

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**FAIRFAX COUNTY WATER AUTHORITY
HEALTH PLAN**

(MEDICAL, PRESCRIPTION DRUG, VISION AND DENTAL)

**AMENDED AND RESTATED AS OF:
January 1, 2014**

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Dental Benefits. Provides a description of dental benefits provided under the Plan.

Filing a Claim. Explains how to submit a claim for consideration of benefits under the Plan.

Claims Procedure. Explains the procedures for filing a claim and the claim appeal process.

Coordination of Benefits. Explains the Plan benefit payment order when a Covered Person is covered under more than one plan providing benefits.

Other Important Plan Provisions. Explains other important Plan provisions.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of expenses when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains continuation options available under the Plan.

Responsibilities for Plan Administration. Explains the responsibilities of the Plan Administrator.

HIPAA Privacy and HIPAA Security. Summary of the Plan's HIPAA Privacy Policy and Security.

General Plan Information. Provides general Plan information.

A copay is an amount that a Covered Person pays to his or her provider at the time of service.

Out-of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses a Covered Person must pay during a calendar year before the Plan payment percentage increases. When there is an In-Network and Out-of-Network out-of-pocket maximum, the In-Network out-of-pocket maximum accrues toward the Out-of-Network out-of-pocket maximum and the Out-of-Network out-of-pocket maximum accrues toward the In-Network out-of-pocket maximum.

The individual out-of-pocket maximum applies separately to each Covered Person. When a Covered Person reaches his or her out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that calendar year.

The Family out-of-pocket maximum applies collectively to all Covered Persons in the same Family. When the Family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any Covered Person in the Family during the remainder of that calendar year.

The Plan will pay the designated percentage of covered charges until the applicable out-of-pocket maximum is reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year.

The following expenses do not count toward the out-of-pocket maximum and are never paid at 100%:

- Precertification penalties
- Excess of Usual and Customary Charges
- Prescription drug copays
- Temporomandibular Joint (TMJ)

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Care			
Routine Well Adult Care	100% no deductible	100% no deductible	Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, colonoscopy, cholesterol tests, x-rays, laboratory blood tests, hearing exam, vision exam and immunizations/flu shots. Frequency for Mammograms: Age 35-39: 1 baseline Age 40-49: 1 every 2 years Age 50 and over: 1 per calendar year
Routine Well Child Care	100% no deductible	100% no deductible	Includes: office visits, vision exam, routine physical examination, laboratory blood tests, x-rays and immunizations through age 26.
Human Papillomavirus (HPV) Vaccine	100% no deductible	100% no deductible	Limited to Covered Persons ages 9 through 26.
X-ray & Laboratory Services			
Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital admission.	90% after deductible	70% after deductible	
Diagnostic Charges (X-ray and Laboratory)	90% after deductible	70% after deductible	
Lab Card Services (Outpatient)	100%	N/A	
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services and will waive any of this Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office – normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under Eligible Medical Expenses for further details of this program.			
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	90% after deductible room and board limited to the semi-private room rate	70% after deductible room and board limited to the semi-private room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed.
Intensive Care Unit	90% after deductible room and board limited to the ICU/CCU room rate	70% after deductible room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed.
Routine Well Newborn Care	90% after deductible	70% after deductible	
Outpatient Hospital	90% after deductible	70% after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Inpatient Surgery (includes anesthesiologists)	90% after deductible	70% after deductible	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed.
Outpatient Surgery (Includes anesthesiologists)	90% after deductible	70% after deductible	
Surgery Performed in a Physician's Office	90% after deductible	70% after deductible	
Inpatient Physician Visits	90% after deductible	70% after deductible	
Consultations	90% after deductible	70% after deductible	
Occupational Therapy	90% after deductible	70% after deductible	Must be Medically Necessary and not work related.
Physical Therapy	90% after deductible	70% after deductible	
Speech Therapy	90% after deductible	70% after deductible	Covered only for speech loss or impairment due to an illness or injury.
Chemotherapy/Radiation Therapy	90% after deductible	70% after deductible	
Physician's Office/Home Visits	100% after \$25 copay	100% after \$35 copay	
Temporomandibular Joint (TMJ)	50% after deductible	50% after deductible	Limited to non-surgical treatment or diagnosis rendered or prescribed by a Physician.
Podiatry	90% after deductible	70% after deductible	
Organ Transplants	90% after deductible (Aetna IOE Facility only)*	70% after deductible	* Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.
Transportation and Lodging Daily Maximum	\$50 per day per person (\$100 per day maximum) per transplant*	N/A	Distance of the Aetna IOE Facility must be more than 100 miles away from Members residence.
Transportation and Lodging Maximum Benefit	\$10,000 per transplant*	N/A	
Second Surgical Opinion	90% after deductible	70% after deductible	
Dental Service	90% after deductible	70% after deductible	Limited to treatment related to an accidental injury, except for chewing, to sound natural teeth and initial treatment is received within 3 months of the accident.
Registered Dietician	90% after deductible 6 visits calendar year maximum	70% after deductible 6 visits calendar year maximum	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

BENEFIT DESCRIPTION	
Pharmacy Option (Lesser of 34-day supply or 100 units)	Copay
Generic Drugs	\$5
Formulary Brand Name Drugs	\$30
Non-Formulary Brand Name Drugs	\$45
Mail Order Prescription Drug Option (90-day supply)	Copay
Generic Drugs	\$10
Formulary Brand Name Drugs	\$60
Non-Formulary Brand Name Drugs	\$90
Specialty Drugs	Copay
	\$115
CuraScript Specialty Pharmacy Program	
Specialty drugs MUST be obtained directly from CuraScript Specialty Pharmacy Program, powered by Express Scripts, after 1 fill at a retail pharmacy.	

Details regarding Prescription Drug Benefits are in the Prescription Drug Benefits section.

SCHEDULE OF DENTAL BENEFITS

Calendar Year Deductible:

\$50 per Covered Person

The Calendar Year Deductible Applies to the Following Classes of Services:

- Class B Services - Basic
- Class C Service - Major
- Class D Services - Orthodontia

BENEFIT DESCRIPTION	BENEFIT
Maximum Benefit Amount For All Classes	
Per Covered Person per Calendar Year (over age 18)	\$2,000
Per Covered Person per Calendar Year (under 18)	Unlimited
Dental Percentage Payable	
Class A Services-Preventive	100% of U&C
Class B Services-Basic	80% of U&C
Class C Services-Major	50% of U&C
Class D Services-Orthodontia	50% of U&C

A written proposed course of treatment for any procedure estimated to be over \$1,000 should be submitted by the Dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to the alternate procedure provision of the Plan and does not guarantee payment of benefits when the actual services are performed.

Details regarding Dental Benefits are in the Dental Benefits section.

plan during which an Employee has no other coverage are not considered Creditable Coverage under the Plan, nor are these days taken into account when determining a Significant Break In Coverage.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and is practicing within the scope of such license.

Diagnostic Charges means charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability means the inability to perform all the duties of the Covered Person's occupation as the result of a non-occupational illness or injury. For an unemployed Covered Person, Disability means the inability to perform the normal duties of a person of the same age.

Disability (Disabled) for an Active Employee means the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of illness or injury. Disability will be determined by the attending Physician.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury and (d) is appropriate for use in the home.

Employer is the Plan Sponsor and any other entity, with the consent of the Plan Sponsor that adopts the Plan.

Endodontic Treatments are procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or
- (2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or
- (3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is the subject of the research, experimental, study, investigational or other

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is a public or private organization, licensed and operated according to the law, primarily engaged in providing Hospice Care Services and Supplies for palliative, supportive, and other related care for a Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and Family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these requirements: It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

"Hospital" also includes:

- (1) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- (2) A facility operating primarily for the treatment of Substance Use Disorders if it meets these requirements: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Illness means a non-occupational bodily disorder, disease, physical sickness, Substance Use Disorder or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, as defined by the Employer.

Infertility means incapable of producing offspring.

Injury means a non-occupational accidental physical injury caused by an unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill and which has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Lifetime is used in the Plan in reference to benefit maximums and limitations and is understood to mean while covered under the Plan.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Language Pathologist, Nutritionist/Dietician and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Participant is any Employee, Retiree (under the age of 65) or Dependent who is covered under the Plan.

Plan Sponsor is Fairfax County Water Authority, as further identified under General Plan Information.

Plan Year refer to the General Plan Information page.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes.

Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an Employee pursuant to a state domestic relations law.

A medical child support order must meet certain requirements specified in the law in order to be considered "qualified."

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer is under the age of 65, and elects to contribute to the Plan the contribution required by the Retired Employee.

Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an illness or injury.

Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an illness or injury.

Skilled Nursing Facility, including an extended care facility and a rehabilitation facility, is a facility that fully meets all of the following:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from injury or illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse is defined in the "Eligibility" section of this document.

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. An Employee of the Employer who is:

- (1) a full-time Employee regularly scheduled to work at least 40 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.
- (2) a part-time, Employee regularly scheduled to work at least 20 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.
- (3) a retired Employee of the Employer who is under the age of 65.

Waiting Period for Employee Coverage.

- (1) If the Employee is employed between the 1st and 15th day of the calendar month, the effective date will be the first day of the calendar month following the Employee's date of hire.
- (2) If the Employee is employed between the 16th and 31st day of the calendar month, the effective date will be the first day of the second calendar month following the Employee's date of hire.

For the purpose of this provision, an Employee shall not be treated as absent from work if the absence is because of a health condition.

Should an Employee of the Employer change to full-time status, any waiting period required to be eligible for coverage under the Fairfax County Water Authority Health Plan will be calculated from the Employee's date of hire. If the Employee has been employed with the Employer longer than the required waiting period, coverage would begin on the first day of the month following the date the Employee changed to full-time status.

Notwithstanding the foregoing, the term Employee shall not include:

- (1) any Employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee's participation in the Plan, or
- (2) any leased employee of the Employer, or
- (3) any person who is not classified by the Employer as a common law employee of the Employer, regardless of whether or not such person is later reclassified by a court or any regulatory agency as a common law employee of the Employer, or
- (4) any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).

Effective Date of Employee Coverage. When the enrollment requirements are met, an eligible Employee's coverage is effective as outlined above. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within the time period established in the Special Enrollment Situation/Status Change section.

An Employee must be an Active Employee (as defined by the Plan) for coverage to begin.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse, unless legally separated.
- (2) A covered Employees Dependent Child until the end of the month in which the child attains age 26.

If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children. A newborn child must be enrolled as a Dependent under the Plan within 31 days of the child's birth in order for coverage to take effect from the date of birth. Charges for covered nursery care and covered routine Physician care will be applied toward the Plan of the newborn child.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the child may only enroll during the annual open enrollment period. The enrollment will be considered a Late Enrollment.

TIMELY INITIAL ENROLLMENT

Initial enrollment is considered "timely" if the completed enrollment form is received by the Plan Administrator no later than 31 days after the person becomes eligible for coverage under the Plan, initially, under a Special Enrollment Situation or during the annual open enrollment.

When two Employees (husband and wife) are covered under the Plan and the Employee covering the Dependent children is no longer eligible for coverage under the Plan, Dependent coverage may continue under the other Covered Employee with no waiting period. However, coverage must be continuous from one Employee to the other.

SPECIAL ENROLLMENT SITUATION/STATUS CHANGE

The Plan provides an Employee and his or her eligible Dependents the opportunity to enroll in the Plan during a special enrollment period, provided certain special enrollment/status change events occur. The special enrollment/status change events that occur resulting in a special enrollment period under the Plan are more fully described below. With respect to the special enrollment events below, any Employee who has a special enrollment right may elect coverage (for such Employee and his or her Dependents) under any Plan option that is available to an Employee during an initial or annual enrollment opportunity, as long as the Employee (or Dependent) is otherwise eligible for that Plan option.

Special Enrollment Events

- (1) **Special Enrollment Rights Because of Loss of Other Coverage.** An Employee or Dependent is eligible for coverage under the Plan, but chose not to enroll in the Plan, because he or she was covered at the time coverage under the Plan was previously offered may enroll later if one of the following conditions is met:
 - (a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility, (as described below);
 - (b) The other coverage was not COBRA coverage and an employer's contributions towards the coverage cease; or
 - (c) The coverage of the Employee or Dependent was under COBRA and the COBRA coverage is exhausted.

It is important to note that when an Employee or Dependent loses coverage due to one of the above events, both the Employee and Dependent may special enroll.

A "Loss of Eligibility" includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. A Loss of Eligibility also occurs if the other coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the Employee or Dependent no longer lives or works in the applicable services area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). "Exhaustion of COBRA coverage" occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of

Coverage for an Employee or Dependent who enrolls in the Plan because of a marriage, birth or adoption special enrollment right will be effective:

- (f) in the case of marriage, no later than the first day of the first month beginning after the date the Plan Administrator receives a completed request for enrollment electing coverage for the Employee or Dependent, if the completed request for enrollment is submitted within 31 days after the marriage;
 - (g) in the case of a Dependent's birth, on the date of birth if the completed request for enrollment is submitted within 31 days of the birth; or
 - (h) in the case of a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted within 31 days of the date of the adoption or placement for adoption.
- (3) **Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP).** If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, he or she will be permitted to later enroll in the Plan under one of the following circumstances:
- (a) The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
 - (b) The Employee or eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The Employee or eligible Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

Status Change Events

An employee or dependent may also enroll in the Plan based on a status change election that is permitted under Section 125 of the Internal Revenue Code and the terms of an applicable Section 125 Plan or the Plan Sponsor. Such coverage will become effective as provided under the terms of the applicable Section 125 Plan.

ANNUAL ENROLLMENT PERIOD

Plan Participants will receive information regarding the annual re-enrollment period from the Employer.

OPEN ENROLLMENT

During the open enrollment period, established by the Plan Sponsor, eligible Employees and their eligible Dependents who are not currently enrolled in the Plan will be allowed to enroll in the Plan. However, all enrollment applications must be received prior to the open enrollment effective date.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless the Employee experiences a Special Enrollment Situation or Status Change (refer to Special Enrollment Situation/Status Change subsection).

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents that were covered under the Plan at the time of leaving for military service.

- (1) The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning the date on which the Employee's absence begins; or
 - (b) The period beginning on the day the Employee's military service absence begins and ending on the day after the date on which the Employee returns to employment with the employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.
- (2) An Employee who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.
- (4) An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to enroll, see the section entitled COBRA Continuation Options):

- (1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death.
- (3) The date the Spouse reports to active military service.
- (4) The date a covered Spouse ceases to be a Dependent.
- (5) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.
- (6) The first day of the period for which the required contribution has not been paid.
- (7) The date the dependent (or any person seeking coverage on behalf of the dependent) performs an act, practice, or omission that constitutes fraud.
- (8) The date the dependent (or any person seeking coverage on behalf of the dependent) makes an intentional misrepresentation of a material fact.

Note: Retiree Dependent's coverage terminates the first day of the month in which the dependent turns age 65.

MEDICAL MANAGEMENT

Medical Management Phone Number

Meritain Medical Management - (800) 242-1199

The Covered Person or a family member must call this number to receive certification of certain health care services. This call must be made in advance of services being rendered or within 48 hours after an admission due to a Medical Emergency.

Penalties for failure to follow Medical Management procedures will not accrue toward the out-of-pocket maximum.

MEDICAL MANAGEMENT

Medical Management is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
 - Hospitalizations
 - Inpatient Substance Use Disorders/Mental Disorder treatments
 - Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility stays
 - Hospice Care
 - Inpatient Surgical Procedure
 - Organ Transplants
- (b) Retrospective review of Medical Necessity of the listed services;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility.

This program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The Covered Person will not be required to obtain precertification from the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, the following provisions should be read carefully.

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives the other listed medical services, Medical Management will, in conjunction with the attending Physician, be required to certify the care as Medically Necessary. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

Medical Management is set in motion by a telephone call from the health care provider, Covered Person or a family member. Medical Management must be called, prior to the listed medical services are scheduled to be rendered, with the following information:

- The name of the Covered Person and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient chooses not to participate.

Examples of Illnesses or Injuries that would be appropriate for Case Management include, but are not limited to:

Terminal Illnesses

Cancer

AIDS

Chronic Illnesses

Multiple Sclerosis

Renal Failure

Obstructive Pulmonary Disease

Cardiac Conditions

Accident Victims Requiring Long-Term Rehabilitative Therapy

Newborns with High Risk Complications or Multiple Birth Defects

Diagnosis Involving Long-Term IV Therapy

Illnesses Not Responding to Medical Care

that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

- (3) **Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility admissions.** The room and board and nursing care furnished by a Skilled Nursing Facility, extended care facility and rehabilitation facility will be payable when approved by Medical Management, as outlined in the Schedule of Medical Benefits.
- (a) the Covered Person is confined as a bed patient in the facility;
 - (b) the Covered Person must be confined in a Hospital for at least five (5) days or the stay must be determined to be Medically Necessary rather than custodial care;
 - (c) the Covered Person commences his stay in the facility within fourteen days following discharge from the Hospital;
 - (d) the attending Physician certifies that confinement is needed for further care of the condition that caused the Hospital confinement; and
 - (e) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, extended care facility or rehabilitation facility.

Covered charges for a Covered Person's care in these facilities are limited to the facility's semi-private room rate.

- (4) **Physician Care.** Inpatient, outpatient, office or home professional services of a Physician for surgical or medical services to treat an illness or injury. Inpatient care includes services by an attending Physician or non-attending Physician. This benefit also includes the following:
- (a) Treatment of Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD) when treated by a covered Physician with an approved treatment plan.
 - (b) Second surgical opinion (and/or second medical opinion) and necessary third surgical/medical opinions.
 - (c) Physician charges for the administration of birth control injections.
 - (d) Multiple surgical procedures, subject to the following provisions:
 - Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one (1) procedure plus 50% of the sum of Usual and Customary charges for all other procedures performed; or
 - Two (2) or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the Usual and Customary charge billed for each procedure performed.
 - (e) Assistant Surgeon, if required. The Assistant Surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance, if applicable.
- (5) **Private Duty Nursing Care.** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:
- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive

- (8) **Other Medical Services and Supplies.** Services and supplies not otherwise included in the items listed above are covered as follows:
- (a) **Acupuncture services**, by a licensed M.D., D.O. or Acupuncturist. Covered only as an anesthetic agent for covered surgery.
 - (b) **Allergy services** includes allergy testing, preparation of serum and allergy injections, as outlined in the Schedule of Medical Benefits.
 - (c) **Ambulance transportation** provided by a professional ambulance service for local land or air transportation for a Medical Emergency. Benefits are also provided for transportation from one Medical Care Facility to another of the patient's or family's choice, not to exceed 50 miles.
 - (d) **Amniocentesis** only when the attending Physician certifies that the procedure is Medically Necessary.
 - (e) **Anesthetic services** when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure.
 - (f) **Biofeedback**, if the services are provided by a Physician for a Medically Necessary covered condition
 - (g) **Blood and blood derivatives** that are not donated or replaced. Administration of these services is also considered an eligible expense.
 - (h) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered under the supervision of a Physician and in a Medical Care Facility as defined by the Plan.
 - (i) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included.
 - (j) **First pair of contact lenses or eyeglasses** when needed to replace the human lens lost due to cataract surgery and other intraocular surgeries.
 - (k) **Diabetes self-management education and training.**
 - (l) **Durable Medical Equipment**, including oxygen and oxygen equipment, if deemed Medically Necessary. A statement is required from the prescribing Physician describing how long the equipment is expected to be Medically Necessary. This statement will determine whether the equipment will be rented or purchased. Benefits are limited to the fair market value of the equipment at the time of purchase. If the equipment is purchased, benefits include expenses related to necessary repairs and maintenance. Initial replacement equipment will be covered if the replacement equipment is required due to a change in the Covered Person's physical condition; or, purchase of new equipment will be less expensive than repair of existing equipment.
 - (m) **Treatment of documented cases of eating disorders (bulimia or anorexia).**
 - (n) **Foot treatment** if deemed Medically Necessary for conditions, including removal of nail roots, surgical procedures or treatment of a metabolic or peripheral vascular disease. Routine foot care such as non-surgical treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia or bunions; corns; callouses; and toe nails is excluded.
 - (o) **Genetic testing** includes diagnostic testing of genetic information and counseling when medically appropriate.
 - (p) **Hearing tests,, hearing aids, office visits and related supplies** for the diagnosis of hearing loss when prescribed by an audiologist, limited as outlined in the Schedule of Medical Benefits.

expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

- (y) **Organ transplant expenses. (other than those received through the Aetna IOE Program):** Transplants deemed Medically Necessary, the facility's recommendations and Physician documentation. Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a Participant. Benefits for such charges, services and supplies are not provided under this provision if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.

- (z) **Orthotics that are the original fitting, adjustment and placement of appliances such as braces, casts, splints, crutches, cervical collars, head halters, or other appliances to aid in their function when impaired. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person.**
- (aa) **Physical therapy provided by a licensed physical therapist. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions which are subject to significant improvement through short-term therapy. Eligible expenses do not include maintenance therapy.**
- (bb) **Pre-admission and pre-surgical testing within seven (7) days of a scheduled inpatient Hospital admission, as outlined in the Schedule of Medical Benefits.**
- (cc) **Routine Preventive Care. Covered charges under Medical Benefits are payable for routine Preventive Care as outlined in the Schedule of Medical Benefits.**
- (dd) **The initial purchase, fitting and repair of fitted prosthetic devices, artificial limbs and artificial eyes, which replace body parts. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person, or, usual and reasonable wear and tear.**
- (ee) **Reconstructive surgery. Correction of abnormal congenital conditions, birth abnormalities resulting in the malformation or absence of a body part or conditions caused by an accidental injury or covered illness.**

Reconstructive mammoplasties will also be considered covered charges. Mammoplasty benefits will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (ff) **Respiratory therapy.**
- (gg) **Services outside of the United States of America. Care, treatment or supplies rendered outside the United States of America or its territories, for all Covered Persons, while traveling for business or pleasure.**

AETNA INSTITUTE OF EXCELLENCE (IOE)

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- (1) Charges for activating the donor search process with national registries.
- (2) Compatibility testing of prospective organ donors that are immediate family member. For purposes of this section an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- (3) Inpatient and outpatient expenses directly related to a transplant.
- (4) Charges made by a Physician or a transplant team.
- (5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- (6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically incurred during the four (4) phases of transplant care described below. Expenses incurred for one transplant during these four (4) phases of care will be considered one (1) transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The four (4) phases of one (1) transplant occurrence and a summary of covered transplant expense during each phase are as follows:

- (1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
- (2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

Limitations

Transplant coverage does not include charges for the following:

- (1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- (2) Services and supplies furnished to a donor when recipient is not a Covered Person.
- (3) Home infusion therapy after the transplant occurrence.
- (4) Harvesting or storage of organs without the expectation of immediate transplant for an existing illness.
- (5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- (6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

- (7) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.
- (8) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed. Mileage reimbursement is \$.23 per mile.
- (9) Lodging allowances. Reimbursement of expenses incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of \$50 per night per person, to a maximum of \$100 per night.
- (10) Overall maximum. Travel and lodging reimbursement is limited to \$10,000 for any 1 transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.
- (11) Companions. One (1) companion is permitted per adult and two (2) parents or guardians are permitted per Child.

- (13) **Gambling Addiction.** Expenses for services related to gambling addiction will not be considered eligible.
- (14) **Government coverage.** Expenses for services furnished by or for the United States government or any other government, unless payment is legally required.
- (15) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.
- (16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.
- (17) **Illegal act.** Expenses for Injuries incurred during the commission or attempted commission of any criminal act, as defined by the State, involving, but not limited to the following:
 - Involving the use of alcohol or illegal drugs, excluding minor traffic violations; or
 - Involving violence or the threat of violence to another person; or
 - In which the Covered Person uses a firearm, explosive or other weapon likely to cause physical harm or death.

This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (18) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence. Prescription drugs will be considered under the Prescription Drug Program.
- (19) **Infertility.** Care, supplies, services and treatment for infertility, including fertility drugs, except for diagnostic services rendered for infertility evaluation.

Impregnation procedures, such as but not limited to artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer) are also excluded.
- (20) **Morbid Obesity.** Reversal of any surgical treatment of Morbid Obesity.
- (21) **Music therapy, vision therapy or remedial reading therapy or treatment for learning disabilities.**
- (22) **No charge.** Care, treatment and services for which there would not have been a charge if no coverage had been in force.
- (23) **Non-emergency Hospital admissions on Friday/Saturday.** Care, treatment and services billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (24) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (25) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; and care, treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or illness.
- (26) **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under the Plan, such as, but not limited to holistic, massage therapy, rolfing, hypnosis, homeopathic and naturopathic services.
- (27) **Nuclear accidents.** Services related to any actual or alleged nuclear reaction, nuclear radiation, radioactive contamination or radioactive substance.

- (44) Surgical sterilization reversal.** Expenses related to reversal of surgical sterilization.
- (45) Surrogate parenting.** Expenses related to surrogate parenting.
- (46) Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (47) Visual acuity testing, visual correction other than cataract removal, by any means, including eyeglasses or contact lenses, except as otherwise specified.**
- (48) War, etc.** Any expenses resulting from losses which are due to riot, revolt, war or any act of war, whether declared or not.

- (5) Norplant.
- (6) Contraceptive Devices.
- (7) Sexual dysfunction.

Expenses Not Covered

The Plan will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for Cosmetic purposes.** Charges for drugs used for Cosmetic purposes, such as anabolic steroids, or medications for hair growth or removal.
- (6) **Experimental/Investigational.** Experimental/Investigational drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Fertility drugs.** A charge for fertility medication.
- (9) **Growth hormones.** Drugs to enhance physical growth or athletic performance or appearance.
- (10) **Immunization.** Immunization agents or biological sera.
- (11) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital or institution confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (16) **No prescription.** Over the counter medications, with the exception of insulin, insulin syringes and insulin-related diagnostic materials.
- (17) **Refills.** Any refill requested more than one year after the date ordered by the Physician.

DENTAL BENEFITS

This benefit applies when a Covered Person incurs covered dental charges while covered under the Plan.

DEDUCTIBLE

Individual Deductibles. A deductible is the amount of covered expenses a Covered Person must pay during each calendar year and or Lifetime, if applicable, before the Plan will consider expenses for reimbursement. The individual deductible is shown in the Schedule of Dental Benefits.

BENEFIT PAYMENT

Covered dental expenses in excess of the deductible amount will be reimbursed at the percentage shown in the Schedule of Dental Benefits.

MAXIMUM BENEFIT AMOUNT

The maximum dental benefit amount is shown in the Schedule of Dental Benefits.

DENTAL CHARGES

Dental charges are the Usual and Customary Charges (U&C), if applicable, made by a Dentist or Physician for necessary care, appliances or other dental material listed as a covered dental service.

A temporary procedure, such as a temporary filling, crown or preparatory procedure will be considered a part of the final dental service, rather than a separate one.

INCURRED DATES OF BENEFITS

A charge is incurred on:

The date the impression is taken, in the case of dentures or fixed bridges.

The date the preparation of the tooth is begun, in the case of crown work.

The date the work on the tooth is begun, in the case of root canal therapy; and

The date the service is provided in the case of any other work.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The maximums on Class A services are for preventive and diagnostic services.

(1) Visits and Routine X-rays.

- (a) Visit during office hours for oral examination (limited to two (2) every calendar year).
- (b) Prophylaxis (limited to two (2) every Calendar Year).
- (c) Topical application of fluoride (limited to two (2) Courses of Treatment, per calendar year, and to Children under age 14).
- (d) Full mouth X-rays (not more than twice every Calendar Year).
- (e) Bitewing X-rays, if necessary (limited to two (2) every Calendar Year).

- (c) Alveoplasty with ridge extension, per arch.
 - (d) Removal of exostosis.
 - (e) Excision of hyperplastic tissue, per arch; and
 - (f) Excision of pericoronal gingival.
- (9) Anesthesia if Dentally Necessary provided in conjunction with Surgery (local Anesthesia is part of procedure expense).
- (10) Periodontics.
- (11) Endodontics.
- (a) Pulp capping.
 - (b) Therapeutic pulpotomy (in addition to restoration).
 - (c) Vital pulpotomy; and
 - (d) Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only.
- (12) Root Canals (devitalized teeth only), including necessary X-rays and cultures, but excluding final restorations.
- (a) Canal therapy.
 - (b) Single rooted.
 - (c) BI-rooted.
 - (d) Tri-rooted, and
 - (e) Apicoectomy (separate procedure).
- (13) Restorative Dentistry excluding Inlays, Crowns (other than stainless steel) and bridges. (Multiple restoratives in one (1) surface will be considered as a single restoration):
- (a) Amalgam filling.
 - (b) Silicate cement filling.
 - (c) Plastic filling; and
 - (d) Composite filling.
- (14) Pins (Retention) when part of the restoration used instead of gold or Crown restoration.
- (15) Full or Partial Denture Repairs:
- (a) Broken dentures, no teeth involved.
 - (b) Partial denture repairs (metal); and
 - (c) Replacing missing or broken teeth.
- (16) Adding teeth to partial denture to replace extracted natural teeth.

- (d) Slotted pontic
 - (e) Porcelain fused to gold
 - (f) Porcelain fused to non-precious metal
 - (g) Plastic processed to gold; and
 - (h) Plastic processed to non-precious metal
- (7) Removable Bridge (unilateral), one (1) piece casting, chrome cobalt alloy clasp attachment (all types) including pontics.
- (8) Dentures and partials, fees for dentures, partial dentures and relining within six (6) months after installation.
- (a) Complete upper denture.
 - (b) Complete lower denture
 - (c) Partial acrylic upper or lower with additional clasps as necessary.
 - (d) Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two (2) clasp; and
 - (e) Laboratory reline.
- (9) Dental Implants.

Class D Services: Orthodontic Treatment and Appliances

This benefit is for treatment to move teeth by means of appliances to correct a malocclusion of the mouth.

These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments, adjustment of appliances, cervical traction, and retention appliances but only when one or more of the following conditions is present:

- (1) The existence of an extreme bucco-lingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)
- (2) A protrusion of the upper teeth of more than four (4) millimeters.
- (3) A protrusive or retrusive relation of the maxillary or mandibular arch of at least one (1) cusp. (The upper and lower teeth buck back.)
- (4) An arch length difference of more than four (4) millimeters in either the maxillary or mandibular arch.
- (5) A bimaxillary protrusion of four (4) millimeters or more.
- (6) A cross-bite.

The Plan will make installment payments for comprehensive full-banded orthodontic treatments.

The Plan will make an initial payment when the first active appliance is placed not to exceed 50% of the calendar year maximum as outlined on the Schedule of Dental Benefits. The remaining amount will be distributed in equal payments each month during the course of treatment until the earlier of the completion of treatment, maximum benefits have been received or the Plan ends.

- (10) **Government coverage.** Expenses for services furnished by or for the United States government or any other government, unless payment is legally required.
- (11) **Harmful Habit appliances.** Harmful Habit appliances, except as specified in Covered Dental Services.
- (12) **Hospital charges.**
- (13) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (14) **Illegal act.** Expenses for injuries incurred during the commission or attempted commission of any criminal act, as defined by the State, involving, but not limited to the following:
 - Involving the use of alcohol or illegal drugs, excluding minor traffic violations; or
 - Involving violence or the threat of violence to another person; or
 - In which the Covered Person uses a firearm, explosive or other weapon likely to cause physical harm or death.

This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (15) **Initial placement of partial or full removable denture, initial placement of partial or full removable denture removable bridge, or fixed bridgework if it includes replacement of one (1) or more natural teeth missing before the Plan Participant was covered under the Plan unless it also includes replacement of a natural tooth that:**
 - (a) Is removed while the Plan Participant is covered hereunder; and
 - (b) Was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior five (5) years.
- (16) **Medical services.** Services that to any extent are payable under any medical expense benefits of the Plan.
- (17) **Myofunctional therapy.**
- (18) **No listing.** Services which are not included in the list of covered dental services.
- (19) **Occupational.** Any expenses relating to an injury or illnesses that arising out of, incurred in, or connected with the course of any activity for wage or profit, or expenses for which the Covered Person would be entitled to benefits under any worker's compensation, U.S. longshoreman and harbor worker's or other occupational health legislation or policy or any exception or settlement made under the same (whether or not actually in force), or expenses eligible for reimbursement under any other plan, program, insurance coverage, arrangement or the like.
- (20) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (21) **Personalization.** Personalization of dentures.
- (22) **Replacement.** Replacement of lost or stolen appliances. Replacement of a partial or full removable denture, a removable bridge or fixed bridgework, or a Crown or gold restoration within five (5) years of installation.
- (23) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are Cosmetic.
- (24) **Temporary.** Temporary dental service will be considered an integral part of the final dental service rather than a separate service.

FILING A CLAIM

HOW TO SUBMIT A CLAIM

The following general steps should be followed in order to submit a claim for Medical, Vision, Dental and Prescription Drugs:

- (1) Obtain a claim form from the Human Resources Department, the Plan Administrator or on-line at myMERITAIN.com.
- (2) Complete the Employee section of the form. Answer all questions, even if the answer is "none" or "N/A" (not applicable), including the section referring to other insurance ("COB"). A separate claim form must be completed for each Covered Person for whom benefits are being requested.
- (3) The Physician, Dentist or other provider must complete the provider's portion of the form.
- (4) Attach bills for services rendered. Documentation must include:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number and federal tax identification number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of service
 - Charges
 - If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to the Plan.
- (5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

Meritain Health
P.O. Box 27257
Minneapolis, MN 55427-0267

or by fax to: 716-319-5599

or by e-mail to: Fairfaxwater@meritain.com

Questions regarding the claim can be addressed by calling the toll-free number on the member's ID card.

WHEN CLAIMS MUST BE SUBMITTED

Claims must be filed with the Claims Processor within 365 days of the date the service was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed after 365 days of the date the service was incurred will be declined.

The Claims Processor will determine if sufficient information has been submitted for appropriate consideration of the claim. If not, additional information may be requested.

of obtaining the health care in question.

- (4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination. If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication

- (1) An explanation of the specific reasons for the denial;
- (2) A reference to the Plan provision or insurance contract provision upon which the denial is based;
- (3) A description of any additional information or material that you must provide in order to perfect the claim;
- (4) An explanation of why the additional material or information is necessary;
- (5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (6) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
- (7) If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances, or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);
- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- (4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
- (5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

Deadline for Internal Review of Initially Denied Claims

- (1) **Urgent Care Claims.** For urgent care claims, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an initial adverse determination by the Plan.
- (2) **Pre-Service Claims.** For a pre-service claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of your request for review of the initial adverse determination.
- (3) **Post-Service Claims.** For a post-service claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives your request for review of the initial adverse determination.

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims. Upon completion of its review of an initial adverse determination, the reviewer will give you a notice of its benefit determination. For an adverse determination, the notice will include:

- (1) A description of the Plan's decision;
- (2) The specific reasons for the decision;
- (3) The relevant Plan provisions or insurance contract provisions on which its decision is based;
- (4) A statement that you are entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
- (5) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
- (6) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and
- (7) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

Any notice of adverse determination will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

Duplication of Benefits – Class E Employees.

The plan that pays first according to the rules will pay as if there was no other coverage. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Non-Duplication of Benefits – Class F Employees.

When a Covered Person is covered under more than one benefit plan, the "primary" plan will determine and pay benefits first without regard to benefits provided under any other group health plan.

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

For example, if another group health plan is "primary" and the Plan is "secondary," and the "primary" plan pays 70% for a covered benefit while the Plan would pay 80% for the same benefit, the Plan would pay the difference between 70% and 80%, or 10% of the remaining covered expenses. This is called non-duplication of benefits. The balance due, if any, is the responsibility of the Covered Person.

Benefit Plan. The Plan will coordinate the medical and dental benefits with the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs, including Medicare.
- (5) Other plans required or provided by law. This provision does not include any benefit plan or Medicaid that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance.

Allowable Charge. The Plan will consider only covered charges under the Plan as Allowable Charges.

In the case of HMO (Health Maintenance Organization) or other in-network only plans, the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of "service type plans" where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

No-Fault limitations. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

- (g) When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.
- (h) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer period of time will determine benefits thereunder first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

- (3) Medicare will pay primary, secondary or last, as specified in applicable law.

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If the Covered Person did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

- (4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an Alternate Recipient, in the manner described in the Plan's QMCSO Procedures.

Inability to Locate Recipient. If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.

Certificates of Creditable Coverage

The Plan will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan before December 31, 2014. In addition, until December 31, 2014 (or later, to the extent required under applicable law), a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information about any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan. All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the General Plan Information page.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered Employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired Employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the Employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, for the reason described in the preceding sentence, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if an Employee, a Spouse or a Dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

- (i) The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

**Human Resources
COBRA Qualifying Event
Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, Virginia 22031
(703) 289-6097**

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- (i) The covered Employee's name, address, phone number and health plan ID number.**
- (ii) The name, address, phone number and health plan ID number for any Dependent child or Spouse whose eligibility is affected by the qualifying event.**
- (iii) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.**
- (iv) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.**
- (v) The signature of the person sending the letter.**

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.**
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.**

- (vi) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered Employee. For example, an Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent child unless an active Employee's entitlement to Medicare would have been an initial Qualifying Event, i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent child.

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary (or a covered Employee or Spouse) must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else) must notify the Plan Administrator of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 100% of the actual cost of coverage.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes.

What is Timely Payment for payment for COBRA continuation coverage? For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

ADMINISTRATIVE ERROR

If, due to an administrative error, an overpayment occurs in a reimbursement amount from the Plan, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the overpayment. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING, MODIFYING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination. If the Plan is amended or modified, expenses incurred prior to the modification or amendment of the Plan will be considered as provided under the terms of the Plan prior to its amendment or modification.

The Employer by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend or terminate the Plan in whole or in part. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by a successor to the Plan Sponsor.

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

- (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
- (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

Benefits are paid from the Plan's Trust.

PLAN NAME

Fairfax County Water Authority Health Plan

TAX ID NUMBER: 54-6301784

INITIAL PLAN EFFECTIVE DATE: January 1, 2006

RESTATED PLAN EFFECTIVE DATE: January 1, 2014

STOP LOSS CONTRACT PERIOD: January 1 through December 31

PLAN YEAR: The 12-month period for the Plan Sponsor preceding December 31, unless otherwise stated.

EMPLOYER INFORMATION

Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, Virginia 22031
(703) 289-6097

AGENT FOR SERVICE OF LEGAL PROCESS

Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, Virginia 22031
(703) 289-6097

CLAIMS PROCESSOR

Meritain Health
P.O. Box 27267
Minneapolis, Minnesota 55427-0267

TRUSTEE(S)

Fairfax Water
Welfare Benefit Trust
8570 Executive Park Avenue
Fairfax, Virginia 22031

SCHEDULE A

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ARIZONA – CHIP	CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

Important Notice from Fairfax Water About

NEW YORK – Medicaid	TEXAS – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	VERMONT – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famls.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpym/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

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

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

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

If you decide to join a Medicare drug plan, your current Fairfax Water coverage will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, coverage under the Fairfax County Water Authority Health Plan will end for you and your eligible dependents.

If you do decide to join a Medicare drug plan and drop your current Fairfax Water coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Fairfax Water changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Schedule C



EXPRESS SCRIPTS®

2014 Express Scripts Preferred Drug List

A

ABILIFY, ABLIFY DISC MELT
ACANYA
ACCU-CHEK LANCETS;
FASTCLIX, MULTICLIX,
SOFT TOUCH, SOFTCLIX
acetaminophen/codeine
ACTONEL
acyclovir
ACZONE
ADCIRCA
AGGRENOX
albuterol
alendronate sodium
allopurinol
ALPHAGAN P 0.1%
alprazolam
ALREX
amiodarone
AMITIZA
amitriptyline
amlodipine
amlodipine/benazepril
amoxicillin
amoxicillin/potassium
clavulanate
amphetamine salt combo
amphetamine salt combo
ext-release
AMPYRA
AMTURNIDE
ANALPRAM ADVANCED
CREAM KIT
ANALPRAM HC 1% CREAM,
2.5% LOTION
anastrozole
ANDRODERM
ANDROGEL
antipyrine/benzocaine
ARANESP (INU)
arbinaxa
ARCAPTA
ASACOL HD
ASMANEX
ASTEPRO
ATELVIA
atenolol
atenolol/chlorothalidone
atorvastatin
ATRALIN
AVELOX
AVONEX (INU)
AXIRON
AZASITE
azathioprine
azelastine nasal spray
AZILECT
azithromycin
AZOR

B

baclofen
benazepril
benazepril/
hydrochlorothiazide

BENCAR, BENCAR HCT
BENZAFLIN PUMP
benzonatate
BEPREVE
BESIVANCE
BEYAZ
bisoprolol/
hydrochlorothiazide
BRILINTA
BROMDAY
budesonide neb susp
bupropion
bupropion ext-release
(12 hour)
bupropion ext-release
(24 hour)
buspirone
butalbital/acetaminophen/
caffeine
BUTRANS
BYDUREON (INU)
BYETTA (INU)
BYSTOLIC

C

calcipotriene
CANASA
carbidopa/levodopa
carvedilol
cefdinir
cefprozil
cefuroxime
CELEBREX
GENESTIN
cephalexin
CETROTIDE (INU)
chlorothalidone
chloronic
ganadotropin (INU)
CIALIS
CIPRODEX
ciprofloxacin
ciprofloxacin eye solution
citalopram
clarithromycin
clindamycin hcl
clindamycin phosphate
clobetasol propionate
clomiphene citrate
clonazepam
clonidine
clepidogrel
clemastine/
betamethasone
dipropionate
COLCRYS
COMBIGAN
COMBIPATCH
COMBIVENT RESPIMAT
COPAXONE (INU)
COREG CR
CREON
CRESTOR
CRINONE
cyanocobalamin (INU)
cyclobenzaprine

CYMBALTA

D

DALIRESP
DAYTRANA
DELZICOL
desloratadine
desonide
DETROL LA
dexamethasone
diazepam
diclofenac sodium
delayed-release
dicyclamine hcl
DIFFERIN 0.3% GEL,
0.1% LOTION
digoxin
diltiazem ext-release
(24 hour)
DIOVAN
difenoxylate/atropine
divalproex sodium
ext-release
DIVIGEL
donepezil
doxolamide/timolol
doxazosin
doxepin
doxycycline hyclate
doxycycline monohydrate
DULERA
DUREZOL

E

EFFIENT
ELIDEL
elilphos
ELIQUIS
enalapril
ENBREL (INU)
ENDOMETRIN
ENUVIA
enoxaparin (INU)
EPIDUO
EPIPEN, EPIPEN JR (INU)
ergocalciferol
erythromycin eye ointment
escitalopram
estradiol
estradiol/norethindrone
acetate
etodolac
EUFLEXA (INU)
EURAX
EVAMIST
EVISTA
EXELON PATCHES
EXFORGE, EXFORGE HCT
EXTAWIA (INU)

F

famotidine
fenofibrate
fenofibrate micronized

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription-drug benefit programs; check your benefit materials for the specific drugs covered and the copayments for your prescription-drug benefit program. For specific questions about your coverage, please call the phone number printed on your ID card.

fenfluramine citrate
FENTORA
FINACEA, FINACEA PLUS
finasteride
flucanazole
fluocinonide
fluoxetine
fluticasone nasal spray
FOCALIN XR
folic acid
FORADIL
FORTEO (INU)
FOSRENOL
FRAGMIN (INU)
furosemide

G

gabapentin
GELNIQUE
gemfibrozil
GENOTROPIN (INU)
glanvi
glimperide
glipizide
glipizide ext-release
GLUCAGON (INU)
glucagon (INU)
glyburide
glyburide/metformin
GONAL-F (INU)
GRALISE

H

HALFLYTELY-BISACODYL
HUMALOG (INU)
HUMATROPE (INU)
HUMIRA (INU)
HUMULIN (INU)
hydalazine
hydrochlorothiazide
hydrocodone/
acetaminophen
hydrocodone/
chlorpheniramine
polistirex
hydrocodone/bimatropine
hydrocodone/ibuprofen
hydrocortisone topical
hydromorphone
hydroxychloroquine
hydroxyzine hcl
hydroxyzine pamoate

I

ibandronate
ibuprofen
ILEVRO
INCHEX
indomethacin
INTUNIV
INVOKANA
irbesartan
isosorbide mononitrate
ext-release

J

JANUMET, JANUMET XR
JANUVIA
JUVISYNC

K

ketocanazole topical
KOMBIGLYZE XR
KRISTALOSE

L

labetalol hcl
LAMICTAL ODT
lamotrigine
lansoprazole
delayed-release
LANTUS, LANTUS
SOLOSTAR (INU)
latanoprost
LATUDA
LETAIRIS
levalbuterol
LEVEMIR, LEVEMIR
FLEXPEN (INU)
levetiracetam
levocetirizine
levofloxacin
levofloxacine sodium
LIALDA
LINZESS
lithyronine
LIPOFEN
LIPTRUZET
lisinopril
lisinopril/
hydrochlorothiazide
lithium carbonate
LOESTRIN 24 FE,
LO LOESTRIN FE
lorazepam
lorazepam
losartan
losartan/
hydrochlorothiazide
LOTEMAX
lovastatin
LOVAZA
LUNIGAN
LUNESTA
LYRICA

M

MAKENA (INU)
meclizine hcl
medroxyprogesterone
acetate
meloxicam
metaxalone
metformin
metformin ext-release
methadone
methimazole
methocarbamol

methotrexate
methylphenidate
methylphenidate
ext-release
methylprednisolone
metoclopramide hcl
metoprolol succinate
ext-release
metoprolol tartrate
metronidazole
metronidazole vaginal gel
microgestin fe
minocycline
mirtazapine
modafinil
memetasone
menonessa
montelukast
morphine sulfate
ext-release
MOVIPREP
MOXEZA
multivitamins/fluoride
mupirocin
MUSE
MYRBETRIQ

N

nabumelone
nadolol
NAMENDA, NAMENDA XR
naproxen, naproxen sodium
NASCOBAL
NASONEX
NATAZIA
neomycin/polymyxin/
hydrocortisone ear drops
NEVANAC
NEXIUM
NIBSPAN
nifedipine ext-release
nitrolurantoin macrocrystal
NITROLINGUAL PUMPSPRAY
NORDITROPIN (INU)
nortriptyline
NOVOFINE
NUCYNTA, NUCYNTA ER
NUEDEXTA
NUVARING
nystatin
nystatin/triamcinolone

O

ofloxacin eye solution
olanzapine
omeprazole delayed-release
ondansetron
ondansetron orally
disintegrating tablets
ONETOUCH KITS/METERS;
BASIC, ULTRA 2,
ULTRAMINI,
ULTRASMART, VERIO IQ

(continued)

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2014 THROUGH DECEMBER 31, 2014. THIS LIST IS SUBJECT TO CHANGE.

You can get more information and updates to this document at our website at www.express-scripts.com.

Schedule D



Specialty Drug List by Disease State

ANTICOAGULANT

Arixtra
Enoxaparin Sodium
Fondaparinux
Fragmin
Iprivask
Innohep
Lovenox

BLOOD CELL DEFICIENCY

Aranesp
Epogen
Leukine
Mozobil
Neulasta
Neumega
Neupogen
Procrit
Promacta

CANCER

Abraxane
Adcetris
Adriamycin
Aducril
Afinitor
Afinitor Disperz
Alferon N
Alimta
Alkeran
Amifostine
Aredia
Arranon
Arzerra
Avastin
Bicnu
Elenoxane
Bleomycin Sulfate
Bosulif
Busulfex
Calcium Folate
Campath
Camptosar
Carboplatin
Carubicidine
Cisplatin
Cladribine
Clolar
Cosmegen
Cyclophosphamide
Cytarabine
Cytosan
Dacarbazine
Dacogen

CANCER cont.

Daunorubicin HCL
Daunoxome
Decitabine
Degarelix
Depocyt
Dexrazoxane
Docefrez
Docetaxel
Doxil
Doxorubicin
DTIC-Dome IV
Eligard
Elitak
Elience
Eloxatin
Elspar
Epirubicin HCL
Erbitux
Erivedge
Ethyol
Etopophos
Etoposide
Faslodex
Flouxuridine
Fludara
Fludarabine Phosphate
Fluorouracil
Fudr
Fusilev
Gemcitabine HCL
Gemzar
Gleevec
Halaven
Herceptin
Hycamtin
Iclusig
Idamycin PFS
Idarubicin HCL
Ifex
Ifex/Mesnex
Ifosfamide
Ifosfamide/Mesna
Inlyta
Intron A
Irinotecan HCL
Istodax
Ixempra
Jakafi
Jevtana
Kadcyla
Kyprolis
Leucovorin Calcium
Leuprolide Acetate

CANCER cont.

Leustatin
Lipodox
Lipodox 50
Lupron
Lupron Depot
Lupron Depot-PEO
Mekinist
Melphalan HCL
Mesna
Mesnex Methotrexate
Methotrexate Sodium
Mitomycin
Mitoxantrone HCL
Mustargen
Mutamycin
Mylotarg
Navelbine
Nexavar
Nipent
Novantrone
Oforta
Oncaspar
Ontak
Orxol
Oxaliplatin
Paclitaxel
Pamidronate Disodium
Paraplatin
Perjeta
Photofrin
Plenaxis
Pomalyst
Proleukin
Ravimid
Rituxan
Rofaron-A
Sprycel
Stivarga
Sutent
Sylatron
Synribo
Tafinlar
Tarabine PFS
Tarceva
Tasigna
Taxol
Taxotere
Temodar
Temozolomide
Thalomid
Theracys
Thiotepa
Thyrogen

CANCER cont.

Tice BCG
Toposar
Torisel
Totect
Treanda
Trelstar Depot
Trelstar LA
Trisenox
Tykerb
Valstar
Vantas
Vectibix
Velcade
Viadur
Vidaza
Vinblastine Sulfate
Vincristine Sulfate
Vinorelbine Tartrate
Votrient
Vumon
Xalkori
Xeloda
Xgeva
Xtandi
Zaltrap
Zanosar
Zelboraf
Zincard
Zoladex
Zolanza
Zometa
Zytiga

ENDOCRINE DISORDERS

DDAVP
Desmopressin Acetate
Egrifta
Kuvan
Octreotide Acetate
Sandostatin
Sandostatin LAR
Somatuline Depot
Somavert

ENZYME DEFICIENCIES

Aldurazyme
Ceredase
Cerezyme
Elaprase
Fabrazyme
Lumizyme
Myozyme
Naglazyme

Note: This drug list is provided as a guide and is updated periodically based on information from Express Scripts. For precise details related to your specialty-drug benefit, please contact Express Scripts.

Schedule D



EXPRESS SCRIPTS®

Specialty Drug List by Disease State

RESPIRATORY CONDITIONS cont.

Kalydeco
Pulmozyme
Tobi
Tobi Podhaler
Xofair

RSV PREVENTION Synagis

TRANSPLANT

Atgam
Cellcept
Prograf
Sandimmune
Simulect
Thymoglobulin
Zenapax

Note: This drug list is provided as a guide and is updated periodically based on information from Express Scripts. For precise details related to your specialty-drug benefit, please contact Express Scripts.