner*.
- Massage therapy, only from a qualified *practitioner*.
- Speech therapy from a qualified *practitioner* when necessary due to an *illness*, an *injury*, a surgical procedure, developmental delays, autism or stuttering. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Occupational therapy, including occupational therapy supplies.
- Acupuncture when performed by a qualified *practitioner*, only when needed due to: post-operative and chemotherapy-induced nausea and vomiting; pregnancy-related nausea; post-operative dental pain; temporomandibular joint (TMJ) disorders; migraine headaches; and pain from osteoarthritis of the knee or hip (adjunctive therapy). Benefits are limited as outlined on the Schedule of Medical Benefits.
- Private-duty nursing. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Home health care provided by a *home health care agency*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- *Home hospice*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Treatment of diabetes, including nutritional counseling.

## Medical Services (continued)

- Dialysis.
- Treatment of or related to sleep disorders.
- Non-surgical treatment of *morbid obesity*.
- Pre-surgical evaluations for bariatric *surgery* ordered by the network bariatric surgeon. Evaluations may include, but are not limited to: psychological; nutritional; cardiac; and exercise evaluations. Psychological evaluations are not subject to the mental/nervous visit maximums as outlined on the Schedule of Medical Benefits. Benefits are limited as outlined on the Schedule of Bariatric Surgery Benefits.
- Non-surgical treatment for the correction of infertility. Benefits are limited as outlined on the Schedule of Medical Benefits. Fertility drugs will be considered through your prescription drug plan (Caremark Customer Service).
- Surrogate expenses of a covered or non-covered female, limited to testing and surgical and non-surgical impregnation procedures. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Non-surgical treatment for temporomandibular joint dysfunction (TMJ). Benefits are limited as outlined on the Schedule of Medical Benefits.
- Biofeedback when performed by a qualified *practitioner*, only when needed due to: urinary incontinence; migraine and tension headaches (muscle, thermal, or skin biofeedback), excluding EEG biofeedback; temporomandibular joint (TMJ) syndrome; neuromuscular rehabilitation of stroke and traumatic brain injury (TBI); fecal incontinence; Raynaud's disease; chronic constipation; irritable bowel syndrome; refractory severe subjective tinnitus; and Levator ani syndrome. Benefits are limited as outlined on the Schedule of Medical Benefits.
- *Medically necessary* treatment of the feet, including treatment of metabolic or peripheral-vascular disease.
- Medical treatment of or related to eating disorders.
- Medical treatment of attention deficit disorder (ADD/ADHD).
- Treatment of or related to an overdose of drug or medication.

## Diagnostic Testing, X-Ray And Laboratory Services

- *Diagnostic charges* for x-rays.
- *Diagnostic charges* for laboratory services.
- Pre-admission testing (PAT).

## **Diagnostic Testing, X-Ray And Laboratory Services** (continued)

- Amniocentesis, including genetic testing/screenings and genetic counseling in connection with this procedure.
- Ultrasounds. Routine pregnancy-related ultrasounds are limited as outlined on the Schedule of Medical Benefits.
- Allergy testing.
- Magnetic Resonance Imaging (MRI).
- Infertility testing. Benefits are limited as outlined on the Schedule of Medical Benefits.

## **Routine And Wellness Benefits**—Benefits are limited as outlined on the Schedule of Medical Benefits.

- Physicals, including related routine x-rays and laboratory services.
- PAP tests, including the gynecological exam.
- Mammograms, for covered females age 40 and over.\*
- PSA tests, for covered males age 50 and over.\*
- Digital rectal exams, for covered males age 40 and over.\*
- Sigmoidoscopies, for covered individuals age 50 and over.\*
- Colonoscopies, for covered individuals age 50 and over.\*
- Occult blood tests.
- EKGs.
- Eye exams.
- Hearing exams.
- Well-child checkups.
- Vaccinations, inoculations and immunizations, including flu and pneumonia shots.

\* The age limit for PSA tests, digital rectal exams, colonoscopies, sigmoidoscopies and mammograms will be waived if you have any family history of cancer, as documented by your *physician/practitioner*.

## Equipment And Supplies

- *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.
- Artificial limbs and eyes and replacement of artificial limbs and eyes if required due to a change in the patient's physical condition; or replacement is less expensive than repair of existing equipment.
- Original fitting, adjustment and placement of orthotic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the patient's physical condition.
- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
- Insulin infusion pumps, including training or instruction for its use.
- Compression garments (e.g., Jobst garments).
- Foot orthotics.
- Orthopedic or corrective shoes and other supportive appliances for the feet.
- Cochlear implants.
- Blood and/or plasma and the equipment for its administration.
- Allergy injections, including serum.
- Rabies shots administered by a local health department.
- Injectable medications administered in conjunction with an *inpatient hospital* visit or in conjunction with a *physician* office visit, only if the medication is not a Caremark Specialty Drug. If the medication is a Caremark Specialty Drug, it must be obtained from Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767.
- Infusion drugs administered in conjunction with an *inpatient hospital* visit. If the drug is a Caremark Specialty Drug, benefits will be considered for the initial *physician* office visit only. Subsequent infusion drugs must be obtained from Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767.
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery*.
- Wigs and artificial hairpieces, limited to replacement of hair loss due to medical treatment, e.g., radiation therapy or chemotherapy. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Sterile surgical supplies after *surgery*.
- Contraceptive devices, limited to intrauterine devices (IUDs) and diaphragms.

## **MEDICAL EXPENSES NOT COVERED**

The plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a description of expenses for services and supplies not covered by the plan.

- Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.
- Services rendered by anyone other than a covered *health care provider*.
- Treatment not prescribed or recommended by a *health care provider*.
- Services, supplies or treatment not *medically necessary*.
- Services or supplies for which there is no legal obligation to pay, or expenses which would not be made, except for the availability of benefits under this plan.
- *Investigational/experimental* equipment, services or supplies.
- Complications arising from any non-covered *surgery* or treatment, except as required by law.
- Services furnished by or for the United States government or any other government, unless payment is legally required.
- Any condition, disability or expense sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an illegal or criminal act.
- Any condition, disability or expense sustained as a result of being engaged in: duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or *accidental* atomic explosion or other release of nuclear energy, whether in peacetime or wartime.
- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under a workers' compensation act or any similar legislation.
- Educational, vocational or training services and supplies, except as specified in Covered Medical Expenses.
- Expenses for preparing or copying medical reports, itemized bills or claim forms.
- Mailing and/or shipping and handling expenses.
- Expenses for missed or canceled appointments, telephone calls or telephone consultations.
- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- Travel expenses of a *physician* or a covered person, except as specified in the Coventry Transplant Network section of this plan.

## Medical Expenses Not Covered (continued)

- Sanitarium, rest or *custodial care*.
- *Maintenance care*.
- Expenses eligible for consideration under any other plan of the *employer*.
- Treatment or services rendered outside the United States of America or its territories, except for an *accidental injury*, a *medical emergency* which occurs while vacationing, while studying abroad or while traveling for purposes other than to receive medical care. (Routine medical care rendered outside the U.S.A. or its territories will not be covered.)
- Sales tax.
- Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone and guest meals.
- Expenses relating to or incurred in connection with autologous hematopoietic support (e.g., autologous bone marrow transplantation or stem cell rescue), including expenses for high-dose chemotherapy or radiotherapy, for any symptom, disease or condition, except as specified in the Coventry Transplant Network section of this plan.
- *Cosmetic surgery*.
- *Oral surgery*. Benefits may be considered through your dental plan.
- Kerato-refractive eye *surgery* (*surgery* to improve nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea including, but not limited to, LASIK, radial keratotomy and keratomileusis *surgery*). Benefits may be considered through your vision plan.
- Reversal of any reproductive sterilization procedure.
- Gender reassignment (sex change) *surgery*.
- Expenses related to insertion or maintenance of an artificial heart.
- Orthognathic *surgery*, except as specified in Covered Medical Expenses for repair of cleft palate.
- Rolfing.
- Fitting of eyeglasses or lenses, orthoptics, vision therapy or supplies. Benefits may be considered through your vision plan.
- Hearing aids or related supplies, except as specified in Covered Medical Expenses for cochlear implants.
- Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.
- Treatment of behavioral or conduct disorders.

## Medical Expenses Not Covered (continued)

- Adoption expenses.
- Bereavement counseling.
- Routine foot care, e.g. treatment of corns, callouses and toenails, except as specified in Covered Medical Expenses.
- Marital counseling. Benefits may be considered through your EAP.
- Family counseling. Benefits may be considered through your EAP.
- Sex counseling. Benefits may be considered through your EAP.
- Hypnosis.
- Treatment, instructions, activities or drugs (including diet pills) for weight reduction or control, except for the diagnosed condition of *morbid obesity*. Contact Caremark Customer Service at 1-866-284-9226 to determine if diet drugs are covered.
- Treatment of infertility, except as specified in Covered Medical Expenses.
- Prescription drugs and medicines, including, but not limited to, prescription vitamins and prenatal vitamins, infertility drugs (fertility medications), oral contraceptives, contraceptive injectables (e.g., Depo-Provera), and insulin and insulin syringes. Benefits are provided by Caremark Customer Service (1-866-284-9226).
- Caremark Specialty Drugs. All injectable medications and infusion drugs must be obtained from Caremark Specialty Services, except as specified in Covered Medical Expenses. You must call (Caremark Connect) 1-800-237-2767 prior to receiving any injectable medications or infusion drugs.
- Nutritional supplements and Norplant implants, whether or not a *physician's* prescription is required.
- Drugs, medicines or supplies that do not require a *physician's* prescription.
- Prescription drug mifepristone, also known as RU-486.
- Breast pumps.
- Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

## **COORDINATION OF BENEFITS**

### **General Provisions**

When you and/or your dependents are covered under more than one group health plan, the primary plan will determine benefits first without regard to benefits provided under any other group health plan.

When this plan is the secondary payor, the plan will coordinate payment with the primary plan in such a way that when this plan's payment is combined with the primary plan's payment, the total does not exceed the amount this plan would have paid if it were primary.

### **Government Programs And Other Group Health Plans**

The term group health plan, as it relates to coordination of benefits, includes the government programs *Medicare*, *Medicaid* and *Tricare/CHAMPUS*. The regulations governing these programs take precedence over the determination of benefits under this plan. For example, in determining the benefits payable under the plan, the plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a *Medicaid* plan.

The term group health plan also includes all group insurance and group subscriber contracts, such as union welfare plans, and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Individual policies or contracts are not included.

### **Automobile Insurance**

This plan provides benefits relating to medical expenses incurred as a result of an automobile *accident* on a secondary basis only. Benefits payable under this plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by this plan will be subject to the plan's reimbursement and/or subrogation provisions.

### **Order Of Payment When Coordinating With Other Group Health Plans**

Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1. The plan covering an individual other than as a dependent (for example, as an active employee, retiree, or disabled termed participant) will be primary to a plan covering the same individual as a dependent.

## Order Of Payment When Coordinating With Other Group Health Plans (continued)

However, if the individual is covered by two group health plans and *Medicare*, and under federal law *Medicare* is:

- secondary to the plan covering the individual as a dependent; and
- primary to the plan covering the individual as other than a dependent (for example, a retiree);

then the order of payment is reversed so the plan covering the individual as an employee, retiree, or disabled termed participant is secondary and the other plan is primary.

For all *Medicare* participants who are qualified either by age or disability that are not actively employed, *Medicare* will be the primary plan and this plan will be secondary.

2. If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:
  - the parents are married; or
  - the parents are not separated (regardless of whether they ever have been married); or
  - a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the child but that parent's spouse does, the spouse's plan is primary.

If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- the plan of the custodial parent;
  - the plan of the spouse of the custodial parent;
  - the plan of the non-custodial parent; then
  - the plan of the spouse of the non-custodial parent.
3. The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under section No. 1 above.
  4. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

### **Order Of Payment When Coordinating With Other Group Health Plans** (continued)

5. The plan that has covered the individual for the longer period of time will be considered primary.
6. If none of the above rules determines the primary plan, the allowable expenses will be shared equally between the plans.

### **Right To Make Payments To Other Organizations**

Whenever payments which should have been made by this plan have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

## **OTHER IMPORTANT PLAN PROVISIONS**

### **Assignment Of Benefits**

All *PPO* (“in-network”) benefits payable by the plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

### **Special Election For Employees And Spouses Age 65 And Over**

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under this plan without reduction for *Medicare* benefits. You may also choose to end coverage under this plan and enroll only in *Medicare*, however, benefits which are payable under this plan may not be covered by *Medicare*. If you choose to remain covered under this plan, this plan will be the primary payor of benefits and *Medicare* will be secondary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

### **Restitution To The Plan**

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict or otherwise, for an *illness* or *injury*. This section is not an imposition of personal liability, but reflects the equitable obligation to reimburse the plan from any recovery by you, your dependent or representative. If another party is legally responsible or agrees to provide any compensation, you or your dependent (or legal representatives, estate, heirs or trusts established on behalf of either you or your dependent), must promptly reimburse the plan for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). If the plan has not yet paid benefits relating to that *illness* or *injury*, the plan may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent or representative.

In order to secure the rights of the plan under this section, you or your dependent hereby:

- (1) Grant to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you or your dependent or your representative;
- (2) Assign to the plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement; and
- (3) Agree that you, your dependent, or representative will hold any compensation in constructive trust for the benefit of the plan and all its participants who have contributed to the funding of the plan.

## **Restitution To The Plan** (continued)

You or your dependent must cooperate with the plan and its agents, and must sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement. You or your dependent must also provide any relevant information, and take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the plan's right of reimbursement. The plan may reduce or deny future benefits on the basis that you or your dependents have refused to sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the *plan administrator*, in the exercise of its sole discretion.

## **Subrogation**

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's *illness* or *injury* and the plan has paid benefits related to that *illness* or *injury*. This section is not an imposition of personal liability, but reflects the equitable right of the plan to restore plan assets to the plan for the benefit of all participants. The actions of another party caused the plan to incur expenses it would not normally have incurred, therefore the plan is entitled to pursue any cause of action or pursue any remedy available to you or your dependents (regardless of how that action may be characterized and regardless of whether you or your dependent have been made whole).

The plan is subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's *illness* or *injury* to the extent of the reasonable value of the benefits provided to you or your dependent under the plan. The plan may assert this right independently of you or your dependent.

You or your dependent are obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the plan under this section. Please see the "Restitution To The Plan" section above regarding yours or your dependent's obligations regarding any compensation received or constructively received.

The costs of legal representation of the plan in matters related to subrogation will be borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

## **Recovery Of Excess Payments**

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered.

## **Right To Receive And Release Necessary Information**

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions. When you request benefits, you must furnish all the information required to implement the plan provisions.

## **Alternate Payee Provision**

Under normal conditions, all *PPO* (“in-network”) benefits are payable to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. All other benefits are payable to you and can only be paid to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The plan must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a qualified medical child support order (QMCSO) or state *Medicaid* law.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

## **Reliance On Documents And Information**

Information required by the *plan administrator* may be provided in any form or document that the *plan administrator* considers acceptable and reliable. The *plan administrator* relies on the information provided by you and others when evaluating coverage and benefits under the plan. All such information, therefore, must be accurate, truthful and complete. The *plan administrator* is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the *plan administrator*. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan.

## **No Waiver**

The failure of the *plan administrator* to enforce strictly any term or provision of this plan will not be construed as a waiver of such term or provision. The *plan administrator* reserves the right to enforce strictly any term or provision of this plan at any time.

## **Physician/Patient Relationship**

This plan is not intended to disturb the *physician/patient* relationship. *Physicians* and other *health care providers* are not agents or delegates of the *employer*, *plan administrator* or the third party *contract administrator*. Nothing contained in this plan will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in this plan will limit or otherwise restrict a *physician's* judgment with respect to the *physician's* ultimate responsibility for patient care in the provision of medical services to you or your dependent.

## **Plan Is Not A Contract Of Employment**

Nothing contained in this plan will be construed as a contract or condition of employment between the *employer* and any employee. All employees are subject to discharge to the same extent as if this plan had never been adopted.

## **Additional Information On Covered And Excluded Benefits**

If you would like to receive additional information regarding a specific drug, medical test, device or procedure which is either a covered or excluded benefit under this plan, you may contact Coventry Health Care at 1-800-272-8931, or via the Internet by logging on to [www.mycoventryhealth.com](http://www.mycoventryhealth.com) and entering login ID: **CMB**.

## **Right To Amend Or Terminate Plan**

The *plan administrator* reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time.

## **FILING A CLAIM FOR PAYMENT OF BENEFITS**

Your *health care provider* should file claims for you. Electronically submitted claims are processed most efficiently. If unable to file electronically, your *health care provider* may submit a HCFA-1500 or UB-92 form for medical expenses. The appropriate claim forms may be obtained from the *contract administrator* or at [www.mycoventryhealth.com](http://www.mycoventryhealth.com) using login ID: **CMB**.

If you use a non-network provider or receive treatment outside the United States of America or its territories, payment for services may be required at the time services are rendered and you will be responsible for completing and submitting the appropriate claim forms. An itemized copy of your bill should accompany the claim form. You will need to provide the plan with the following information:

- employee's name, Social Security number and address;
- patient's name, Social Security number and address if different from the employee's;
- *health care provider's* name, tax identification number, address, degree and signature;
- date(s) of service;
- diagnosis;
- procedure codes (describes the treatment or services rendered);
- assignment of benefits, signed (if payment is to be made to the provider);
- release of information statement, signed;
- explanation of benefits (EOB) information if another plan is the primary payor.

You should submit claims for each individual. Please do not attach or staple claims together. If additional information is needed to process your claim or the claim of your dependent, you or your *health care provider* will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim. The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within 45 days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Send complete information to:

Coventry  
P.O. Box 8400  
London, KY 40742

### **Filing A Claim For Payment Of Benefits** (continued)

The plan will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This time period will be delayed, if the plan requests additional information, until the requested information is received by the plan. The plan may also request a 15-day extension if matters beyond its control require the extension and notice is provided to you within the 30-day period.

If you have any questions regarding your claim, please call: 1-800-272-8931.

All claims must be received by the plan within 12 months from the date of the expense or benefits will not be considered.

## **HOW TO APPEAL A DENIAL OF BENEFITS OR CLINICAL NON-CERTIFICATION**

To request a clarification of a benefit determination or clinical certification recommendation, you or your *authorized representative* may always call the *contract administrator* at the toll-free number on the back of your identification card, or submit the request by logging on to [www.mycoventryhealth.com](http://www.mycoventryhealth.com). However, if you believe a *claim denial* or clinical non-certification was improper, the following processes are available:

### **Oral Appeal**

For an oral appeal of a clinical non-certification for a *request for certification involving urgent care*, please call 1-800-272-8931. Oral appeals will only be accepted for this type of *claim denial*.

### **Written Appeal**

Within 180 days of receipt of the notice of the *claim denial* or clinical non-certification, you may request, in writing, that the plan conduct a review of the processed claim. However, for an appeal of a clinical non-certification of a *request for certification involving urgent care*, you or your *health care provider* may appeal verbally. All requests for a review of *claim denial* or clinical non-certification should include a copy of the initial denial letter and any other relevant information (e.g. written comments, documents, articles or records). Any discrepancies between a benefit description in the plan document and the way a claim was processed will be corrected promptly. The *contract administrator* will provide all relevant information to the *plan administrator*. Upon receipt of the appeal information from the *contract administrator*, the *plan administrator* will:

1. Review all comments, documents, records, and other information submitted by you;
2. Consult with an appropriate health care professional if the claim was denied because it was not considered *medically necessary*, or the service was considered *investigational/experimental*. You may request the name of the health care professional who was consulted;
3. Request additional information necessary to review the appeal. You should provide the information as soon as possible;
4. Use discretionary authority in making an appeal determination, however, such discretionary authority will be consistent with determinations for similarly situated plan participants; and
5. Provide notice of the appeal determination in writing, or orally, where appropriate.

Send all written information to the *contract administrator*:

Coventry  
P.O. Box 8400  
London, KY 40742

## **Written Appeal** (continued)

Requests for appeal which do not comply with these procedures will not be considered, except in extraordinary circumstances. You will be notified if the appeal request has not been considered and you will be allowed to present evidence of why the appeal should be considered.

Because claims filing periods and appeals periods may overlap, the plan will coordinate appeals of clinical non-certifications, claims for payment of benefits and appeals of claims for payment of benefits. If you submit an appeal for a clinical non-certification but have already received the services which are the subject of the appeal, and Coventry Health Care has received a claim for benefits while the appeal is under consideration, the appeal will be reviewed as follows:

1. The appeal will be consolidated and all submitted information will be taken into consideration when the claim for benefits is reviewed. A notice of claim determination will be provided. If the claim for benefits is denied, you may file a final appeal of the claim denial; and
2. If the claim for benefits was already denied prior to your submitting the appeal of a clinical non-certification, the plan will consider this your appeal of the claim for benefits denial.

The *plan administrator* will notify you of the final decision within a reasonable time period, but not later than:

1. 72 hours for an oral appeal of a clinical non-certification for a *request for certification involving urgent care*;
2. 30 days for all appeals of a clinical non-certification which are not considered to fall under No. 1 above;
3. 60 days for all other appeals.

## **Time Period For Filing Legal Actions**

No action at law or in equity shall be brought to recover under this plan until the appeal procedures of this plan have been exhausted with respect to the claim, nor (unless applicable state law permits a longer period) will any action be brought unless within 2 years from the expiration of the time within which proof of loss is required to be furnished under this plan.

## OPTIONAL CONTINUATION OF COVERAGE

This section explains continuation coverage, when it may become available to you and your eligible dependents, and what you need to do to protect the right to receive it. Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights.

### **Continuation Of Coverage Under Federal Law (COBRA)**

As mandated by federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, otherwise known as COBRA), the plan offers optional continuation coverage to you and/or your dependents, if coverage of the eligible beneficiary would otherwise end due to one of the following events (domestic partners do not qualify for COBRA benefits regardless of the qualifying event):

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.
- Your death. Coverage may continue for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may continue for that spouse and your other eligible dependents.
- You become entitled to *Medicare* (Part A, Part B, or both). Coverage may continue for eligible dependents who are not entitled to *Medicare*.
- Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.
- Your *employer* files a Title 11 bankruptcy petition. Coverage may continue for retirees and their beneficiaries if the plan covers such retirees and beneficiaries within one year of the date of the bankruptcy petition and if such retiree coverage ends or is substantially reduced within one year before or after the filing for bankruptcy. (Please note that the plan may not cover retirees, in which case *employer* bankruptcy is not a qualifying event.)

NOTE: To choose this continuation coverage, an individual must be a covered person under the plan on the day before the qualifying event. You can also obtain continuation coverage for children born to or adopted by you during the period of your continuation coverage if they are timely enrolled under the terms of the plan. In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or be a beneficiary of the retired employee on the day before the bankruptcy.

## **Notification Requirement**

You or other qualifying individual(s) have the responsibility to inform the *plan administrator* of a divorce, legal separation or a child losing dependent status under the Caremark Rx, Inc. Flexible Benefit Plan (Out-Of-Area Plan) within 60 days of the qualifying event or, if later, the date coverage under the plan would end. You must provide this information in writing to the person or department listed at the end of this section. Please include documents that verify the change, such as a divorce decree or separation papers. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

If notification is more than 31 days following the qualifying event, you are not permitted to change your current election for employee contribution purposes. The spouse or child will in no event, continue to be eligible for coverage under your plan.

Your *employer* has the responsibility of notifying the *plan administrator* of your death, termination of employment, reduction in hours, entitlement to *Medicare* or the *employer's* bankruptcy within 30 days of the qualifying event.

The plan will notify you and other qualifying individual(s) of continuation coverage rights within 14 days of its receipt of the notice described above. Each qualifying individual will have an independent right to elect COBRA continuation coverage. You and any other qualifying individuals will then have 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after being notified by the *plan administrator* (or, if later, the date coverage under the plan would end) will result in loss of continuation coverage rights.

## **Maximum Period Of Continuation Coverage**

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled family members who are also entitled to continuation coverage may be extended to 29 months. The qualifying individual or family member, if applicable, must notify the *plan administrator* within the 18-month continuation coverage period and within 60 days after receiving notification of disability. You must provide this notice of information to the person or department listed at the end of this section. You must also provide notice within 30 days of the date the same qualifying individual is subsequently determined by the Social Security Administration to no longer be disabled.

The maximum period of continuation coverage for individuals who qualify due to any qualifying event other than termination of employment, reduction in hours or bankruptcy, is 36 months from the date of the qualifying event, subject to the following requirements:

If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event. Notice must be provided to the plan within 60 days of the date the second qualifying event occurs, and the extension will only occur if the second qualifying event would have caused the individual to lose coverage under the plan had the first qualifying event not occurred.

## **Maximum Period Of Continuation Coverage** (continued)

If within 18 months of the date continuation coverage begins you became entitled to *Medicare* or have a qualifying event, that would not result in a loss of coverage if you were an active employee, your covered spouse and dependent children will only be entitled to 18 months of continuation coverage from the date of the first qualifying event, or 29 months in the case of disability.

Qualifying retirees who retired before bankruptcy are entitled to continuation coverage for life, unless coverage would end as otherwise noted in this section. In this situation, the retiree's eligible dependent spouse and children are also entitled to continuation coverage until the earlier of: the dependent spouse's or child's death; or 36 months after the retiree's death. This only applies if the retiree's coverage previously allowed dependent coverage.

## **Cost Of Continuation Coverage**

The cost of continuation coverage is determined by your *employer* and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the plan's cost of coverage.

You and other qualified individual(s) must make the first payment within 45 days of notifying the plan of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless your *employer* establishes a longer payment schedule. Rates and payment schedules are established by your *employer* and may change when necessary due to plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

## **When Continuation Coverage Ends**

Continuation of coverage ends on the earliest of:

- The date the maximum continuation period expires.
- The date the qualifying individual becomes entitled to coverage under *Medicare*, if the *Medicare* entitlement date is after the date that the individual elected continuation coverage.
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- The date the *employer* no longer offers a group health plan to any of its employees.
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

## **Special Additional Continuation Coverage Election Period For “TAA-Eligible Individuals”**

In addition to the other COBRA rules described above, there are some special rules that apply if you are classified as a “TAA-eligible individual” by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.) The *plan administrator* will require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, federal income tax filings, etc. The plan need not require every available document to establish evidence of TAA eligibility. You will be responsible for providing evidence of TAA eligibility when applying for coverage under the plan. The plan will not be required to assist you in gathering such evidence.

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this notice, your coverage period will be measured from the date of your TAA-related loss of coverage. For example:

If you lose coverage on January 1, 2007 because your job is transferred out of the country, you will be eligible to make a continuation coverage election within 60 days of your loss of coverage and your coverage would be available for up to 18 months beginning on the date you lose coverage. However, if you do not elect continuation coverage during that period and the Department of Labor classifies you as a TAA-eligible individual on May 30, you will qualify for a second election period, lasting from May 1 through June 30. If you elect coverage during that period, your coverage will be effective retroactive to May 1, and you will be entitled to coverage for the remainder of your continuation coverage period measured from the time you actually lost coverage, so your coverage will be available until June 30, 2008 (18 months after January 1, 2007) unless the period is cut short or extended for one of the reasons described above.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some of your expenses for continuation coverage. You should consult with a financial advisor if you have questions about the tax credit.

### TAA Coverage and HIPAA Creditable Coverage

If you are a TAA-eligible individual who elects COBRA after becoming TAA eligible, the period beginning on the date of the TAA-related loss of coverage and ending on the first day of the TAA-related election period will be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the plan’s pre-existing condition provision.

## **Special Additional Continuation Coverage Election Period** (continued)

### Applicable Premium Payments

Payments of any portion of the applicable COBRA premium by the federal government on behalf of a TAA-eligible individual pursuant to TAA will be treated as a payment to the plan. Where the balance of any premium owed the plan by such individual is determined to be significantly less than the required applicable premium, as explained in IRS regulations 54.4980B-8, A-5(b), the plan will notify such individual of the deficient payment and permit 30 days to make full payment. Otherwise the plan will return such deficient payment to the individual and coverage will terminate as of the original premium due date.

### **If You Have Questions**

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the person or department listed at the end of this section. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep Your Plan Informed Of Address Changes**

In order to protect your family's rights, you should keep the *plan administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *plan administrator*.

### **Plan Contact Information**

Corporate Employee Benefits Plan Administrator  
c/o Caremark Rx, Inc.  
2211 Sanders Road  
Northbrook, IL, 60062  
1-888-769-1717

## DEFINITIONS

The following terms define specific wording used in this plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this plan.

### *Accident (Accidental)*

An unforeseen and unavoidable event resulting in an *injury*.

### *Ambulatory Surgical Facility*

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; supply registered professional nursing services whenever a patient is in the facility; and be *Medicare* approved or accredited as an ambulatory surgical facility by the Joint Commission on Accreditation of Healthcare Organizations.

### *Authorized Representative*

A person authorized by you to act on your behalf with regard to requests for certification and claims. You will be considered an authorized representative for all your dependents, without a written request, unless the plan is notified otherwise, or the dependent is the subject of a QMCSO. For certification requests, a *health care provider* with knowledge of your or your dependent's condition will be considered an authorized representative. All other authorizations must be in writing and signed by you. You should include this with any claims.

### *Benefit Year*

The 12-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.

### *Birthing Center*

A public or private facility, other than private offices or clinics of *physicians*, which meets the free-standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least 2 beds or 2 birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers and maintain medical records on each patient and child.

### *Chiropractic Services*

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

### *Claim Denial*

A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit. The basis for the determination of the denial, reduction or termination of, or failure to provide or make payment (in whole or in part) includes, but is not limited to: (a) your or your dependent's eligibility to participate in the plan; (b) the application of any prior notification requirements; or (c) the plan specifically does not cover the item or service, or considers the item or service to be *investigational/experimental* or not *medically necessary*.

### *Contract Administrator*

Coventry Management Services, Inc. has been hired as the third party contract administrator by the *plan administrator* to perform claims processing and other specified administrative services in relation to the plan. The contract administrator is not an insurer of health benefits under this plan, is not a fiduciary of the plan and does not exercise any of the discretionary authority and responsibility granted to the *plan administrator*. The contract administrator is not responsible for plan financing and does not guarantee the availability of benefits under this plan.

### *Cosmetic Surgery*

A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an *illness* or *injury*.

### *Custodial Care*

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

### *Diagnostic Charges*

The *usual and customary charges* for x-ray or laboratory examinations made or ordered by a *physician* or *practitioner* in order to detect a medical condition.

### *Durable Medical Equipment*

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

### *Employer*

Caremark Rx, Inc.

### *Health Care Provider*

A *physician, practitioner, nurse, hospital or specialized treatment facility* as those terms are specifically defined in this section.

### *Home Health Care Agency*

A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group; at least one *physician* and one registered graduate nurse to supervise the services provided; and be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

### *Home Hospice*

A program, licensed and operated according to the law, which is approved by the attending *physician* to provide palliative, supportive and other related care in the home for a covered person diagnosed as terminally ill.

### *Hospice Facility*

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a covered person diagnosed as terminally ill.

The facility must have an interdisciplinary medical team consisting of at least one *physician*, one registered nurse, one social worker, one volunteer and a volunteer program. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics or a hotel or similar institution.

### *Hospital*

A public or private facility, licensed and operated according to the law, which provides care and treatment by *physicians* and *nurses* at the patient's expense of an *illness* or *injury* through medical, surgical and diagnostic facilities on its premises.

The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A hospital does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged or convalescent care.

### *Illness*

Any bodily sickness or disease.

### *Incapacitated*

The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and be diagnosed by a *physician* as a permanent and continuing condition.

### *Injury*

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or *accident*.

### *Inpatient*

Treatment in an approved facility during the period when charges are made for room and board.

### *Intensive Care Unit*

A section, ward or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate nurses or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purpose of providing normal post-operative recovery treatment or service.

### *Intensive Outpatient Treatment*

Treatment of a *mental/nervous disorder* or substance abuse in an *outpatient* setting, typically 3 hours per day, 2 to 4 times per week.

### *Investigational/Experimental*

A health product or service is deemed experimental if one or more of the following criteria are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in *peer-reviewed medical literature*.

### *Lifetime*

The period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.

### *Maintenance Care*

Services and supplies provided primarily to maintain a level of physical or mental function.

### *Medicaid*

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

### *Medical Emergency*

A sudden, serious, unexpected and acute onset of an *illness* or *injury* where a delay in treatment could cause irreversible deterioration resulting in a threat to the patient's life or a body part, or an organ not returning to full, normal function.

Such conditions include, but are not limited to, suspected heart attack or stroke, loss of consciousness, actual or suspected acute poisoning, acute appendicitis, toxicity due to drugs or alcohol, acute renal failure, heat exhaustion, convulsive disorder, severe hemorrhage/allergic reaction, airway obstruction or aspiration, emergency medical care rendered for an *accidental injury* and other acute conditions.

### *Medically Necessary (Medical Necessity)*

Medically necessary services and/or supplies the *plan administrator* determines, in the exercise of its discretion, to be:

1. Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
2. Necessary to meet the basic health needs of the patient as a minimum requirement;
3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan;
5. Consistent with the diagnosis of the condition;
6. Required for reasons other than the comfort or convenience of the patient or his or her *physician*; and,
7. Of demonstrated value based on clinical evidence reported by *peer reviewed medical literature* and by generally recognized academic medical experts; that is, it is not *investigational/experimental*.

A treatment, procedure, service or supply must meet all of the criteria listed above to be considered medically necessary and to be eligible for coverage under this plan. In addition, the fact that a *health care provider* has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above.

### *Medicare*

Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

### *Mental/Nervous Disorder*

For purposes of this plan, a mental/nervous disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Medical Expenses Not Covered, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

### *Mental/Nervous Treatment Facility*

A public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation and effective treatment of *mental/nervous disorders*; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility must also have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

### *Morbid Obesity*

A diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction, and conventional weight reduction measures have failed.

Body mass index (BMI) is calculated from your weight in kilograms divided by your height in meters squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254. Contact your *physician* to determine if you meet this definition.

### *Nurse*

A person acting within the scope of his/her license and holding the degree of Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

### *Oral Surgery*

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

### *Outpatient*

Treatment either outside of a *hospital* setting or at a *hospital* when room and board charges are not incurred.

### *Partial Hospitalization*

A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a *mental/nervous disorder* when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric *nurses* and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a *physician*.

### *Peer-Reviewed Medical Literature*

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-reviewed literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

### *Physician*

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

### *Plan Administrator*

The plan administrator, Caremark Rx, Inc., is the sole fiduciary of the plan, and exercises all discretionary authority and control over the administration of the plan and the management and disposition of plan assets. The plan administrator shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the plan, and benefits under the plan will be paid only if the plan administrator decides, in its discretion, that the participant or beneficiary is entitled to such benefits.

The plan administrator has the right to amend, modify or terminate the plan in any manner, at any time, regardless of the health status of any plan participant or beneficiary.

The plan administrator may hire someone to perform claims processing and other specified services in relation to the plan. Any such contractor will not be a fiduciary of the plan and will not exercise any of the discretionary authority and responsibility granted to the plan administrator, as described above.

### *Plan Sponsor*

Caremark Rx, Inc.

### *Plan Year*

The 12-month fiscal period for Caremark Rx, Inc. beginning January 1 and ending December 31.

### *Practitioner*

A *physician* or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Chemical Abuse Dependency Counselor (C.A.D.C.), Alcohol and Chemical Dependency Counselor (A.C.D.C.), Speech Therapist, Occupational Therapist, Acupuncturist, Physician's Assistant, Registered Respiratory Therapist, Nurse Practitioner, Nutritionist, Registered Dietician (R.D.), Licensed Professional Counselor (L.P.C.) or Licensed Clinical Psychologist (L.C.P.).

### *Preferred Provider Organization (PPO)*

Coventry Health Care National Network, including those *health care providers* who have contracted with the network to provide services at a contracted rate.

### *Psychiatric Day Treatment Facility*

A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than 8 hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Healthcare Organizations, or be *Medicare* approved.

### *Reconstructive Surgery*

A procedure performed to restore the anatomy and/or functions of the body which are lost or impaired due to an *injury* or *illness*.

### *Rehabilitation Facility*

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *mental/nervous disorders*, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, *Medicare* approved, or is accredited as such a facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

### *Request For Certification Involving Urgent Care*

Any request for certification of proposed services to which the application of the time periods for making non-urgent care certifications: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a *physician* with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

### *Residential Treatment Facility*

A residential treatment facility provides 24-hour, subacute care for children, adolescents or adults. The facility must be licensed by the state as a health care facility and accredited for residential treatment by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

The treatment must be directed by a health care *practitioner*, licensed for independent practice in the state, who evaluates and treats the patient no less frequently than weekly and who meets directly with the treatment team on a regular, scheduled basis. Individual, group and family psychotherapy must be provided by licensed mental health *practitioners* or, in the case of chemical dependency, certified chemical dependency counselors.

### *Second Surgical Opinion*

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

### *Skilled Nursing Facility*

A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered nurse or *physician* on full-time duty in charge of patient care; at least one registered nurse or licensed practical nurse on duty at all times; a daily medical record for each patient; transfer arrangements with a *hospital*; and a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *illness* or *injury*, and is not, other than by coincidence, a rest home for *custodial care* or for the aged. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

### *Specialized Treatment Facility*

Specialized treatment facilities as the term relates to this plan include *birthing centers, ambulatory surgical facilities, hospice facilities, skilled nursing facilities, mental/nervous treatment facilities, substance abuse treatment facilities, psychiatric day treatment facilities, chemical dependency/substance abuse day treatment facilities, residential treatment facilities, rehabilitation facilities* and *urgent care treatment facilities* as those terms are specifically listed in Covered Medical Expenses.

### *Substance Abuse Treatment Facility*

A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation and effective treatment of substance abuse; detoxification services; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility also must have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must also be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

### *Surgery*

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

### *Third Surgical Opinion*

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

### *Urgent Care Facility*

A public or private facility, licensed and operated according to applicable state law, where ambulatory patients can receive immediate, non-emergency care for mild to moderate *injuries* and/or *illnesses* without scheduling an appointment.

### *Usual And Customary Charge (U&C)*

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical or dental service area for the service or procedure as billed by other *physicians* or *practitioners*. Usual and customary charges do not apply to *PPO* ("in-network") providers.

### *Year*

See *benefit year*.

## **RIGHTS OF PLAN PARTICIPANTS**

As a participant in the Caremark Rx, Inc. Flexible Benefit Plan (Out-Of-Area Plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan And Benefits**

1. Examine, without charge, at the *plan administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).
2. Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions By Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your *employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *plan administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance With Your Questions**

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

## **YOUR PRIVACY RIGHTS**

As a participant in the Caremark Rx, Inc. Flexible Benefit Plan (Out-Of-Area Plan) (the “Plan”), you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The following describes how health information about you may be used and disclosed and how you may access this information.

The Plan is permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment and health care operations purposes.

### **Use And Disclosure Of Information To And From Caremark Rx, Inc.**

The Plan may disclose protected health information to Caremark Rx, Inc. (the “*plan sponsor*”) under limited circumstances. The Plan will disclose protected health information to the *plan sponsor* only upon receipt of a certification by the *plan sponsor* that the plan documents have been amended to incorporate and to abide by these privacy provisions.

The Plan may disclose summary health information to the *plan sponsor* for the purposes of obtaining premium bids, insurance coverage, or modifying, amending or terminating the Plan.

The Plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information to the *plan sponsor* for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the *plan sponsor*.

A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are in the Corporate Benefits Department.

These employees will only use protected health information for plan administration functions, consistent with the Plan’s Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law and the departments’ privacy policies. Should an employee of the *plan sponsor* not comply with the Plan’s Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The *plan sponsor* will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by Caremark Rx, Inc. employees or by the Plan’s business associates.

If feasible, the *plan sponsor* must return or destroy all protected health information received from the Plan that the *plan sponsor* maintains in any form. The *plan sponsor* cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the *plan sponsor* will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The *plan sponsor* has an obligation under the law to retain records for its plan administrative functions, and will retain the required records, which may or may not contain protected health information as required under the law. The *plan sponsor* must report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for, of which, the *plan sponsor* becomes aware.

## **Use And Disclosure Of Information To And From Caremark Rx, Inc. (continued)**

The *plan sponsor* must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

## **Use And Disclosure Of Health Information By The Plan**

The Plan will not use or disclose protected health information other than as permitted or required by the Plan documents or as required by law. For instance, the Plan is permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research and judicial and administrative proceedings. The Plan is permitted to disclose protected health information to law enforcement officials as required by law. The Plan is also required to disclose protected health information to you or your personal representative to the extent you have a right of access to the information and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The Plan's business associates are permitted to use protected health information received from the Plan for the specific activities for which those business associates are contracted. Before receiving your protected health information, the Plan's business associates must agree to the same restrictions and conditions that apply to the Plan under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The *contract administrator* is considered a business associate of the Plan.

## **Access, Amendment And Accounting Of Health Information**

You have a right to request access to inspect and obtain a copy of your protected health information that the Plan and the Plan's business associates maintain in a designated record set. The Plan has established procedures in its Privacy Policies and Procedures to grant access to your protected health information. The Plan has a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524. The designated record set that the Plan maintains includes documentation about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information, contact the Privacy Officer (Vice President of Employee Benefits) for the Caremark Rx, Inc. Health and Welfare Plan, located in the Northbrook Office of Caremark Rx, Inc. by calling 1-847-559-4700.

You have a right to request the Plan amend your protected health information that the Plan and the Plan's business associates maintain in a designated record set if you believe it is incorrect or incomplete. The Plan has established procedures in its Privacy Policies and Procedures to allow amendment to your protected health information. The Plan has a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, submit your request in writing to: Corporate Employee Benefits Plan Administrator, c/o Caremark Rx, Inc., 2211 Sanders Road, Northbrook, IL 60062.

## **Access, Amendment And Accounting Of Health Information** (continued)

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the Plan six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

**Example 1:** You request an accounting on September 14, 2003. The Plan is obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

**Example 2:** You request an accounting on September 14, 2010. The Plan is obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plan does not have to account for disclosures made:

- to you;
- to carry out treatment, payment and health care operations;
- pursuant to your authorization;
- incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- for national security or intelligence purposes;
- as part of a limited data set;
- occurred prior to April 14, 2003; or
- for other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, submit your request in writing to: Corporate Employee Benefits Plan Administrator, c/o Caremark Rx, Inc., 2211 Sanders Road, Northbrook, IL 60062.

## **Complaints**

If you believe your privacy rights have been violated, you may complain to the Plan at Caremark Rx, Inc., 2211 Sanders Road, Northbrook, IL 60062. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

## **Your Health Information And Privacy**

Your health information is confidential and your privacy will be protected. Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of Case Management or other programs available to you as described in the Plan. You may receive information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

Note: The following terms as used in this section are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): “protected health information,” “summary health information,” “business associates,” “personal representative,” “designated record set,” and “limited data set.”

## Security

On April 21, 2005, the final rule implementing the Security Standards (“Security Rule”) under the Health Insurance Portability and Accountability Act of 1996 will be effective. To comply with the Security Rule, the *plan sponsor* must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits. The Plan’s business associates must agree to implement reasonable and appropriate security measures to protect health information received from the Plan or *plan sponsor*. A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business, and there are reasonable and appropriate security measures in place to ensure that only these employees will have access to information. The *plan sponsor* will report to the Plan any security incident of which it becomes aware.

## GENERAL INFORMATION

### Type Of Plan

A welfare plan providing group medical benefits.

### Name And Address Of The *Plan Sponsor*

Caremark Rx, Inc.  
2211 Sanders Road  
Northbrook, IL 60062  
(847) 559-3830

### Name And Address Of The *Plan Administrator*

Caremark Rx, Inc.  
2211 Sanders Road  
Northbrook, IL 60062  
(847) 559-3830

### Name And Address Of The Designated Agent For Service Of Legal Process

Caremark Rx, Inc.  
2211 Sanders Road  
Northbrook, IL 60062  
(847) 559-3830

### Name And Address Of The Third Party *Contract Administrator*

Coventry Management Services, Inc.  
P.O. Box 8400  
London, KY 40742

### Internal Revenue Service And Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 63-1151076.  
The plan number is 599.

### *Plan Year*

The *plan year* is the 12-month fiscal period for Caremark Rx, Inc. beginning January 1 and ending December 31.

### Method Of Funding Benefits

Health benefits are self-funded from accumulated assets and are provided directly from the *plan sponsor*. The *plan sponsor* may purchase excess risk insurance coverage which is intended to reimburse the *plan sponsor* for certain losses incurred and paid under the plan by the *plan sponsor*. Such excess risk coverage, if any, is not part of the plan.

Payments out of the plan to *health care providers* on behalf of the covered person will be based on the provisions of the plan.

**SIGNATURE PAGE**

The effective date of the Caremark Rx, Inc. Flexible Benefit Plan (Out-Of-Area Plan) is January 1, 2007.

It is agreed by Caremark Rx, Inc. that the provisions of this document are correct and will be the basis for the administration of the Caremark Rx, Inc. Flexible Benefit Plan (Out-Of-Area Plan).

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

BY

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TITLE

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BY

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TITLE

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