

Over 65 Medicare Supplement Program

If you have Medicare Part A and Part B coverage and you do not have other Part D prescription drug coverage, the Over 65 Medicare Supplement Program is available to you. This program provides an additional level of protection for hospital and medical expenses after Medicare pays.

The program includes prescription drug coverage and a Health Reimbursement Arrangement. An outside vendor, OneExchange, also makes Medicare Supplement Plans through a Medicare Exchange available to retirees of the Company.

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Highlights

Your Over 65 Medicare Supplement Program Benefits ...

- ... Are Available to Retirees and Eligible Spouses Who are at Least Age 65 and are Covered Under Medicare Part A and Part B, *but not Other Part D.*
- ... Provide Prescription Drug Coverage that Exceeds the Level of Coverage Provided by Medicare Part D
- ... Provide Assistance with the Cost of Health Care Expenses through a Health Reimbursement Arrangement (HRA)

What happens to your benefits when ...

For more information about what happens to your Over 65 Medicare Supplement Program coverage when certain changes or events occur, see “How Changes Affect Your Benefits” in the “About Your Benefits” chapter.

How the Over 65 Medicare Supplement Program Works

OneExchange, an outside vendor that is not affiliated with the Company, offers a Medicare Exchange to assist retirees with selecting individual health coverage in the Medicare market. The Company only makes this exchange available to retirees and in no way sponsors or promotes the individual plans sold on the OneExchange Medicare Exchange. A licensed benefit advisor with OneExchange is available to help you evaluate options and enroll in individual coverage that fits your health, dental, and vision needs. Cost is dependent on the plan(s) you select. You will pay premiums directly to the insurance provider(s).

When you enroll in a Medicare supplement plan through the OneExchange Medicare Exchange, the Company will provide a comprehensive group prescription drug plan so you will not experience a gap—known as the “donut hole”—in drug coverage that is part of Medicare Part D plans.

In addition, if eligible, the Company will assist with the cost of health care expenses by providing benefit dollars through a Health Reimbursement Arrangement (HRA) that can be used to reimburse health care expenses, including insurance premiums and other eligible out-of-pocket health care expenses.

Medicare Part A and Part B benefits are primary to any of the individual plans that you may choose in the OneExchange Medicare Exchange for Medicare-eligible retirees and their eligible dependents. This means Medicare pays benefits first. Then the individual plan you purchased may pay eligible expenses that are more than the amount payable for the same medical expenses under Medicare Part A or Part B.

You must enroll when first eligible, and maintain coverage, under both Medicare Part A and Part B to be eligible for coverage in this program.

If you enroll in a Medicare Part D prescription drug plan other than the ORNL Prescription Drug Plan, your Health Reimbursement Arrangement and prescription drug coverage under this program will be cancelled, and you cannot re-enroll later. These eligibility rules apply to retirees and to eligible spouses of retirees.

If you or your spouse cancels coverage or loses coverage for any reason (including enrolling in Medicare Part D), there is no future opportunity to re-enroll in this plan.

In order for a spouse to participate in this plan, the retiree must participate. A surviving spouse may be able to participate in the plan if enrolled or eligible to enroll prior to the retiree's death.

You must elect coverage when you are first eligible. If you do not, or if you elect and later cancel coverage, neither you nor your spouse can later enroll or re-enroll.

More information about Eligibility is found in the chapter titled “About Your Benefits.”

Your Prescription Drug Benefit ...

... Provides Comprehensive Drug Coverage

Your plan combines coverage through the Medicare Part D program with Company-provided additional coverage. This added coverage lowers the cost you pay for your prescriptions and provides coverage for drugs that are not on the Medicare Part D formulary.

... Allows You the Flexibility to Use a Network Pharmacy or any Pharmacy You Choose

Benefits are higher when you use a network pharmacy, but you can go to any pharmacy you choose and still receive prescription benefits.

- Call Express Scripts at 1-877-701-9946 for assistance with locating a network pharmacy. This number is listed on your Express Scripts ID card.

... Offers a Convenient Home Delivery Option

The home delivery option, designed for maintenance drugs, provides up to a 90-day supply of a drug. You will pay the required copayment. New prescriptions can be ordered by mail if you complete an order form and mail it with your new prescription. Ordering options:

- *Mail to:* Express Scripts
PO Box 30493
Tampa, FL 33633-0561
- *Fax:* Have your doctor call 1-888-327-9791 for information on how to fax to Express Scripts.
- *Internet Refills:* www.express-scripts.com
- *Telephone Refills:* 1-877-701-9946
 - Have your ID card and refill bottle with the prescription information ready.

ORNL Prescription Drug Plan, Administered by Express Scripts

You may have to pay an additional income-related adjustment if you meet certain income criteria as determined by Centers for Medicare & Medicaid Services (CMS). See www.CMS.gov for more information.

Deductible stage	<ul style="list-style-type: none"> • You pay a \$150 yearly deductible for prescriptions filled at retail pharmacies. • Prescriptions filled by mail are not subject to a deductible. • After you pay your yearly retail-only deductible, you will pay the following: 		
Tier Name	Retail Final Cost-Share (31 day supply)	Retail Final Cost-Share (90 day supply)	Mail-Order Final Cost-Share (90 day supply)
Tier 1: Generic Drugs	20% coinsurance \$10 minimum	20% coinsurance \$30 minimum	\$15 copayment
Tier 2: Preferred Brand Drugs	30% coinsurance \$10 minimum	30% coinsurance \$30 minimum	\$35 copayment
Tier 3: Non-Preferred Brand Drugs	30% coinsurance \$10 minimum	30% coinsurance \$30 minimum	\$35 copayment

Health Reimbursement Arrangement

The purpose of the HRA Plan is to reimburse Participants for Eligible Medical Expenses which are not otherwise reimbursed by any other plan or program.

An HRA Account is a bookkeeping account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Company's general assets.

HRA Account and Benefit Credits

A joint HRA Account will be established for the eligible retiree and eligible spouse. Benefit credits will be credited to your HRA account by the Company at the beginning of each Plan Year. You will receive an HRA credit each Plan Year that you are a Participant. You also will receive an additional HRA credit each Plan Year that your spouse is a Participant. The amount of the HRA credit is determined by the Company.

If an eligible retiree and/or spouse becomes eligible to participate in the HRA Plan after the beginning of a Plan Year, the individual's HRA credit will be prorated based on the number of months that the individual is a Participant in the HRA Plan.

At any time, the Participant may receive reimbursement for eligible medical expenses up to the amount in his or her HRA Account. The account will be reduced by the amount of any eligible medical expenses for which you are reimbursed under the HRA Plan.

Note that the law does not permit Participants to make any contributions to their HRA Accounts. If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years.

Casual Retiree

If you become a Casual Retiree, access to your HRA will be suspended during the period that you have Casual Retiree status. Furthermore, your spouse, if applicable, will not be able to access the account. Neither you nor your spouse will be reimbursed for any eligible expenses incurred during the time that you are a Casual Retiree. Access to your HRA will be reinstated when you return to full Retiree status. You will not receive

any benefit credits for the period that you are a Casual Retiree. In the year that you return to full Retiree status, benefit credits will be prorated for the remainder of the Plan Year as of the date you return to Retiree status, unless you already received a full credit for that year from being a full Retiree as of the first of the Plan Year. Even upon reinstatement, you will not be able to submit reimbursements for eligible expenses incurred while you were a Casual Retiree.

Taxation

Reimbursements for eligible medical expenses paid by the HRA Plan generally are excludable from the Participant's taxable income. However, the Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Eligible Medical Expenses

An "eligible medical expense" is an expense incurred by you or your covered spouse for medical care, as that term is defined in IRC Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease). Some common examples of eligible medical expenses include:

- Medications (in reasonable quantities), but only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin;
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision, or long-term care insurance.

Health Reimbursement Arrangement

For more information about what items are and are not eligible medical expenses, consult IRS Publication 502, “Medical and Dental Expenses,” under the headings “What Medical Expenses Are Includible” and “What Expenses Are Not Includible.” Be careful in relying on this publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account. If you need more information regarding whether an expense is an eligible medical expense under the Plan, contact the Third Party Administrator.

Some examples of common items that are *not* eligible medical expenses include the following:

- Babysitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

Only eligible medical expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only eligible medical expenses incurred while your spouse is a Participant in the Plan may be reimbursed from the HRA Account.

Eligible medical expenses are “incurred” when the medical care is provided, not when you or your Spouse is billed, is charged, or pays for the expense. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may *not* be reimbursed from an HRA Account:

- Expenses incurred for qualified long-term care services;
- Expenses incurred *prior to the date* that you became a Participant in the HRA Plan;
- Expenses incurred *after the date* that you cease to be a Participant in the HRA Plan; and
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

What Happens Upon Your Death

If you die with no spouse who is a Participant, your HRA Account is immediately forfeited upon death, but your estate or representatives may submit claims for eligible medical expenses incurred by you before your death. Claims must be submitted within 180 days of your death. If you die with a spouse who is a Participant, your HRA Account shall continue, and your spouse can continue to submit his or her eligible medical expenses for reimbursement after your death.

At the later of the eligible retiree’s or spouse’s death, the HRA Account is immediately forfeited, but the deceased eligible retiree’s or spouse’s estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree or spouse before his or her death. Claims must be submitted within 180 days of his or her death.

Continuation of Coverage

Your covered spouse may continue HRA coverage for a limited time after that date he or she would otherwise lose coverage because of a divorce from the participant. Refer to COBRA in the “Administrative Information” chapter.

Other Important Information

Prescription Drug Claims Review and Appeal Procedures

Claims and appeal for benefit coverage claims

Urgent Care Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to

review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 800-753-2851. In addition, you also may have the right to request a written translation of your letter if 10 % or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo, or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Other Prescription Drug Claims (Pre-Service and Post-Service)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45 day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

Other Important Information (cont.)

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that may be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Appeals Procedure

The plan has a two-step appeals procedure for coverage decisions. If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered “deemed” denied because missing information was not submitted in a timely manner), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

Level-One Appeal

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims.

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not submitted in a timely manner) if your situation is urgent. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim.

If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond before issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

Other Important Information (cont.)

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or if you do not agree with the determination of the external review organization, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

Level-Two Appeal

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician).

To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any considered by the plan in relation to your appeal; the plan provisions on which the decision is based; and a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond before issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

Other Important Information (cont.)

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to bring a civil action under ERISA Section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and also are described below.

External Review Procedure

The right to an independent external review is available only for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions) generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal before, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.)

Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO also will be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and that you have the right to bring civil action under ERISA Section 502(a).

Other Important Information (cont.)

Urgent External Review

Once you have submitted your urgent external review request, your claim will be reviewed immediately to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will be reviewed immediately to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

Direct Reimbursement Claims and Appeals

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The claim will be processed based on your plan benefit. To request reimbursement, send your claim to:

Express Scripts
PO Box 14711
Lexington, KY 40512

You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 30 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed, and you will have until that date to submit the missing information. If you

do not submit the information by the required date, your claim is deemed denied, and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information the claim's stale date cannot be determined, your claim will be denied, and you will have the right to appeal the decision as described below

If your claim is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim.

If you are not satisfied with the decision on your claim or if your claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Appeals Procedure

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal including missing information

Other Important Information (cont.)

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable external review processes; and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or if your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and also are described below.

Other Important Information (cont.)

External Review Procedures

The right to an independent external review is available only for claims involving medical judgment or rescission. You can request an external review by an IRO as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts

Attn: External Review Requests

PO Box 631850

Irving TX 75063-0030

Phone: 1-800-753-2851

Fax: 1-888-235-8551

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for

reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and that you have the right to bring civil action under ERISA Section 502(a).

HRA Claims Procedures

Only medical care expenses that have not been or will not be reimbursed by any other source may be considered eligible medical expenses (to the extent all other conditions for eligible medical expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to the HRA Plan for reimbursement.

You may use your HRA account for automatic reimbursement of your Medicare supplement premium payments. Contact OneExchange to set up this option.

OneExchange is the Claims Administrator for the HRA. You may submit claims for reimbursement online, by fax, or through the mail. When you submit a claim, you must provide supporting documents such as a copy of your insurance premium bill and an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from OneExchange. Your claim is deemed filed when it is received by OneExchange.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by OneExchange.

Other Important Information (cont.)

If it is later determined that you or your spouse received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your spouse will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after OneExchange receives your claim. If OneExchange determines that an extension of this time period is necessary due to matters beyond the control of the Plan, they will notify you within the initial 30 day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the HRA provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the HRA's appeal procedures and the time limits applicable to such procedures;
- a description of your right to request all documentation relevant to your claim; and
- a statement of your right to bring an external review and/or civil action under ERISA Section 502(a) following a denied appeal.

Appeals Procedure

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of OneExchange, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by OneExchange.

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law. You must submit a written request for external review to the Plan Administrator within 4 months of the notice of the internal appeal determination. You may submit additional information that you think is important for review.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Medicare Supplement Plan Claims

Any plans you purchase from the OneExchange Medicare Exchange are individual insurance policies. The Company has no involvement in the claims or appeals process for these individual plans. Please contact your insurance carrier to determine how and when you must submit claims or make an appeal.