Benefit Booklet

CVS Caremark
Hawaii PPO

Administered by HMA

Effective

June 1, 2012

SUMMARY OF BENEFITS

This is a summary of our coverage levels under this *plan.* It includes information about *coinsurance, copayments, deductibles,* and some benefit limits. This summary is intended to give you a general understanding of the coverage available under this *plan*. **For more detailed information, please read Section 3.0 for the description of coverage for each particular *covered health care service* along with the related exclusions, and Section 5.0 for a list of general exclusions.** Words or phrases used throughout this *plan* that are in italics are defined in Section 8.0 - Glossary.

IMPORTANT NOTE: All of our payments at the benefit levels noted below are based upon a fee schedule called our *allowance*. If you receive services from a *participating provider*, the *provider* has agreed to accept our *allowance* as payment in full for *covered health care services*, excluding your coinsurance, *copayments*, *deductible*, and the difference between the *maximum benefit* and our *allowance*, if any. If you receive *covered health care services* from a *non-participating provider*, you will be responsible for the *provider's charge*. You will then be reimbursed based on the lesser of the *provider's charge,* our *eligible charge*, or the *maximum benefit;* less any coinsurance, *copayments* and/or *deductibles.* The *deductible* and *maximum out-of-pocket expense* are calculated based on the lower of our *eligible charge* or the *provider's charge,* unless otherwise specifically stated in this *plan*.

***** *Prior Authorization* is required for this service. If you do not obtain *Prior Authorization* and the services are determined to be not *medically necessary* or the setting where services were received is determined to be inappropriate, we will not cover these services. *Participating providers* are responsible for obtaining *prior authorization* for all applicable *covered health care services*. When the *provider* is *non-participating*, you are responsible for obtaining *prior authorization*. If you receive services from a *provider* that participates with an out of state MultiPlan / HMN network, you are responsible for obtaining *prior authorization*. See Section 8.0 - definition of *prior authorization* for details.

****** *Copayment* amounts applicable to this benefit will not accumulate to the *maximum out-of-pocket expense*. This benefit level will not increase due to having satisfied the *maximum out-of-pocket expense* through other benefits. See Section 8.0 - Glossary for the definition of *maximum out-of-pocket expense*.

***Prior Authorization and Treatment Plan is required for this service. If you do not obtain *Prior Authorization* and the services are determined to be not *medically necessary* or the setting where services were received is determined to be inappropriate, we will not cover these services. *Participating providers* are responsible for obtaining *prior authorization* for all applicable *covered health care services*. When the *provider* is *non-participating*, you are responsible for obtaining *prior authorization*. If you receive services from a *provider* that participates with an out of state MultiPlan / HMN network, you are responsible for obtaining *prior authorization*. See Section 8.0 - definition of *prior authorization* and *treatment plan* for details.

DEPENDENT AGE LIMITS	
Dependent Age	**See Section 2.1 – Who is Eligible for Coverage.**
Children	Children are covered until their 26th birthday.

SUMMARY OF MEDICAL BENEFITS

Deductible/Maximum Out-of-Pocket Expense	**Type of Contract**	***Participating Provider***	***Non-Participating Provider***
Deductible The *deductible* applies to *participating provider* and *non-participating provider* services combined.	Individual	\$300 per *plan year*	
	Individual & Spouse/Domestic Partner	\$600 per *plan year*	
	Individual & Child(ren)	\$900/\$600 per *plan year* The *plan year deductible* is met when at least 3 members (or 2 *members* if individual & child) meet the individual deductible; however no one (1) *member* can contribute more than \$300 towards the *plan year deductible*.	
	Family	\$900 per *plan year* The *plan year* family *deductible* is met when at least 3 members meet the individual deductible; however no one (1) family *member* can contribute more than \$300 towards the *plan year* family *deductible*.	
Maximum Out-of-Pocket Expense *(*Copayments *for* contraceptives and medical foods do not apply.) *Copayment* amounts for the services marked with a double asterisk (******) in the Summary of Medical Benefits DO NOT apply to the *maximum out-of-pocket expense*. The maximum *out-of-pocket* expense applies to *participating provider* and *non-participating provider* services combined.	Individual	\$3,000 per *plan year*	
	Individual & Spouse/Domestic Partner	\$6,000 per *plan year*	
	Individual & Child(ren)	\$9,000/\$6,000 per *plan year* The *plan year maximum out-of-pocket expense* is met when at least 3 (or 2 *members* if individual & child) *members* meet the individual *maximum out-of-pocket expense*; however no one (1) *member* can contribute more than \$3,000 towards the *maximum out-of-pocket expense*.	
	Family	\$9,000 per *plan year* The plan *year* family *maximum out-of-pocket expense* is met when at least 3 members meet the individual *maximum out-of-pocket expense*; however, no one (1) family *member* can contribute more than \$3,000 towards the *plan year* family *maximum out-of-pocket expense*.	

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
Ambulance	3.1			
• Ground	3.1	Per occurrence.	After *deductible* 80% coverage	After *deductible* 80% coverage
• Air/water	3.1	Per occurrence.	After *deductible* 80% coverage	After *deductible* 80% coverage
Behavioral Health	3.2			
Mental Health Services	3.2			
• *Inpatient* *	3.2	* *Prior Authorization* is required. See Section 3.2.	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Outpatient* Mental Health/ Intermediate Care Services***	3.2	*** See Section 3.2 for *program*s, limitations and for those specific services for which *Prior Authorization* and *Treatment Plan* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
• In a *Provider's* office, or in your home***	3.2	Includes individual and group sessions. *** *Prior Authorization* and *Treatment Plan* required. See Section 3.2.	100% coverage less $20 *copayment*	After *deductible* 70% coverage
Chemical Dependency Treatment	3.2			
• *Inpatient, Chemical Dependency Treatment Facility* (inpatient)*	3.2	Detoxification: unlimited days per *plan* year. Rehabilitation: unlimited days per plan year. *** *Prior Authorization* is required. See Section 3.2.	After *deductible* 80% coverage	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• *Outpatient*, in a *Chemical Dependency Treatment Facility (outpatient)*, Intermediate Care Services [***]	3.2	*** See Section 3.2 for details about partial *hospital program*, intensive *outpatient program*, adult intensive services, and child and family intensive treatment, limitations and for those specific services *Prior Authorization* and *Treatment Plan* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
• In a *Provider's* office, or in your home ***	3.2	*** *Prior Authorization* and Treatment Plan required. See Section 3.2.	100% coverage less $20 *copayment*	After *deductible* 70% coverage
Blood & Blood Products	3.3	See Section 3.3 for details and limitations.	After *deductible* 80% coverage	After *deductible* 70% coverage
Cardiac Rehabilitation	3.4	Unlimited visits.	After *deductible* 80% coverage	After *deductible* 70% coverage
Chemotherapy Services	3.30			
• *Inpatient* , *Outpatient,* In a *doctor's* office	3.30		After *deductible* 80% coverage	After *deductible* 70% coverage
Chiropractic Medicine	3.5	Up to the *benefit maximum* of $1,000 per *plan year* for all chiropractic services, excluding x-rays.	After *deductible* 80% coverage	After *deductible* 70% coverage
Colonoscopy	3.6			
• First colonoscopy per *member* per *plan year*	3.6	This level of coverage applies to a preventive colonoscopy. See Section 3.6 for details.	100% coverage *Deductible* does not apply.	Not Covered.
		This level of coverage applies to a diagnostic colonoscopy. See Section 3.6 for details.	100% coverage *Deductible* does not apply.	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		**Level of Coverage**		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• Subsequent colonoscopies per *member* per *plan year*	3.6	See Section 3.6 for details.	After *deductible* 80% coverage	After *deductible* 70% coverage
Consultations in the *Hospital*	3.7	Must be requested by *doctor* in charge of your care.	After *deductible* 80% coverage	After *deductible* 70% coverage
Contraceptive Drugs and Devices	3.8	Coverage varies based on type of contraceptive service, except for the services listed below. See Section 3.8.		
• Implants and IUDs	3.8	See Section 3.8.	After *deductible* 80% coverage**	After *deductible* 70% coverage**
• Diaphragms/ Cervical Caps	3.8	Per device.	After *deductible* 80% coverage**	After *deductible* 70% coverage**
Diagnostic Imaging, Lab, and Machine Tests*	3.9			
• *Inpatient**	3.9	* See Section 3.9 for limitations and for those specific services for which *Prior Authorization* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Outpatient Hospital* Facility*	3.9	Includes allergy testing. * See Section 3.9 for limitations and for those specific services for which *Prior Authorization* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Outpatient* Non-Hospital Facility*	3.9	Includes allergy testing. * See Section 3.9 for limitations and for those specific services for which *Prior Authorization* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
Preventive Imaging, Lab and Machine Tests *Inpatient/ Outpatient*	3.9			

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• Imaging and Lab tests *other than* mammograms, pap smears, bone densitometry, hearing tests, and biometric screening	3.9	See Section 3.9 for coverage details and limitations. Includes coverage for an annual Prostate Antigen (PSA) test for men beginning at age 45, or earlier as a result of family history.	100% coverage *Deductible* does not apply.	Not Covered
• Mammograms	3.9	Baseline mammogram between ages 35-40; annual mammogram beginning at age 40 (earlier if *medically necessary* or as a result of family history)		
• First mammogram per member per *plan year*	3.9	This level of coverage applies to a preventive mammogram.	100% coverage *Deductible* does not apply.	After *deductible* 70% coverage
		This level of coverage applies to a diagnostic mammogram.	100% coverage *Deductible* does not apply.	After *deductible* 70% coverage
• Subsequent mammograms per *member* per *plan year*	3.9		After *deductible* 80% coverage	After *deductible* 70% coverage
• Pap Smears	3.9			
• First pap smear per *member* per *plan year*	3.9	This level of coverage applies to a preventive pap smear.	100% coverage *Deductible* does not apply.	Not Covered
		This level of coverage applies to a diagnostic pap smear.	100% coverage *Deductible* does not apply.	After *deductible* 70% coverage
• Subsequent pap smears per *member* per *plan year*	3.9		After *deductible* 80% coverage	After *deductible* 70% coverage
• Hearing Test	3.9			

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• Preventive hearing test	3.9	Covered when rendered during a Well Child Office Visit. See Section 3.24-Pediatric Office Visits. Routine hearing tests are NOT covered for *members* aged 20 and over.	100% coverage *Deductible* does not apply.	70% coverage *Deductible* does not apply.
• Diagnostic hearing test	3.9		80% coverage *Deductible* does not apply.	70% coverage *Deductible* does not apply.
• Biometric Screening performed at a *provider* other than *MinuteClinic*				
• First biometric screening per *member* per plan year	3.9	For level of coverage for services performed at *MinuteClinic*, see Section 3.24	100% coverage. *Deductible* does not apply.	Not Covered.
• Subsequent biometric screening per *member* per *plan year*	3.9	For level of coverage for services performed at *MinuteClinic*, see Section 3.24	After *deductible* 80% coverage	After *deductible* 70% coverage
Doctor's *Hospital* Visits	3.10		After *deductible* 80% coverage	After *deductible* 70% coverage
Emergency Room Services	3.11	See Section 8.0 – definition of *Emergency*.	After *deductible* 80% coverage	After *deductible* 80% coverage
• *Doctor* Services	3.11		After *deductible* 80% coverage	After *deductible* 80% coverage
Experimental/ Investigational Services	3.12	Coverage varies based on type of service. See Section 3.12.		
Hemodialysis Services	3.13			
• *Inpatient, Outpatient,* In your home	3.13		After *deductible* 80% coverage	After *deductible* 70% coverage
Hemophilia Services	3.14			
• *Outpatient*	3.14		After *deductible* 80% coverage	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• In a *Doctor's* Office	3.14		After *deductible* 100% coverage less $20 *copayment*	After *deductible* 100% coverage less $20 *copayment*
Home Health Care *	3.15	Up to 120 visits per *plan year* for intermittent skilled services when billed by a home health care agency. * *Prior Authorization* is required. See Section 3.15. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 100% coverage	After *deductible* 70% coverage
Hospice Care *	3.16	Up to 120 visits per *member* per lifetime when provided by an approved hospice care *program*. * *Prior Authorization* is required. See Section 3.16. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 80% coverage	After *deductible* 70% coverage
Hospital Services *	3.17	Unlimited days at *general hospital* or *a specialty hospital;* a maximum of 45- days per *plan year* for physical rehabilitation.* *Prior Authorization* is required. See Section 3.17.	After *deductible* 80% coverage	After *deductible* 70% coverage
House Calls	3.18		After *deductible* 80% coverage	After *deductible* 70% coverage
Human Leukocyte Antigen Testing	3.19	See Section 3.19 for limitations.	After *deductible* 80% coverage	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
Infertility Services*	3.20	$10,000 lifetime maximum for both *participating and non-participating* services combined. Coverage is limited to in-vitro fertilization services only. Oral and injectable infertility drugs are not covered under this *plan.* See your Employer's Prescription Drug Agreement. * *Prior Authorization* is required. See Section 3.20 for details.	After *deductible* 80% coverage	After *deductible* 70% coverage
Infusion Therapy	3.21			
• *Inpatient*	3.21		After *deductible* 80% coverage	After *deductible* 70% coverage
• *Outpatient*	3.21	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 80% coverage	After *deductible* 70% coverage
• In the *Doctor's* office, or In your home	3.21	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 80% coverage	After *deductible* 70% coverage
Lyme Disease Diagnosis and Treatment	3.22	Coverage varies based on type of service. See Section 3.22		
Medical Equipment, Medical Supplies, Enteral Formula and Food, and Prosthetic Devices*	3.23	* *Prior Authorization* is required for certain services. See Section 3.23 for details.		
• *Inpatient*	3.23		After *deductible* 80% coverage	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• *Outpatient*	3.23	Note: Coverage excludes certain diabetic equipment and supplies which are available for purchase at CVS pharmacies through your employer's prescription drug agreement. See related exclusions in Section 3.23.	After *deductible* 80% coverage	After *deductible* 70% coverage
• Enteral formula delivered through a feeding tube*	3.23	Must be sole source of nutrition * Prior Authorization required. See Section 3.23.	After *deductible* 80% coverage**	After *deductible* 70% coverage**
• Enteral formula or food taken orally*	3.23	* *Prior Authorization* is required. Up to a *maximum benefit* of $2,500 per *member* per *plan year* applies to *participating and non-participating* services combined. See Section 3.23 for details.	After *deductible* 80% coverage**	After *deductible* 70% coverage**
• Hearing Aid Services	3.23	Limited to one hearing aid per ear every sixty (60) months.	After *deductible* 80% coverage	After *deductible* 70% coverage
Office Visits	3.24			
• Adult Immunizations	3.24	Level of coverage is for the administration of the injection. Includes flu, pneumonia, & Hepatitis-B immunization. Meningitis immunizations are covered for high risk beneficiaries (one dose).	100% coverage *Deductible* does not apply.	After deductible 70% coverage
• Allergist and Dermatologist	3.24		100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage
• Asthma Education	3.24		100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• Diabetes Education	3.24	1 pre-assessment, 5 individual and 7 group sessions.	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Hospital* Based Clinic Visits	3.		100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage
• Nutritional Counseling	3.	First 3 visits per *member* per *plan year* are covered (regardless of diagnosis) and 3 subsequent visits per *member* per *plan year* are covered when prescribed by physician for treatment of illness.	100% coverage less $20 *copayment* *Deductible* does not apply.	Not Covered
• *MinuteClinic* office visit and biometric screening	3.24	See Section 3.24 for further benefit details. Lab services other than biometric screenings, rendered at a *MinuteClinic* are reimbursed based on type of service. See Section 3.9 – Diagnostic/ Preventive Imaging, Lab and Machine Tests. See Section 8.0 – definition of *MinuteClinic.*	100% coverage *Deductible* does not apply.	Not Applicable.
• Primary Care Office Visits (other than Pediatric Office Visits)	3.24	Preventive Visit One routine adult physical examination and one routine gynecological examination per *plan year* per *member* will be covered.	100% coverage *Deductible* does not apply.	Not Covered
		Sick Visit	100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
• Pediatric Office Visits	3.24	Well-Child Office Visits: 7 exams in the first 12 months 3 exams in the 2nd 12 months 3 exams in the 3rd 12 months 1 exam per plan year from 36 months through age 5.	100% coverage *Deductible* does not apply.	100% coverage *Deductible* does not apply.
		Well-Child Office Visits: From age 6 to age 18: 1 exam per plan year	100% coverage *Deductible* does not apply.	After *deductible* 70% coverage
		Sick Visit	100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage
• Pediatric Immunizations	3.24	See Section 3.24 for details.	100% coverage *Deductible* does not apply.	70% coverage Deductible does not apply
• Specialist Visits	3.24	Routine and non-routine visits.	100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage
• *Urgent Care Center* Visits	3.24	See Section 8.0 – definition of *urgent care center.*	100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage
Organ Transplants *	3.25	* *Prior Authorization* required. See Section 3.25 for detailed information.	After *deductible* 80% coverage	After *deductible* 70% coverage
Physical/ Occupational Therapy*	3.26	* *Prior Authorization* required. See Section 3.26.		
• *Inpatient*, Outpatient, In a doctor's/ therapist's office*	3.26	* *Prior Authorization* required. See Section 3.26.	After *deductible* 80% coverage	After *deductible* 70% coverage
Podiatrist Services	3.27	See Section 3.27 for routine foot care exclusions.	100% coverage less $20 *copayment* *Deductible* does not apply.	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
Pregnancy, Nursery Care and Interrupted Pregnancy Services	3.28	Initial visit (pregnancy)	100% coverage less $20 *copayment* for initial visit. *Deductible* does not apply.	After *deductible* 70% coverage
		Includes pre-natal, delivery, and postpartum services.	After *deductible* 80% coverage	After *deductible* 70% coverage
		Elective and induced abortions – limited to two per member per lifetime.	100% coverage, less $20 copayment	After *deductible* 70% coverage
Prescription drugs dispensed and administered by a licensed health care *provider* (other than a retail or online pharmacy)	3.29	See Section 3.29 - Prescription Drugs for details.		
• Medications other than injected drugs, infused drugs, or Anti-neoplastic (chemotherapy) drugs used for Cancer Treatment.	3.29	Medications are included in the *allowable* for the medical service being rendered. Includes chemotherapy drugs used for other than cancer treatment.		
• Injectable drugs	3.29	Includes chemotherapy drugs used for other than cancer treatment.	After *deductible* 80% coverage	After *deductible* 70% coverage
• Infused drugs	3.29	Includes chemotherapy drugs used for other than cancer treatment.	After *deductible* 80% coverage	After *deductible* 70% coverage
• Anti-neoplastic (chemotherapy) drugs used for Cancer Treatment	3.29	Limited to injectable and infused anti-neoplastic drugs used for cancer treatment.	After *deductible* 80% coverage	After *deductible* 70% coverage
Prescription Drugs Purchased at a Retail, Specialty, or Mail Order Pharmacy	3.29	For drug coverage information, see your Employer's prescription drug agreement.	Not Covered	Not Covered
Radiation Therapy	3.30			
• *Inpatient / Outpatient*	3.30		After *deductible* 80% coverage	After *deductible* 70% coverage

SUMMARY OF MEDICAL BENEFITS		Level of Coverage		
Type of Service	**Section**	**Benefit Limit**	***Participating Provider***	***Non-Participating Provider***
Respiratory Therapy	3.31	See *program* requirements in Section 3.31.	After *deductible* 80% coverage	After *deductible* 70% coverage
Skilled Care in a Nursing Facility *	3.32	* *Prior Authorization* required. See Section 3.32. Up to a maximum of 100 days per *member* per *plan year.*	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Doctor* Visits	3.32		After *deductible* 80% coverage	After *deductible* 70% coverage
Speech Therapy	3.33			
• *Outpatient* *	3.33	* *Prior Authorization* required. See Section 3.33.	After *deductible* 80% coverage	After *deductible* 70% coverage
• In a *doctor's* / therapist's office *	3.33	* *Prior Authorization* required. See Section 3.33.	100% coverage less $20 *copayment* per visit. *Deductible* does not apply.	After *deductible* 70% coverage
Surgery Services	3.34			
• *Inpatient* *	3.34	* See Section 3.34 for limitations and for those specific services for which *Prior Authorization* is required.	After *deductible* 80% coverage	After *deductible* 70% coverage
• *Outpatient*	3.34		After *deductible* 80% coverage	After *deductible* 70% coverage
Temporo-mandibular joint disorder (TMJ) services	3.35	Coverage varies based on type of TMJ service. See Section 3.35.		
Vision Care Services	3.36	*Medically necessary* eye exams are covered. Routine eye exams are NOT covered.	100% coverage less $20 *copayment* per visit. *Deductible* does not apply.	After *deductible* 70% coverage

Hawaii PPO

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1.0 INTRODUCTION

This benefit booklet describes the medical benefits available to you and your covered family members under the CVS Caremark Build Your Own Medical Plan (the "*plan*") administered by HMA. This *plan* is a component plan under the CVS Caremark Welfare Benefit Plan. This benefit booklet describes the main features of the plan, including:

- who is eligible for coverage;
- services that are covered, called c*overed health services;*
- services that are not covered;
- what to do when you need care;
- how benefits are paid;
- when coverage ends; and
- your rights and responsibilities under the *plan*.

1.1 How to Find What You Need to Know

The Summary of Benefits at the front of this benefit booklet will show you what health care services are covered under this *plan* along with any benefit limits, *copayments*, *coinsurance,* and *deductibles* you are responsible to pay as well as services for which *Prior Authorization* is required. The Table of Contents will help you find more details about these *covered health care services* as well as other important information about eligibility, how this *plan* pays for your *covered health care services*, health care services which are not covered under this *plan,* how to file a *claim,* and how to appeal a *claim* when you or your health care *provider* does not agree with a benefit decision we have made.

1.2 You and Your Plan

Your *plan* sponsor is CVS Caremark. HMA administers *claims and* makes benefit determinations on behalf of the *plan* sponsor.

This *plan* pays for *medically necessary covered health care services* listed in this benefit booklet. This *plan* only covers a service listed in Section 3.0 if we determine that it is *medically necessary*. The term *medically necessary* is defined in Section 8.0 - Glossary. It does not include all medically appropriate services.

This *plan* provides coverage for health care services that we have reviewed and determined are eligible for coverage. Health care services which we have not reviewed or which we have reviewed and determined are not eligible for coverage under this *plan* are not covered under this *plan*. If a service or category of service is not listed as covered, it is not covered under this *plan*. Section 3.0 lists the health care services covered under this *plan* along with their related exclusions and Section 5.0 lists general exclusions.

When possible, we review *new services* within six (6) months of the occurrence of one of those events described below to determine whether the *new service* is eligible for coverage under this *plan*:

(a) the assignment of an American Medical Association (AMA) □Current Procedural Terminology (CPT) code in the annual CPT publication;

(b) final FDA approval;

(c) the assignment of processing codes other than CPT codes or approval by governing/regulatory bodies other than the FDA; and
(d) submission to us of a *claim* meeting the criteria of (a), (b) or (c) above.

A health care service remains non-covered (excluded) if any of the following occur:

- a service is not assigned a CPT or other code;
- a service is not approved by the FDA or other governing body;
- we do not review a service within six (6) months of the effective date of the service; OR
- we make a determination, after review, not to cover the service under this *plan*.

Entitlements for payment shall not be more than our *eligible charge*, as defined in Section 8.0. Any *deductibles*, *copayments, coinsurance*, and *charges* over our *eligible charge* must be paid by you. The coverage provided after the application of any *deductible* is a credit toward *charges* equal to our *eligible charge* less your required *copayment* and *coinsurance*, if any. All our payments are subject to the terms and conditions outlined in this benefit booklet.

Non-Discrimination
Notwithstanding anything in this *plan* to the contrary, this *plan* may not discriminate against any individual or dependent of that individual with respect to health coverage on the bases of a health factor. Further, this *plan* shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family *member* of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment in the *plan* or coverage in connection with enrollment in the *plan*.

1.3 Plan and Its Interpretation
This *plan* shall be construed under and shall be governed by applicable laws and regulations.

1.4 Words with Special Meaning
Some words and phrases used in this benefit booklet are in italics. This means that the words/phrases have a special meaning as they relate to your health care coverage. The glossary at the end of this benefit booklet defines many of these words. Other sections of this benefit booklet which also contain definitions of certain words and phrases are Section 3.0 which describes *Covered Health Care Services* and their related exclusions, Section 6.0 which describes how we coordinate benefits when you are covered by more than one plan, and Section 7.0 which addresses your right to appeal a decision that we make.

1.5 General Information
If you have questions or issues regarding your benefits under this *plan*, call the HMA Customer Service Department. Our normal business hours are Monday - Friday from 7:30 a.m. - 5:00 p.m. Hawaii Standard Time (HST). If you call after normal business hours, our answering service will document your call and a HMA Customer Service Representative will return your call on the next business day. When you call, identify yourself as a CVS *subscriber* and have your ID number ready. Below are a few examples of when you should call our Customer Service Department at 1-866-826-5335 or 808-954-8796:

- To learn if a *provider* participates with HMA's designated MultiPlan / HMN PPO *network*.
- If you live or travel outside the HMA service area and need medical care, call HMA Customer Service for information on the nearest PPO *doctors* and *hospitals*. You can also visit the HMA web page at www.hma-hi.com
- To file a *grievance* or *administrative appeal. Ask for the Grievance and Appeals Department.* .
- To file an appeal regarding a medical necessity determination or learn about the status of your appeal process. Ask for the Grievance and Appeals Department
- To obtain information on *Prior Authorization* for all *covered medical health care services* provided by *non-participating providers*.

To obtain *Prior Authorization* for all *covered* mental health and *chemical dependency* provided by *non-participating providers* call 1-866-826-5335 or 808-954-8796 prior to receiving care.

You may request an expedited *Prior Authorization* review if the circumstances are an emergency.
If an expedited *Prior Authorization* review is received by us, we will respond to you with a determination within seventy two (72) working hours following receipt of the request.

To find out all the latest HMA news and *plan* information, visit our Web site at hma-hi.com/cvs
Medical policies are available on the hma-hi.com website. Our medical policies are medical information designed to assist in the administration of *benefits* for the purpose of *claims* payment and are made available to you for informational purposes. Our medical polices are subject to change and are not meant to be used as a guide for your medical treatment. Your medical treatment remains a decision made by you with your *doctor*. If you have any questions about the medical information in our medical policies, we suggest you provide a copy of the medical policy to your *doctor* and discuss the policy with your doctor or you may contact our Customer Service Department with any questions you may have.

1.6 Your Right to Choose Your Own Provider

Your relationship with your *provider* is very important. This *plan* is intended to encourage the relationship between you and your *provider*. However, we are neither obligated to provide you with a *provider*, nor are we liable for anything your *provider* does or does not do. We are not a health care *provider* and we do not practice medicine, furnish health care, or make medical judgments. We review *claims* for payment to determine whether the *claims* were properly authorized, constitute *medically necessary* services for the purpose of benefit payment, and are *covered health care services* under this *plan*. The determination by us of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of health benefits under this *plan*, and not an exercise of professional medical judgment.

Obstetrical and Gynecological Care

You do not need *prior authorization* from us or from any other person (including a *personal physician*) in order to obtain access to obstetrical or gynecological care from a *participating doctor* who specializes in obstetrics or gynecology. Your *provider,* however, may be required to comply with certain procedures, including obtaining *Prior Authorization* for certain services. For a

list of *participating* providers who specialize in obstetrics or gynecology, contact the Customer Service Department at 1-866-826-5335 or 808-954-8796.

1.7 Your Responsibility to Pay Your Providers

Covered health care services may be subject to benefit limits, *deductibles*, and/or *copayments*, as described in the Summary of Benefits. It is your responsibility and obligation under this *plan* to pay *providers* the *deductible* and *copayment* and/or the difference between the *maximum benefit* and our *eligible charge*, if any, that may apply to *covered health care services*. Your *provider* may require payment at the time of service or may bill you after the service. If you do not pay your *provider*, he or she may decline to provide current or future services or may pursue payment from you. Your *provider* may, for example, begin collection proceedings against you. See Section 4.0 - How Your Covered Health Care Services Are Paid for more information.

1.8 Our Right to Receive and Release Information About You

We are committed to maintaining the confidentiality of your health care information. However, in order for us to administer this *plan*, we may release and receive information about your health, treatment, and/or condition to or from authorized *providers* and insurance companies, among others. We may release or receive this information as permitted by law for certain purposes, including, but not limited to:

- adjudicating health insurance *claims*;
- administration of *claim* payments;
- health care operations;
- case management and *utilization review*; and
- coordination of health care *benefits* provided.

Our release of information about you is regulated by law.

1.9 Our Right to Approve Alternative Benefits

We may in our sole discretion cover benefits not listed in this benefit booklet or benefits that are excluded (not covered). This is our right to approve alternative benefits. Alternative benefits are health service specific and time-limited authorizations which must be pre-approved by us for each individual. Alternative benefits are only offered on an individual, case-by-case basis when approved by us.

We approve alternative benefits based upon information we receive from your treating physician that a *covered health care service* may be less effective than a requested alternative benefit. We determine whether covering the alternative benefit will not only be helpful to you, but be more cost effective than a covered alternative. This review takes place in our Case Management Department and includes the review of a Medical Director. The determination by us of whether to cover an alternative benefit is solely for the purpose of *claims* payment and the administration of health benefits under this *plan*. Your treatment remains a decision made by you with your provider. Any decision to cover or not to cover alternative benefits is within our sole discretion, and any decision not to approve alternative benefits made by us in good faith is binding upon you.

If we approve an alternative benefit, you must verbally agree to our specific terms and conditions and are required to sign a letter of agreement acknowledging acceptance of the specific terms and conditions of the alternative benefits.

We do not make alternative benefits available to all *members* or to any *member* a second time without additional approval. Alternative *benefits* must be consistent with our goals to offer cost-effective health care *benefits*. *Copayments* and/or *deductibles* for alternative *benefits* will be applied based on how *copayments* and/or *deductibles* would be applied for similar *covered health care services*.

1.10 Our Right to Conduct Utilization Review

To ensure a *member* receives appropriate benefits, we reserve the right to conduct *utilization review* or to contract with an organization to conduct *utilization review* on our behalf. If another company performs *utilization review* on our behalf, such company will act as an independent contractor and not a partner, agent, or employee of HMA. This *plan* provides coverage for only *medically necessary* care. The determination by an entity conducting *utilization review* of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of your health benefit *plan*, and is not a professional medical judgment. Although we may conduct *utilization review*, HMA does not act in the capacity of a health care *provider*, does not furnish medical care and does not make medical judgments. You are not prohibited from undergoing a treatment or hospitalization for which reimbursement has been denied, and nothing herein shall alter or affect your relationship with your *provider(s).*

2.0 ELIGIBILITY

This section of the benefit booklet describes rules for who is eligible for coverage, how eligible persons are enrolled, and how and when coverage may be terminated. CVS, your *plan* sponsor, is responsible for making all determinations related to eligibility, unless otherwise indicated.

2.1 Who Is Eligible for Coverage

Your Eligibility

You are eligible for coverage under this *plan* if:

- you are an eligible employee (described below); and
- CVS determines that you live in the service area covered by the *plan*.

As a resident of Hawaii, state regulations require that employers extend medical/prescription coverage to employees who work at least 20 hours per week for four (4) consecutive weeks. Thus, you are an eligible employee if you are an active employee of CVS who works at least 20 hours per week for four (4) consecutive weeks (or related company or business division that has adopted this *plan)*, working in the United States, and you meet employment requirements (discussed in Section 2.2 - How to Enroll and When Your Coverage Begins). To remain eligible for this *plan*, you must work at least 20 hours per week each month. If you are not actively at work due to a health factor, your absence will be counted for purposes of determining eligibility. Continued eligibility for coverage is reviewed regularly.

You will not be eligible to participate in this *plan* if you are covered by a collective bargaining agreement where coverage was the subject of good faith bargaining (unless that agreement provides for participation in this *plan*).

Dependent Eligibility

You may enroll your eligible dependents when you are first eligible for coverage and during the Annual Enrollment period. Generally, you may also enroll newly eligible dependents within 30 days of their becoming eligible by marriage, and within 60 days of their becoming eligible by birth, or adoption, or placement for adoption. You may also drop coverage of an eligible dependent only upon a Change in Status event or at Annual Enrollment, unless your dependent's coverage is paid for on an after-tax basis (in which case you can disenroll that dependent at any time).

No person can be covered as both an employee and a dependent. In addition, no dependent may be covered without the employee having coverage. No person can be covered as a dependent of more than one employee under this *plan*.

You should be aware that not all coverage for eligible dependents under this *plan* can be paid for on a pre-tax basis. As discussed under the "Paying for Coverage" section, coverage for dependents can be paid for on a pre-tax basis only if the dependent meets the IRS' definition of a tax dependent under Section 152 of the Internal Revenue Code.

Shortly after you enroll a dependent, CVS's audit partner, HR Advance, a Hewitt Associates company, will send you a letter requesting proof that your dependent is eligible under the terms of this *plan*. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return.

Note: If a covered person is ineligible or unverified, you will be required to pay to this *plan* all claims incurred on behalf of your ineligible or unverified dependent(s); if this is the case, you may not be eligible for future coverage under the *plan* until you pay all amounts owed. If the termination of a person results in a coverage level change, such as from family to individual coverage, you will not be refunded for premiums deducted from your pay at the higher coverage level. Your coverage level will be adjusted only for pay periods that occur after the removal of any non-verified

Eligible Spouses and Domestic Partners
The following is a list of the eligible spouses and domestic partners for medical coverage under the Plan:

- Your legal spouse* of the same or opposite sex where the marriage is legally certificated. A marriage between same-sex spouses will be considered "legally certificated" if the marriage certificate was legal on the date of issuance under applicable state laws, or, for marriage certificates issued outside the United States, under applicable foreign laws. To confirm eligibility for coverage under the Plan, CVS requires a copy of your marriage certificate and proof that you remain married.

  *If you are legally separated from your spouse, your spouse is not an eligible dependent.

- Your same-sex domestic partner* for whom you do not qualify under a State's marriage law, but where you meet the Plan's requirements you and your domestic partner be in a committed, exclusive relationship, must have resided together for at least six months, and must be mutually responsible for basic living expenses

  Shortly after you enroll your same-sex domestic partner, you will be required to attest and verify to the Plan Administrator that these requirements are met (and provide requested supporting documentation). In addition, you may be asked to recertify annually that you continue to meet the domestic partner criteria.
- Your registered domestic or civil union partner where the partnership/marriage qualified under your State's marriage law.

  **Domestic Partner coverage is not available in states where same-sex marriage is legal.*

If you terminate your domestic or civil union partner relationship or cease to meet any of the domestic or civil union partner eligibility criteria, your domestic or civil union partner and his or her children will cease to be an eligible dependent.

Eligible Children (Medical Coverage)

The following is a list of dependent children who are eligible for medical benefits under the Plan.

- A child who is under age 26, provided the child is one of the following:
    - Your biological child, legally adopted child (including a child placed with you for adoption), stepchild* from an opposite-sex spouse, or child for whom you are the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court).

      **A child who is your step-child will no longer be an eligible dependent in the event of a divorce.*
    - Your same-sex spouse's or eligible domestic or civil union partner's unmarried biological or legally adopted child, provided he or she:
        - resides with you (or his or her biological parent if divorced or separated) for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), *and*
        - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic or civil union partner.
    - An unmarried child for whom your spouse or eligible domestic or civil union partner is the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court), provided he or she:
        - resides with you (or his or her biological parent if divorced or separated) for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), and
        - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic partner.
    - Your, your spouse's or domestic or civil union partner's unmarried grandchild, provided he or she:
        - is also your tax dependent,
        - resides with you for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), and
        - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic or civil union partner.

Shortly after you enroll a dependent, you will be required to attest to the Plan Administrator (and provide supporting documentation) that a child meets the above requirements. In addition, you may be asked to re-certify annually that a grandchild continues to meet the Plan's requirements.

- A child who is 26 or older and has a physical or mental disability that is expected to last for a continuous period of not less than 12 months (as determined by the Claims Administrator), provided the child:
- is incapable of engaging in substantial gainful activity;

- receives over 50% of his or her support and maintenance from you, your spouse or your eligible domestic or civil union partner; and
- has the same residence as you for more than one-half of the year (or if less than one-half of the year, has resided with you since birth or adoption)

You must provide proof of the ongoing disability as often as requested by the Plan. The child must be disabled prior to age 26 or become disabled while covered as a dependent under the Plan.

- A child who is the subject of a "qualified medical child support order" ("QMCSO") as determined by a judgment, decree, or any order of a court. Note that the Plan Administrator will not recognize an order that requires a child of your spouse (other than your stepchild) or your eligible domestic or civil union partner to be covered under the Plan if your spouse or domestic or civil union partner does not live with you.

2.2 How to Enroll and When Your Coverage Begins

You can enroll from home or work anytime (24/7) by logging onto **myhr.cvs.com**. Once at the **myhr.cvs.com** site, you will need to follow the prompts on screen to make your coverage elections. Also, additional instructions are supplied with your enrollment materials

Customer Service Representatives are available to answer your enrollment questions. Call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287), during normal business hours. If you're using My Benefits Resources, you can also open an online chat with a ***myHR*** representative. If you have questions regarding benefit coverage, call HMA at the number provided on your ID card. You must enroll prior to your eligibility date. Your Eligibility Date will be the date that your coverage begins – provided you enroll in advance of that date. When you enroll at **myhr.cvs.com**, your Eligibility Date will be reflected.
If you wish to waive coverage, you may do so by completing an HC-5 form prior to your eligibility date. If you fail to enroll or complete an HC-5 form prior to your eligibility date, you will automatically be enrolled into the lowest cost individual plan and your employee contribution towards such coverage will be deducted from your pay.
By enrolling in this *plan,* you authorize CVS to deduct coverage contributions from your pay. In the event you owe premiums, you are also authorizing CVS to deduct the outstanding benefit contribution balance through payroll deductions in an amount not to exceed double the required contribution of the benefit option and level you selected, until the balance is repaid in full. Any questions about enrolling should be directed to ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

New Hire
As a resident of Hawaii, your coverage begins on the first day of the month immediately following the first four (4) consecutive weeks of working 20 or more hours per week (this is your Eligibility Date), assuming you properly and timely enroll in the Plan . Your enrolled dependents' coverage takes effect on the same date your coverage takes effect. As a new hire, you must enroll prior to your eligibility date. If you do not enroll in a medical plan, you will be defaulted to the lowest cost individual coverage option.

If you are not continuously at work due to a health factor (such as being absent from work on sick leave), your absence will be counted for purposes of determining eligibility under this *plan* However, if you are not continuously at work due to a reason other than a health factor, your absence will not be counted.

Rehires. If you are a rehired employee who returns to employment after a 30-day break in employment, you will have to re-satisfy the waiting period described above, measured from your date of rehire.

If you are a re-hired eligible employee who has returned to employment within 30 days of your date of termination, you will not have to satisfy the waiting periods described above and the benefit elections you had in place on your last day of employment will resume on the date you are re-hired. You may not change these elections upon your re-hire. However, if you are rehired during a new plan year, you will have to make a new benefit election if your prior coverage option is no longer available.

Annual Enrollment
The Annual Enrollment period is the period of time during which you are given the opportunity to enroll in this *plan*, drop coverage, or change your coverage level (for example, from employee to employee plus more than one dependent). The Annual Enrollment period commences in April, and elections made during this period are effective June 1. You may need to re-enroll in the Plan during each Annual Enrollment period to continue your previous year's coverage. Look for information from CVS regarding Annual Enrollment to determine whether re-enrollment action is required to continue coverage into the next *plan year*.

Waiving Coverage
You may waive coverage in this *plan* upon your eligibility or at annual enrollment by completing the State of Hawaii Employee Notification to Employer Form (HC-5). The HC-5 form expires at the end of each calendar year, resulting in the requirement to complete a new HC-5 form annually.

Coverage Required (Termination of Exemption)
If you had previously claimed an exemption or waived health care coverage, and now would like to terminate your exemption, you must call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) during normal business hours to advise CVS that you would like to terminate your HC-5 exemption. ***MyHR*** will provide you with a **State of Hawaii Employee Notification to Employer (HC-5)** form to complete. In completing the form, please fill in the Employer Information section, including checking off box 5 and filling in the effective date; then, print your name, sign and date the form, and enter your address and phone number. Return the completed form to ***myHR***.

Special Enrollment
Ordinarily, if you do not enroll for coverage when you are first eligible, you must wait until the next Annual Enrollment period. However, in certain cases you and/or your dependents may be eligible for "Special Enrollment" outside of the Annual Enrollment period. If this is the case, you may make election changes with regards to your medical benefits under this *plan*. You may also change your medical plan selection when a Special Enrollment event is the result of marriage, birth, or adoption. If you or your dependent experience a Special Enrollment event described

below, you must take action within the time period described below to make your election change. You can do this by logging onto myhr.cvs.com, or calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) during normal business hours – to advise CVS of the Special Enrollment event and make your election change. Once at myhr.cvs.com, look for the "Life Events" menu, which will provide you with directions on how to make your election change online. If you do not see the Life Event that pertains to you at myhr.cvs.com, be sure to call ***myHR*** within the required time period to make your election change. Note that for Special Enrollment events relating to Medicaid or CHIP eligibility, you must call ***myHR*** within the required time frame to make your election change (online election changes due to these events are not available).

Note: Coverage is retroactive to the date of the event or loss of coverage, provided you complete the enrollment transaction by the required deadline. By completing the enrollment transaction you authorize CVS to deduct contributions required for retroactive coverage from your paycheck.

A special enrollment period is not available to an eligible employee and his or her dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

Loss of Other Private Health Coverage

If you decline enrollment for medical benefits under this *plan* for yourself and your dependents due to other health coverage, you may be able to enroll yourself and dependents for medical benefits under this *plan* within 30 days after the other coverage ends. Go to ***myHR*** at **myhr.cvs.com**.

For this special qualifying event to apply, all of the following conditions must be met:

(a) you must have stated that you were declining coverage under this *plan* for you and/or your dependents due to other health coverage; and

(b) you or your dependent's other coverage must be lost because it was:

  (i) COBRA coverage that was exhausted, or

  (ii) other coverage for which you or your dependent are no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or

  (iii) provided by another employer which ceased to pay for it.

If you fail to provide the written statement required above (stating that you were declining coverage due to coverage under another plan), this *plan* may not provide Special Enrollment to you or any of your dependents. Note that neither a loss of coverage due to a failure to pay premiums will not trigger Special Enrollment rights; nor will loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation) will trigger Special Enrollment rights.

Addition of New Dependent
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for coverage under the *plan*, provided you enroll your new dependent within 30 days after your date of marriage, and within 60 days after a birth, adoption, or placement for adoption. To enroll, go to ***myHR*** at **myhr.cvs.com**. Changes to your coverage are effective as of the date of the event.

Change in Eligibility for Medicaid or CHIP
If you or a dependent are eligible but not enrolled for coverage under the terms of this *plan*, you or your dependent may enroll for coverage under the terms of this *plan* if either one of the following conditions is met:

1. you or your dependent is covered under a Medicaid plan or a State child health plan under the Children's Health Insurance Program ("CHIP") and coverage under the Medicaid or CHIP plan is terminated as a result of a loss of eligibility for such coverage. You may then request coverage under the Plan no later than 60 days after termination of the Medicaid or CHIP coverage, *or*
2. you or your dependent become eligible for a premium assistance program (that could be used toward the *plan* costs) under a Medicaid or state child health plan under CHIP (including any waiver or demonstration project conducted under or in relation to such a plan). You may then enroll under the Plan no later than 60 days after the date you or your dependent is determined to be eligible for the premium assistance.

Call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) and the call center representative will make your election changes on the phone at the time of your request.

Call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) during normal business hours within 60 days after termination of the Medicaid or CHIP coverage or the date you or your dependents are determined to be eligible for premium assistance, as applicable. The call center representative will make your election changes on the phone at the time of your request.

Level of Coverage
You may choose from four levels of coverage under this *plan*:

a) coverage for you;
b) coverage for you plus your spouse/domestic partner;
c) coverage for you plus one or more children; or
d) family coverage.

Paying for Coverage
Generally, you and CVS share the cost of your coverage under this *plan* (with CVS paying the majority of the cost). Your contributions are not used to pay expenses for vendors or other service providers who are affiliated with CVS (such as Caremark), except as may be permitted by ERISA.

Your contributions will be deducted from your pay on a pre-tax basis and are subject to change on June 1 of each year or when you change your benefits. (Paying for your coverage on a pre-tax basis means you don't pay Social Security or Federal (and, in most cases, state) income tax on your contributions. Since your taxable earnings are lower, you pay less in taxes.) Also, CVS's contributions toward your coverage are not taxed. However, pre-tax treatment is not available where coverage is provided to a dependent who is not considered your dependent for federal tax purposes. For example, unless your domestic partner qualifies as a "dependent" for federal tax purposes, the cost of a same-sex domestic partner's coverage and a domestic partner's child(ren)'s coverage (both the portion withheld from your pay on a pre-tax basis and CVS's contributions) is taxable and thus will be reflected as imputed income. This means that if you have coverage for a domestic partner or a child of a domestic partner who is not your federal tax dependent, your payroll contribution will be made with pre-tax dollars, but CVS will impute income to you to reflect the cost of their Plan coverage.

Changing Your Coverage

You may change your coverage under this *plan* during the Annual Enrollment period each year, or during the year if you have a Change in Status as provided below. Changes to your coverage which are made during the year due to a Change in Status are effective as of the date of the Change in Status.

If you want to change your coverage as a result of a Change in Status, you must notify ***myHR*** at **myhr.cvs.com** within 30 days of the date of your Change in Status. You will be able to report your change in status and change your coverage at the same time. If you do not complete the transaction within the required timeframe, you will have to wait until the next Annual Enrollment period to add coverage under this *plan*.

A change in coverage must be consistent with your Change in Status. For example, if you become divorced, you may drop coverage for your former spouse, but you cannot change your own coverage options. Changes in Status include:

- marriage, divorce, legal separation, annulment, or termination of a domestic partner relationship;
- birth or adoption (or placement for adoption) of your child or eligible grandchild, or the addition of your stepchildren;
- death of a dependent;
- change in employment status including termination or commencement of employment, a commencement of or return from an unpaid leave of absence or change in work schedule (including part-time to full-time or vice versa) for you, or your dependent that affects eligibility for this plan or another employer health plan;
- change in health insurance eligibility due to a relocation of residence or work place for you;
- a judgment, decree, or order resulting from your marriage, divorce, legal separation, annulment, or change in child custody requiring you to add or allowing you to drop coverage for your dependent child (this is dependent on state mandates);

- your or your spouse's or dependent child's entitlement, or loss of entitlement, to Medicare or Medicaid benefits;
- a significant increase in cost of coverage, or a reduction in benefits, under this *plan* or your spouse's health plan; and
- a change in a dependent's coverage under another employer health plan that is permitted under that plan and applicable IRS regulations.

You may also drop coverage if your spouse or domestic partner gains coverage for you during his/her plan's annual enrollment, or add coverage if your coverage under another employer plan is dropped at the other plan's annual enrollment. You must show documentation from your spouse's or domestic partner's plan of such activity, in addition to completing the State of Hawaii Employee Notification to Employer Form (HC-5). You are not allowed to drop your coverage other than during the Annual Enrollment period unless you have a Change in Status.

For more information, go to ***myHR*** at **myhr.cvs.com** or call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287). If you believe you are eligible to make a mid-year election change due to a change in status described above, go to ***myHR*** at **myhr.cvs.com** and make your enrollment change within 30 days of the date of the event (except in the case of a birth, adoption, or placement for adoption, in which case you have 60 days to make your enrollment change).

When you are enrolled in another CVS health plan, not administered by us, HMA, and enroll in *this plan* you must provide an Explanation of Benefits (EOB) to us and the appropriate carry over adjustments will be made to the concurrent *plan year deductible* and *maximum out-of-pocket expense.* If you are enrolled in a CVS health plan, administered by us, and choose to enroll in another CVS health plan option administered by us, the concurrent *plan year deductible* and *maximum out-of-pocket expense* will carry over automatically.

Coverage for Members Who Are Hospitalized on Their Effective Date

If you are in the *hospital* on your effective date of coverage, health care services related to such hospitalization are covered provided that the health care services are received in accordance with the terms, conditions, exclusions and limitations of this *plan*. We request that you notify us of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible. As always, *benefits* paid in such situations are subject to the Coordination of Benefits provisions of Section 6.0.

Note: If you (the employee) are disabled and prevented from working, the plan will continue your coverage for up to 180 days at the active-employee rate, provided:

- your disability has been certified by your physician, and
- you continue to pay your portion of the premiums to CVS, unless your collective bargaining agreement indicates otherwise.

2.3 When Your Coverage Ends

Your coverage under this *plan* will end:

(a) on the date your employment ends;

(b) if you decide to discontinue coverage;

(c) if you or your *employer* does not pay any required membership fees within thirty-one (31) days of the date they are due. If your employer does not pay the required fees, the termination will be effective five (5) days after we mail you a notice of discontinuance;

(d) if you cease to be an *eligible person;*

(e) if we cease to offer this type of coverage;

(f) if your *employer* contracts with another insurer or entity to provide or administer *benefits* for the *covered health care services* provided by this *plan*, your group's agreement with us will end. You will NOT be offered membership in our direct pay plan;

(g) if fraud is determined by us. Fraud includes, but is not limited to, misuse of your identification card and any misrepresentation made by you or on your behalf that affects your coverage. Fraud may result in retroactive termination, and you will be responsible for all costs incurred by CVS or by HMA as a result of the fraud. Furthermore, HMA at its discretion may decline your reinstatement under your group coverage, or any other coverage that may become available in the future. You will NOT be offered membership in our direct pay plan; or

(h) the date abuse or disregard for *provider* protocols and policies is determined by us. If after making a reasonable effort physicians are unable to establish or maintain a satisfactory relationship with a *member*, coverage may be terminated after 31-days' written notice. Examples of unsatisfactory physician-patient relationships include abusive or disruptive behavior in a physician's office, repeated refusals by a *member* to accept procedures or treatment recommended by a physician, and impairing the ability of the physician to provide care. You will NOT be offered membership in our direct pay plan.

Coverage for your dependents will end on the date any of the following events occurs:

(a) your coverage ends;

(b) your dependent child turns age 26 (except with regard to disabled children);

(c) you are divorced or legally separated, you terminate your domestic partner relationship or same-sex marriage, or you (i) no longer hold yourselves out to the public as spouses or domestic partners, or (ii) either you or your same-sex spouse has married, or entered into a domestic partnership or civil union with someone else. These events affect your spouse/domestic partner's eligibility and the eligibility of their children and grandchildren. This means that your step-child ceases to be your eligible dependent upon your legal separation or divorce from your spouse, and your domestic partner's child or grandchild ceases to be your eligible dependent upon termination of your domestic partner relationship;

(d) your dependent child no longer meets the eligibility requirements for coverage under this *plan*;

(e) you stop making contributions for dependent coverage;

(f) you disenroll your dependent as provided under this *plan* (for example, due to a Change in Status). You may disenroll your dependents who are domestic partners at any time, unless your domestic partner coverage is paid for on a pre-tax basis; or

(g) the *plan* is terminated (if CVS *c*ontracts with another insurer or entity to provide or administer *benefits* for the *covered health care services* provided by this *plan*, your group's agreement with us will end. You will NOT be offered membership in our direct pay plan.)

Note that you are required to provide notice by going to ***myHR*** at myhr.cvs.com or by calling *myHR* at 1-888-MY-HR-CVS (1-888-694-7287) no later than 30 days following your dependent ceasing to be eligible under this *plan*.

You may contact and inquire to seek coverage through an insurance company in the state in which you reside.

Rescissions of Coverage

Fraud and Misrepresentation

The Plan may rescind (*i.e.*, cancel or discontinue on a retroactive basis) coverage if you or your dependents perform an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If the rescission relates to medical/prescription coverage, you and/or your dependents (as applicable) will receive at least 30 days advance notice before the coverage is rescinded.

Administrative Delays and Failure to Pay Premiums

Coverage may be retroactively terminated due to administrative delays in processing or due to a failure to timely pay required premiums or contributions toward the cost of coverage. Except where required by law, coverage may be terminated for these reasons without advance notice.

Loss of Benefits

You or your dependents also may experience a reduction or loss of benefits in any of the following circumstances:

(a) you fail to follow *plan* procedures;

(b) you fail to reimburse the *plan* for a claim that was paid in error;

(c) you receive reimbursement for a covered expense by another similar insurance plan which is primary to this *plan* while also receiving primary reimbursement from this *plan*;

(d) you receive a judgment, settlement or otherwise from any person or entity with respect to the sickness, injury or other condition which gives rise to the expenses that this *plan* pays;

(e) you are found to have committed a fraudulent act against this *plan*, including, but not limited to, the fraudulent filing of a claim for reimbursement;

(f) the *plan* is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective, or

(g) you or your provider fails to file a claim within 12 months of the date service is provided.

The sections below, including but not limited to the following, also explain how you or your dependents may experience a reduction or loss of benefits:

- Section 2.2 - How to Enroll and When Your Coverage Begins;
- Section 2.3 - When Your Coverage Ends;
- Section 5.13 – Clerical Errors
- Section 5.15 - Clerical Errors
- Section 5.15 – Deductibles and Copayments
- Section 6.3 - Our Right to Make Payments and Recover Overpayments;
- Section 7.1 - How to File a Claim;
- Section 7.3 - Our Right to Withhold Payments and Review Payments; and
- Section 7.4 - The Plan's Right of Subrogation and/or Reimbursement.

Continuation Coverage under the Uniformed Services Employment and Re-Employment Rights Act of 1994

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you have certain rights regarding continuance of benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a "military leave of absence"). The terms "uniformed services" or "military service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. A "leave of absence" is a predetermined period of time in which you are not working for CVS. You are, however, expected to return to active employment at the end of your leave of absence.

It is CVS's policy to allow employees on a military leave of absence to continue health coverage for up to 12 months at the active-employee cost. If you continue to be on a military leave of absence at the time the foregoing 12-month period is exhausted, under USERRA, you may elect to continue your coverage for an additional 24 months (or if less, for the period you are on military leave) by paying for the full cost of the benefits plus a 2% administrative charge under COBRA. Under USERRA, covered dependents also have a right to continue their health coverage during the employee's period of military leave of absence.

If you choose not to continue health coverage while on a military leave of absence, and you return to a position of employment with CVS, your health coverage and that of your eligible dependents will be reinstated provided you call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) to re-enroll or enroll online at myhr.cvs.com within 30 days of your return to work.

If you do not call ***myHR*** to go to myhr.cvs.com and take the necessary step for re-enrollment within the first 30 days of returning to work, you will be required to wait until the Annual Enrollment period to reinstate your coverage. No exclusions or waiting period may be imposed

on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information about filing for coverage while you are on a military leave of absence, and applicable costs, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

Family and Medical Leave Act (FMLA)

All eligible participants who have worked for CVS for at least one year and worked at least 1,250 hours over the previous 12 months are covered under a federal law called the Family and Medical Leave Act (FMLA). According to this law, you are eligible for at least 12 weeks of unpaid job-protected leave for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth; or
- to care for your child after birth, or placement for adoption or foster care; or
- to care for your spouse, son or daughter, or parent who has a serious health condition; or
- for your own serious health condition that makes you unable to perform your job; or
- because of any qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the armed forces in support of a contingency operation; or
- to care for your spouse, son, daughter, parent, or next of kin who is recovering from a serious injury or illness suffered while on active duty in the armed forces. You are eligible for 26 work weeks in a single 12-month period.

If you experience a qualifying FMLA leave event and want to take a leave of absence under FMLA, you should first discuss it with your supervisor as soon as possible. You must then contact the Leave of Absence Department to initiate your leave by calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

If you take a leave of absence under FMLA, you may continue your medical coverage during the leave period by continuing to pay the required contributions.

To the extent any portion of your FMLA leave is paid leave, you will continue to have your benefit contributions deducted from your pay. Otherwise, you must submit your contributions on an after-tax basis. If your required contribution during FMLA leave is more than 30 days late, your coverage will be terminated in accordance with the FMLA retroactive to the date through which you have paid for coverage.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for continued coverage on the same terms as would be applicable to you if you were actively at work, not on an approved FMLA leave.

If you choose not to continue your coverage while on a FMLA leave, you will not be reimbursed for any benefit claims incurred while you are on the FMLA leave. Reinstatement of coverage is

not automatic, therefore when you return from the leave, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287), or go to myhr.cvs.com to re-enroll within 30 days of returning from your FMLA leave. If you do not call ***myHR*** or visit myhr.cvs.com and follow the necessary steps for re-enrollment, you will be required to wait until the Annual Enrollment period to reinstate your coverage.

If you do not return to work after your FMLA leave ends, you may be allowed to continue your coverage at the active-employee rate under another CVS leave policy (provided premiums are paid). Otherwise, your coverage at the active-employee rate will terminate (although as described below you and your dependents may have COBRA continuation coverage rights).

If your medical coverage ends because your approved FMLA leave is considered terminated by CVS, you and your dependents may, on the date of such termination, be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct, on such date.

Impact of Leaves of Absences (Other than FMLA or USERRA) on Coverage

Company-Approved Leaves
If you are on a CVS-approved leave of absence (other than a personal leave or military leave of absence), it is CVS's policy to allow you and your dependents to continue your medical coverage under this *plan* for up to 180 days at the active-employee rate, provided you continue to pay premiums to CVS, unless your collective bargaining agreement indicates otherwise. If you continue to be on a company-approved leave of absence at the end of the foregoing 180 day period, you may be eligible to elect to continue your health coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct. Under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Personal Leaves
If you are on a personal leave of absence, it is CVS's policy to allow you and your dependents to continue your medical coverage under this *plan* for up to 30 days at the active-employee rate, provided you continue to pay premiums to CVS. If you continue to be on a leave of absence at the end of the foregoing 30-day period, you may be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated (for reasons other than gross misconduct). Under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Return from Leave
If you choose not to continue your coverage while on a CVS-approved leave of absence (including a personal leave), you may reinstate your coverage when you return to work. Reinstatement of coverage is ***not*** automatic. When you return from the leave, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287), or visit myhr.cvs.com within 30 days of returning from your FMLA leave to re-enroll. If you fail to timely complete the re-enrollment process as directed, you

will be required to work at least 20 hours per week for four (4) consecutive weeks to qualify for coverage.

Plan is Not an Employment Contract
Enrollment in this *plan* is not to be construed as a contract for or of employment. Accordingly, nothing in this document says or should be read to imply that participation in this *plan* is a guarantee of continued employment with CVS.

2.4 Continuation of Coverage

Continuing Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)
CVS is responsible for making COBRA coverage available to you, and for complying with all of COBRA's requirements. You should call ***myHR*** or the COBRA Administrator, if you have any questions about COBRA.
A federal law called "COBRA" requires CVS to offer employees and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage otherwise would end due to the occurrence of a "qualifying event." Thus, in accordance with COBRA and as described below, if you are no longer eligible to participate due to a qualifying event, you and your covered spouse and covered dependents will be entitled to continue coverage under COBRA as described below.

Limited Continuation of Coverage
You and your covered dependents may be able to continue coverage under this *plan* upon the occurrence of a qualifying event. If your coverage terminates because your employment is terminated (for reasons other than gross misconduct) or your number of hours of employment is reduced, such that you are no longer eligible for coverage, then you and your covered dependents may elect to continue coverage for up to 18 months as a result of these qualifying events.

The 18 months of continuation coverage may be extended in two situations: (a) if you or your covered dependents are determined to be disabled or (b) another event occurs which would cause your covered dependent(s) to lose coverage, provided certain notices are timely provided to the COBRA Administrator. (Contact information for the COBRA Administrator is below. HMA is not your COBRA Administrator.) See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

Your covered dependents may elect to continue coverage under the *plan* for up to 36 months, if their coverage terminates as a result of one of the following qualifying events:

- you die;
- you are divorced, legally separated, or your domestic partnership is terminated;
- you become entitled to Medicare benefits under the Social Security Act (under Part A, Part B, or both); or
- your covered dependent ceases to be a dependent under the terms of this *plan*.

Notice: General

Covered Person's Responsibility

You or your covered dependents must notify ***myHR***, by calling 1-888-MY-HR-CVS (1-888-694-7287), to advise them of a divorce, legal separation, termination of your domestic partnership, or when a covered dependent ceases to be a dependent under the terms of this *plan*, within 60 days of such event. Failure to do so will result in the loss of the right to elect to continue coverage under this continuation of coverage provision. Notice must be given prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs. After calling ***myHR***, you or your covered dependents will be provided with additional instructions regarding the information needed to process the specific qualifying event. You or your covered dependents will be required to complete the Qualifying Event transaction by the later of (a) 14 days of calling ***myHR*** or (b) 60 days following the occurrence of the qualifying event. When ***myHR*** receives a completed Qualifying Event transaction in a timely manner, it will direct the COBRA Administrator to notify the applicable covered persons (individually or jointly) of the right to elect COBRA coverage.

If you or your covered dependents fail to provide ***myHR*** with timely notice (which, as described above, includes timely completion of the Qualifying Event transaction) when one of these qualifying events occurs, the right to COBRA coverage will be waived. A covered person who elects COBRA coverage will have the same enrollment rights that apply to active employees.

CVS's Responsibility

For other qualifying events (your end of employment or reduction of hours of employment or your death), CVS will notify the COBRA Administrator. Upon notice of a qualifying event, the COBRA Administrator will notify you and your covered dependents (individually or jointly) of the right to elect COBRA coverage.

Notice: Disability Extension

If you or your covered dependent is totally disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or become(s) disabled within 60 days of beginning COBRA coverage, all covered persons with respect to the disabled individual(s) may extend the continuation coverage period an additional 11 months for up to a total of 29 months.

To extend coverage beyond the 18-month period, you or your covered dependent must notify the COBRA Administrator of the Social Security Administration's ("SSA's) determination within 60 days after the later of: (a) the date of the SSA's determination, (b) the date on which the qualifying event occurs under this *plan*, or (c) the date on which you or your covered dependent are informed of your responsibility to provide notice of your disability to the COBRA Administrator and of this *plan's* procedures for providing such notice, and in all cases before the end of the 18-month period of COBRA coverage. Notice must be provided in writing to the COBRA Administrator and must be sent, along with a copy of the SSA's disability determination, to the COBRA Administrator at the address listed under the "General Plan Information" section below.

If there is a determination by the SSA that you or the applicable covered dependent is no longer disabled, the COBRA Administrator must be notified of that fact within 30 days of the SSA's determination. This notice must be provided in writing to the COBRA Administrator, and must be

sent along with a copy of the SSA's disability determination, to the COBRA Administrator at the address listed under the "General Plan Information" section at the end of this Summary. Upon receipt of this notice, COBRA coverage extended beyond the maximum period that would otherwise apply will be terminated on the first day of the month which is 30-days after the determination that you or your covered dependent is no longer disabled.

Notice: Second Qualifying Events
If you or your covered dependent experiences another qualifying event while already on COBRA coverage due to your termination of employment or reduction in hours, your covered dependents may elect to extend the period of COBRA coverage for up to 36 months from the date of termination or reduction in hours, provided notice of the second qualifying event is properly given (as described below). For example, assume that you and your covered dependents elect COBRA coverage because of your termination of employment. If you die during the first 18 months of COBRA coverage, your covered dependents could elect to continue COBRA coverage for up to 36 months from your date of termination.

A covered person must notify the COBRA Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided in writing to the COBRA Administrator at the address listed under the "COBRA Contact Information" section below and under the "General Plan Information" section of the CVS Addendum found at the end of this document.

Election
You and your covered dependents are entitled to a period of 60 days in which to elect to continue coverage under this *plan*. The 60-day election period begins on the date you or your covered dependents would lose coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the notice is sent about eligibility to elect to continue coverage.

If you or your covered dependents elect continuation coverage within the 60-day election period, continuation coverage will generally begin on the date your *plan* coverage ceases. Even if you or your covered dependents waive continuation coverage, but within the 60-day election period revoke the waiver, continuation coverage will also begin on the date your *plan* coverage ceases. A waiver may not be revoked after the end of the 60-day election period.

If you or your covered dependents do not choose continuation coverage within the 60-day election period, eligibility for continuation coverage ends at the end of that period.

Cost of Continuation Coverage
To receive continuation coverage, you or your covered dependents, or any third party, must pay the required monthly premium plus a two percent administrative charge. If you or your covered dependents are eligible for an extension of coverage due to disability, the cost of continuation coverage will be 150% of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which you and/or your covered dependents initially elect continuation coverage.

Benefits under Continuation Coverage
If you or your covered dependents choose continuation coverage, the coverage is identical to the coverage being provided to similarly situated employees, and their covered dependents who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

Payment of Claims
No claim will be payable under this continuation of coverage provision until the applicable premium is paid to the COBRA Administrator.

Termination
Coverage under this continuation of coverage provision will terminate on the earliest of:

- the date on which CVS ceases to provide a group health plan to any employee;
- the date you or your covered dependents first become covered under any other group health plan after electing continuation coverage, provided that the new plan does not contain any pre-existing condition exclusion that would affect the covered person's coverage under the new plan;
- the date you or your covered dependents become entitled to Medicare benefits under Title XVIII of the Social Security Act after electing continuation coverage;
- the date the required monthly premium is due, if you or your covered dependents fail to make payment within 30 days after the due date; or
- the end of the applicable continuation coverage period described above.

In no case will coverage extend beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

If You Have Questions
Questions concerning your *plan* or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your COBRA Administrator Informed of Address Changes
In order to protect you and your covered dependents rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

COBRA Contact Information
Information regarding your COBRA continuation coverage can be obtained upon request from the COBRA Administrator, as listed below.

Aon Hewitt
myHR
P.O. Box 563927
Charlotte, NC 28256
Phone: 1-888-694-7287

2.5 Qualified Medical Child Support Order

This *plan* complies with the requirements of any "Qualified Medical Child Support Order" as defined in Section 609(a)(2)(A) of ERISA. A Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that:

- provides for child support with respect to your child under a group health plan or provides for health benefit coverage for your child; and
- is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the company's health care plan.

A Qualified Medical Child Support Order creates or recognizes the existence of an Alternate Recipient's rights to — or assigns to an Alternate Recipient the right to — receive benefits for which you are eligible under this *plan*. CVS has developed procedures to determine whether a medical child support order is qualified and for complying therewith (which among other things, address the effective date of coverage). A covered person may obtain, without charge, a copy of these procedures upon request to CVS.

3.0 COVERED HEALTH CARE SERVICES

This *plan* provides coverage for *medically necessary covered health care services* listed in this benefit booklet. If a service or category of service is not specifically listed as covered, it is not covered under this *plan*. Only services that we have reviewed and determined are eligible for coverage under this *plan* are covered. All other services are not covered. See Section 1.2 for how we identify *new services* and our guidelines for reviewing and making coverage determinations.

This *plan* covers a service listed in this benefit booklet if it is *medically necessary*. Medical necessity is reviewed in accordance with our medical policies and related guidelines. The term *medically necessary* is defined in Section 8.0 - Glossary. It does not include all medically appropriate services.

The amount of coverage we provide for each health care service differs according to whether or not the service is received:

(a) as an *inpatient*;

(b) as an *outpatient*;

(c) in your home;

(d) in a *doctor's* office; or

(e) from a pharmacy.

Also coverage differs depending on whether or not:

(a) the health care *provider* is a *participating provider* or *non-participating provider;*

(b) *deductibles*, *copayments, coinsurance,* and/or *maximum benefit* apply;

(c) you have reached your *plan year maximum out-of-pocket expense*;

(d) there are any applicable exclusions from coverage; or

(e) our *allowable* for a *covered health care service* is less than the amount of your *copayment* and/or *deductible*. In this case, you will be responsible to pay up to our *allowable* when services are rendered by a *participating provider*.

Please see the Summary of Benefits at the front of this benefit booklet to determine the amount of coverage this *plan* provides for *covered health care services.*

3.1 Ambulance Services

Ground Ambulance

Ground ambulance services are covered up to the benefit limits and level of coverage listed in the Summary of Benefits.

Local professional or municipal ground ambulance services are covered when it is *medically necessary* to use these services, rather than any other form of transportation, to the following destinations:

(a) to the closest available *hospital* for an *inpatient* admission;

(b) from a *hospital* to home or to a skilled nursing facility or to a rehabilitation facility after being discharged as an *inpatient;*

(c) to the closest available *hospital* emergency room immediately in an *emergency*; OR

(d) to and from a *hospital* for *medically necessary* services not available in the facility where you are an *inpatient*.

Our *allowable* for the ground ambulance includes the services rendered by an emergency medical technician or paramedic, drugs, supplies and cardiac monitoring.

Related Exclusion

This *plan* does NOT cover ground ambulance transportation to a physician's office.

Air/Water Ambulance

Medically necessary air and water ambulance services are covered up to the *maximum benefit* limit and level of coverage listed in the Summary of Benefits. When you receive services from a *participating provider* you are responsible to pay the *deductible*, *copayment*, and the difference between our *allowable* and the *maximum benefit* limit, if applicable. You are responsible to pay up to the total *charge* when a *non-participating provider* renders air/water ambulance services.

Air ambulance service involves transportation by means of a helicopter or fixed wing aircraft. The aircraft must be a certified ambulance and the crew, maintenance support crew and aircraft must meet the certification requirements and hold a certificate for air ambulance operators under Part 135 of the Federal Aviation Administration (FAA) regulations.

Water ambulance involves transportation by a boat. The boat must be specially designed and equipped for transporting the sick or injured and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

Use of an air/water ambulance is *medically necessary* when the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient's condition or survival or the proper equipment required to treat the patient is not available on a land ambulance.

The patient must be transported for treatment to the nearest appropriate facility that is capable of providing a level of care for the patient's illness and that has available the type of physician or physician specialist needed to treat the patient's condition.

This *plan* will only cover air and water ambulance services originating and terminating in the United States and its territories. Our *allowable* for the air/water ambulance includes the services rendered by an emergency medical technician or paramedic, drugs, supplies and cardiac monitoring.

Related Exclusions

This *plan* does NOT provide coverage for air/water ambulance transportation unless the destination is an acute care *hospital*. Examples of non-covered air/water ambulance include transportation to a physician's office, nursing facility, or a patient's home.

This *plan* does NOT provide coverage for transport from cruise ships when not in United States waters.

3.2 Behavioral Health Services

Behavioral health services are the evaluation, management, and treatment of a patient with a mental health or *chemical dependency* disorder.

For the purposes of this *plan*, mental illness means:

- Any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness;
- Substance abuse does not include addiction to or abuse of tobacco and/or caffeine;
- Mental disorders do not include mental retardation, learning disorders, motor skills disorders, communication disorders, and "V" codes as defined in DSM/IV Diagnostic Criteria published by the American Psychiatric Association.

Mental disorders are covered under Section A. **Mental Health Services** and substance abuse disorders are covered under Section B. **Chemical Dependency Treatment**.

A. Mental Health Services

Inpatient

If you are an *inpatient* in a *general* or *specialty hospital* for mental health services, this *plan* covers *medically necessary hospital services* and the services of an attending physician. See Section 3. 2 – Behavioral Health, Mental Health Services in the Summary of Benefits for the level of coverage. *Prior Authorization* is required for inpatient care.

Outpatient/ Intermediate Care Services

We cover *outpatient* services for the treatment of mental health disorders for individuals covered under this *agreement.*

Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. See the Summary of Benefits for benefit limits and level of coverage. *Prior Authorization* and *Treatment Plan* are required for outpatient/intermediate care services.

This *plan* covers the following *medically necessary* mental health Intermediate Care Services:

- **Partial Hospital Program (PHP)** – This *plan* covers partial *hospital programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of five (5) hours per day, five (5) days per week and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support to patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.
- **Intensive Outpatient Program (IOP)** – This *plan* covers intensive *outpatient programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of three (3) hours per day, three (3) days per week and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support for patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

In a Provider's Office/In your Home

This *plan* covers the following *outpatient* mental health specialists:

- Board certified psychiatrists;
- Licensed clinical psychologists;
- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a masters degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);
- Licensed mental health counselor; AND
- Licensed marriage and family therapists.

The above *providers* must be licensed and certified in the state where you receive the service and must meet our credentialing criteria.

Covered mental health services include *medically necessary* individual psychotherapy, group psychotherapy, and family therapy when rendered by a mental health specialist, as listed above. See the Summary of Benefits for benefit limits and level of coverage. *Prior Authorization* and *Treatment Plan* are required for outpatient services.

This *plan* covers *outpatient* medication visits when rendered by a psychiatrist or a clinical nurse specialist in behavioral health. The applicable office visit *copayment* and/or *deductible* will apply. See the Summary of Benefits for the level of coverage. See Section 3.24- Office Visits.

Electroconvulsive Therapy – This *plan* will cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. This *plan* covers anesthesia services when rendered by an anesthesiologist. See Section 3.34Surgery Services - Anesthesia Services.

Related Exclusions

This *plan* does NOT cover the following mental health services:

- Recreation therapy, non-medical self-care, or self-help training;
- Mental health residential treatment programs (including eating disorder residential treatment programs) and mental health services performed in a residential treatment facility or in the portion of a *hospital,* or any *inpatient* facility, used for residential treatment purposes. We review the program, *hospital* or *inpatient* facility and the specific services provided to decide whether a program, *hospital* or *inpatient* facility meets our medical guidelines and criteria;
- Telephone consultations (See Section 5.14),
- Therapeutic recreation programs or wilderness programs;
- Services provided in any covered *program* that are reviewed by us and we decide are recreation therapy programs, wilderness programs, or non-clinical services;
- Behavioral training assessment, education or exercises, including applied behavioral analysis.

This *plan* does NOT cover mental health services when the *provider* does NOT meet the eligibility and/or credentialing requirements or the *program* is not approved by us.

This *plan* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 5.5 for Services Provided by Facilities We Have Not Approved and Section 5.6 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

For benefit information regarding coverage of *chemical dependency* in a *network hospital, chemical dependency treatment facility,* or a community residential facility see Section B. **Chemical Dependency Treatment**, below.

B. Chemical Dependency Treatment

This *plan* covers *medically necessary* services for the treatment of *chemical dependency* in a *network hospital, chemical dependency treatment facility,* or a community residential facility.

In order for a facility to be a *network provider,* the facility must meet specific requirements including, but not limited to, the following:

(a) The *provider* must be licensed under the laws of the State of Hawaii or by the state in which the facility is located as a *hospital,* a *chemical dependency treatment facility*, or a community residential facility for *chemical dependency* treatment; AND

(b) The *provider* must sign an agreement to provide covered *chemical dependency* services.

Related Exclusions

This *plan* does NOT cover *chemical dependency* services provided in any covered *program* that are reviewed by us and we decide are recreation therapy programs, wilderness programs,

or non-clinical services. We review the program, *hospital* or *inpatient* facility and the specific services provided to decide whether a program, *hospital* or *inpatient* facility meets our medical guidelines and criteria.

This *plan* does NOT cover *chemical dependency* treatment when the *provider* does NOT meet the eligibility and/or credentialing requirements or the *program* is not approved by us.

This *plan* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 5.5 for Services Provided by Facilities We Have Not Approved and Section 5.6 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

Inpatient/ Chemical Dependency Treatment Facility

This *plan* covers the following *inpatient chemical dependency* services:

- *Inpatient* detoxification as indicated in the Summary of Benefits.
- Acute Rehabilitation/Residential treatment as indicated in the Summary of Benefits.

Prior Authorization is required for inpatient services.

Outpatient/Chemical Dependency Treatment Facility/ Intermediate Care Services

This *plan* covers *outpatient* services for the treatment of *chemical dependency* for individuals and family *members* covered under this *plan* when rendered *outpatient* in a *hospital*, a *chemical dependency treatment facility*, or a state-licensed *provider/program* that we have approved. See the Summary of Benefits for the level of coverage.

Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. See the Summary of Benefits for level of coverage. *Prior Authorization* and *Treatment Plan* are required for outpatient/intermediate care services.

This *plan* covers the following *chemical dependency* Intermediate Care Services:

- **Partial Hospital Program (PHP)** – This *plan* covers partial *hospital programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of five (5) hours per day five (5) days per week and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support to patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.
- **Intensive Outpatient Program (IOP)** – This *plan* covers intensive *outpatient programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of three (3) hours per day, three (3) days per week and must consist of, but

not limited to, individual, group, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support for patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

In a Provider's Office/In your Home
We cover services for the treatment of *chemical dependency* for individuals and family *members* covered under this *agreement.* The services may be rendered in a *provider's* office or in your home. *Prior Authorization* and *Treatment Plan* are required.

Related Exclusions
This *plan* does NOT cover methadone clinics and treatments. See Section 5.5- Services Provided By Facilities We Have Not Approved and Section 5.6- Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

3.3 Blood and Blood Products
Outpatient
This *plan* covers blood costs, blood bank services, and blood processing. See the Summary of Benefits for level of coverage.

Related Exclusions
This plan does NOT cover peripheral stem cell transplants except as described in Section 3.34 - Surgery Services for bone marrow transplants.

3.4 Cardiac Rehabilitation
Outpatient

This *plan* covers visits in a cardiac rehabilitation *program* up to the level of coverage shown in the Summary of Benefits if one of the following conditions is met:

- Acute myocardial infarction within the previous twelve (12) months from the start of cardiac rehabilitation.
- Following coronary artery bypass graft surgery within the preceding twelve (12) months. Cardiac rehabilitation must begin within six (6) months of the coronary artery bypass graft surgery.
- Following percutaneous transluminal coronary angioplasty.
- Following valve replacements or repairs.
- Stable angina pectoris: all patients must have had a pre-entry stress test that is positive for exercise induced ischemia within six (6) months of starting cardiac rehabilitation. The positive stress test should include perfusion studies demonstrating the ischemia.
- Compensated heart failure.
- Post-heart transplantation.

3.5 Chiropractic Medicine

This *plan* covers *medically necessary* chiropractic visits up to the benefit limit and level of coverage as indicated in the Summary of Benefits. The benefit limit applies to any visit for the purposes of chiropractic treatment or diagnosis, regardless of the place of service. In addition, this *plan* covers selected lab tests and X-rays ordered by a chiropractic physician.

Related Exclusions

This *plan* does NOT cover massage therapy, aqua therapy, maintenance therapy, and aromatherapy. Therapies, procedures, and services for the purpose of relieving stress are NOT covered. This *plan* does NOT cover pillows. This agreement does NOT cover X-rays read by a chiropractic physician.

3.6 Colonoscopy Services

This *plan* covers colonoscopy services including the administration of anesthesia. The level of coverage differs depending on whether the colonoscopy is preventive or diagnostic. Coverage is also dependent upon whether it is your first colonoscopy or subsequent colonoscopies of the *plan* year. See the Summary of Benefits for benefit limits and level of coverage.

For coverage information regarding other services performed such as lab services and facility services see Section 3.9 - Diagnostic/Preventive Imaging, Lab and machine test and Section 3.17 - Hospital Services. See the Summary of Benefits for benefit limits and level of coverage for each section.

3.7 Consultations in the Hospital

If, while you are in the *hospital*, the attending *doctor* in charge of your care requests the assistance of a *doctor* who has special skills and knowledge to diagnose your condition, this *plan* covers a consultation performed by a specialist as indicated in the Summary of Benefits.

The transferring of a patient from one *doctor* to another is not considered to be a consultation. A specialized *doctor* who then treats you as his or her patient is not considered to be a consultant.

3.8 Contraceptive Drugs and Devices

This *plan* provides coverage for the following FDA approved contraceptive devices requiring a prescription when dispensed by a licensed health care provider, other than a pharmacist:

- surgical insertion, removal and removal with reinsertion of contraceptive implants. surgical implantation and removal of intrauterine device (IUD).
- diaphragms/cervical caps are covered per device.
- injectable contraceptive drugs supplied and administered by a *doctor* are covered as an injectable drug dispensed and administered by a licensed health care *provider* (other than a pharmacist). See Section 3.29 Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions

A church or qualified church-controlled organization as defined in 26 USC §3121 may opt to exclude coverage for contraceptive drugs and devices. See Summary of Benefits to determine coverage of contraceptive drugs and devices, if any.

3.9 Diagnostic/Preventive Imaging, Lab, and Machine Tests Inpatient/Outpatient/In a Doctor's Office

Diagnostic Imaging, Lab and Machine Tests

If a *doctor* orders the following tests to diagnose a condition resulting from illness or injury, this *plan* covers the *doctor* or *hospital services*:

(a) Imaging including Plain film radiographs, Ultrasonography (ultrasounds), Mammograms (including digital mammograms), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT or CT scans), Nuclear scans, and Positron Emission Tomography (PET scan).

MRI examinations must be performed in accordance with applicable laws of the state in which the examination has been conducted.

For the purpose of coverage under this *plan*, *Prior Authorization* is required for the following services:

- MRI
- MRA
- CAT scans
- PET scans
- Nuclear Cardiac Imaging

(b) Laboratory tests including blood tests, urinalysis, pap smears, and throat cultures. This *plan* covers pathological examinations performed in a *hospital* only when billed by the *hospital*. Some lab tests are not covered. See the related exclusions in this section.

(c) Machine tests including Electrocardiograms (EKGs) and Electroencephalograms (EEGs).

This *plan* covers services for the initial reading or initial interpretation of the diagnostic imaging, lab, and machine tests listed above.

We may conduct *utilization review* on any test to determine if the service is *medically necessary*.

HIV Testing is covered under this plan including lab or physician charges for drawing blood.

Preventive Imaging, Lab and Machine Tests

This *plan* covers the following *preventive care services* when performed for routine cancer screening, in accordance with the most currently available comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The following list is based on the most current guidelines which are subject to change. This includes coverage for *doctor* services for reading and interpretation when billed by a *doctor* for:

(a) One Prostate Specific Antigen (PSA) test per plan year for men beginning at age 45, or earlier as a result of family history;

(b) Colorectal screening tests; limited to fecal occult blood lab test annually OR double contrast barium enema every 5 years.

This *plan* covers the following *preventive care services* when performed for routine screening.

This includes coverage for *doctor* services for reading and interpretation when billed by a *doctor* for:

(a) One baseline bone density screening per lifetime for *members* under age 65 and a bone density screening every two years for *members* age 65 and older;

(b) Cholesterol screening; every 5 years beginning at age 35; or at age 20 if other risk factors for CAD are present;

(c) Diabetes screening; Fasting blood sugar at age 45; if normal, every 3 years thereafter, annually if borderline.

See the Summary of Benefits for benefit limits and level of coverage.

Mammograms/Pap Smears

This *plan* covers preventive and diagnostic mammograms and pap smears. The level of coverage differs depending on whether the mammogram or pap smear is preventive or diagnostic and depending on whether it is your first mammogram or pap smear or subsequent mammograms or pap smears of the *plan* year. See the Summary of Benefits for benefit limits and level of coverage.

Hearing

This *plan* covers preventive and diagnostic hearing tests. The level of coverage differs depending on whether the hearing test is preventive or diagnostic and depending on whether it is your first hearing test or subsequent hearing test of the *plan* year. See the Summary of Benefits for benefit limits and level of coverage.

Biometric Screening

This *plan* covers biometric screening, which includes screening for blood pressure, and lipid disorders, diabetes (fasting blood sugar) and body mass index. The level of coverage differs depending on whether it is your first biometric screening or subsequent biometric screening of the *plan* year. The level of coverage also differs depending upon where you have the service rendered. For a *provider*, other than *MinuteClinic*, see the Summary of Benefits for this section

for the level of coverage. For the level of coverage for a service performed at *MinuteClinic*, see Section 3.24- Office Visits, *MinuteClinic*.

Other Preventive Care Services

In accordance with the guidelines coverage is provided for other preventive care services such as office visits and surgical procedures (e.g. colonoscopy and sigmoidoscopy). For information regarding office visits see Section 3.24- Office Visits, for colonoscopy see Section 3.6- Colonoscopy Services and for surgical procedures see Section 3.34- Surgical Services. See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions

This *plan* does NOT cover preventive hearing tests except when rendered during a well child office visit (for *members* from birth to nineteen years old).
This *plan* does NOT cover re-reading of X-rays by a second *doctor*.
This *plan* does NOT cover the following:

- dental X-rays (except when ordered by a *doctor*/dentist to diagnose a condition due to an accident to your *sound natural teeth*. See Section 3.11 - Emergency Services for details);
- bone marrow blood supply MRI;
- genetic testing for screening purposes or parentage testing;
- audiometric hearing or speech services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or handicapped children. (See laws and applicable regulations, in your state, governing the health of school children and the special education of handicapped children or comparable requirements established by federal law.)

3.10 Doctors' Hospital Visits

For coverage of surgeons, see Section 3.34 - Surgery Services.

If you are admitted to *a general hospital* as an *inpatient* for a medical condition, this *plan* covers the services of a *doctor* in charge of your medical care, up to one (1) visit per day, for the same number of days allowed under Section 3.17 - *Hospital Services*. See the Summary of Benefits to determine the number of *hospital* days available.

If you are admitted for surgical, obstetrical, or radiation services, our *allowance* to the *doctors* who performed your surgery, delivered your child, or supervised your radiation includes payment for all your related *hospital* visits by these *doctors* during your admission.

If you need *inpatient* specialty care for a condition that requires skills the *doctor* in charge of your care does not have, this *plan* will cover specialist visits as *medically necessary*.

3.11 Emergency Room Services
Hospital

This *plan* covers emergency room services only for an *emergency*. See Section 8.0 for the definition of an *emergency*. If your condition requires immediate or urgent, but non-*emergency* care, contact your *doctor* or use an *urgent care center*.

If you have an accident or medical *emergency* that requires emergency room services and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, this *plan* covers the *hospital* or emergency room services and the *doctor's* services. See the Summary of Benefits for benefit limits and level of coverage.

Bandages, crutches, canes, collars, and other supplies incidental to your treatment in the emergency room are covered as part of our *allowable* for the emergency room services.

If you are admitted to a *non-participating hospital* from the emergency room to receive *inpatient* services, you must inform us of the *emergency* within forty-eight (48) hours, or as soon as reasonably possible. Call the Customer Service Department at (808) 954-8796 or 1-866-826-5335.

Accident includes an accidental injury to your *sound natural teeth*. Accidental injuries are those caused by unexpected and unintentional means. If you receive treatment in an emergency room for an accidental injury to your *sound natural teeth*, and/or any facial fractures, and the injury is the direct cause, independent of disease or bodily injury, this *plan* covers the *hospital* or emergency room services and the *doctor's* services. *Medically necessary* services are covered when received within seventy-two (72) hours of the accidental injury to your *sound natural teeth.* The following services are covered:

- Extraction of teeth needed to avoid infection of teeth damaged in the injury;
- Suturing;
- Reimplanting and stabilization of dislodged teeth;
- Repositioning and stabilization of partly dislodged teeth; and
- Dental x-rays.

Suture removal performed where the original *emergency* medical or dental services were received is covered as part of our *allowable* for the original *emergency* treatment. This *plan* will ONLY cover a separate charge for suture removal if the suturing and suture removal are performed at different locations (i.e. sutures at emergency room and suture removal at *doctor's* office).

Related Exclusions

This *plan* does NOT cover:

- *hospital* or other facility's services for treatment received in an emergency room for a non-*emergency* condition;
- follow-up visits to the emergency room;

- dental injuries incurred as a result of biting and/or chewing;
- any dental services other than those specifically listed above for injury to your teeth;
- treatment of an accidental injury to your *sound natural teeth* rendered in a dentist's office.

3.12 Experimental/Investigational Services

This *plan* only provides coverage for *experimental/investigational* services as required by laws concerning New Cancer Therapies and Off Label Use of Prescription Drugs.

New Cancer Therapies

This plan provides coverage for investigational new cancer therapies only when the following circumstances are present:

(1) Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health in cooperation with the National Cancer Institute (NCI), community clinical oncology programs; the Food and Drug Administration in the form of an investigation new drug exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;

(2) The proposed therapy has been reviewed and approved by a qualified Institutional Review Board (IRB);

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

(4) The *subscriber* receiving the investigational treatment meets all protocol requirements;

(5) There is no clearly superior, non-investigational alternative to the protocol treatment; and

(6) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the non-investigational alternative.

Any portion of a new cancer therapy treatment provided pursuant to a phase II clinical trial which is funded by a national agency or a commercial organization will not be covered.

Off-Label Uses of Prescription Drugs for Cancer Treatment

This plan provides coverage for primary anti-cancer or anti-neoplastic prescription drugs used in the treatment of cancer which have not been approved by the federal Food and Drug Administration (FDA) for that indication ("off-label use") provided that:

(1) The drug is recognized for treatment of that indication in either:

  (a) one of the standard reference compendia set forth in subsection 4(c) under "Related Exclusions" in this Section 3.12, or

(b) scientific studies published in at least two (2) articles from major peer reviewed medical journals unless clear and convincing contradictory evidence is presented in a major peer reviewed medical journal;

The plan may request the above documentation from the prescribing *doctor* supporting the proposed off-label use of the drug.

(2) The drug has been fully licensed and approved by the FDA;

(3) The drug has not been determined by the FDA to be contraindicated for that use; and

(4) The drug is not an experimental drug that has not been approved for any indication by the FDA.

If the drug serves as the primary treatment, then *this plan* covers *medically necessary* services associated with administration of the drug.

Related Exclusions

Except as stated above, *this plan* does NOT cover any treatments, procedures, facilities, equipment, drugs, devices, supplies or services that are experimental or investigational.

Recognition as having been proven effective in clinical medicine shall only be obtained through the following:

- Final approval for the use of a specific service for a specific condition from the appropriate governmental regulatory body; OR
- Demonstrated, reliable evidence based upon an entry in at least one of the three standard reference compendia set forth in subsection 4 (c) of this Section 3.12 based upon sound scientific studies published in authoritative, peer reviewed medical journals that illustrate statistically significant outcomes about the effectiveness of the service, and that permit a consensus of opinion that the service improves the net health outcome, is as beneficial as any established alternatives and that said improvement is attainable outside the *investigational* setting.

The determination by an expert medical consultant retained by us, for the purpose of reviewing a particular service, that the service is not *experimental/investigational* for that particular case.

A service is considered "*experimental/investigational*," if we determine that one or more of the following circumstances are true:

(1) The service is the subject of ongoing phase I or phase II clinical trial or is the *experimental* arm of phase III clinical trial or is under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

(2) The prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

(3) The current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications. We will determine the applicability of this criterion based on:

(a) Published reports in authoritative, peer-reviewed medical literature; AND

(b) Reports, publications, evaluations, and other sources published by government agencies, such as the National Institutes of Health, the FDA, and the Agency for Healthcare Research and Quality; or

(4) If the benefit in question is a drug, a device or other supply that is subject to approval by the FDA, at least one of the following criteria will apply:

(a) it has not received FDA approval; or

(b) it has limited FDA approval under regulations such as Treatment Investigational New Drugs; or

(c) it has FDA approval but the indication for the drug or device, or the dosage, is not an accepted off-label use. We will judge this criterion through review of reports published in authoritative peer-reviewed United States medical literature OR entries in one or more of the following drug compendia:

i. The AMA Drug Evaluations;

ii. The American Hospital Formulary Service Drug Information;

iii. The U.S. Pharmacopoeia Dispensing Information; or

(5) The Institutional Review Board (IRB) of the *provider* of the service or supply acknowledges that use of it is *experimental/investigational* and is subject to the approval of the IRB; or

(6) The *provider* IRB requires the patient (or parent or guardian) to give an informed consent for the service or supply that states the service or supply is *experimental/investigational*, or federal law requires such a consent; or

(7) The research protocols related to the requested service or supply state or indicate the service or supply is *experimental/investigational*.

We have the right and discretionary authority to determine whether a service is *experimental/investigational*, and any such determination made by us in good faith is binding on you.

3.13 Hemodialysis Services

Inpatient

Inpatient hemodialysis services are covered as a *hospital service*. See Section 8.0 - definition of *hospital services.*

Outpatient

If you receive hemodialysis services in a *hospital's outpatient* unit or in a hemodialysis facility, this *plan* covers the use of the treatment room, related supplies, solutions, and drugs, and the use of the hemodialysis machine.

In Your Home

If you receive hemodialysis services in your home and the services are under the supervision of a *hospital* or *outpatient* facility hemodialysis *program*, we cover the purchase or rental (whichever is less, but never to exceed our *allowance* for purchase) of the hemodialysis machine, related supplies, solutions, and drugs, and necessary installation costs.

Related Exclusions

If you receive hemodialysis services in your home, this *plan* does NOT cover installation or modification of electric power, water and sanitary disposal or charges for these services, moving expenses for relocating the machine, installation expenses not necessary to operate the machine or to train you or members of your family in the operation of the machine.

This *plan* does NOT cover hemodialysis services when received in a *doctor's* office.

3.14 Hemophilia Services

Outpatient/In a Doctor's Office

We cover the following *medically necessary* services for treatment of hemophilia:

- yearly evaluation;
- office visits;
- hemophilia *outpatient* physical therapy;
- clotting factor drugs; and
- supplies.

3.15 Home Health Care

In Your Home

If you qualify to receive health care at home, this *plan* covers home health care services provided by a *hospital* or community home health care agency. This *plan* covers the following *medically necessary* services:

- nurse services;
- services of a home health aide;
- visits from a social worker; and
- physical and occupational therapy.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, for home care equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, for radiation therapy or chemotherapy

services See Section 3.30 - Radiation Therapy/Chemotherapy Services, and for prescription drugs see Section 3.29 - Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions

This *plan* does NOT cover any homemaking, companion, or chronic (custodial) care services.

This *plan* does NOT cover:

- *charges* for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion/sitter; OR
- services of a private nurse who is a *member* of your household or the cost of any care provided by one of your relatives (by blood, marriage or adoption).

3.16 Hospice Care

Inpatient

If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, this *plan* covers inpatient hospice care admissions to an approved hospice care *provider*.

Related Exclusions

This *plan* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 5.5- Services Provided by Facilities We Have Not Approved.

In Your Home

If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, this *plan* covers some hospice care services provided by a hospice care *program* listed below:

- services of a hospice coordinator billed by the hospice care *program*;
- services of grief counselors and pastoral care;
- services of a social worker;
- services of a nurse; and
- services of a home health aide.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, hospice care equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, and for prescription drugs see Section 3.29 - Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

3.17 Hospital Services

Inpatient

Semi-Private Room Charges/Days of Hospital Coverage
If you are hospitalized as an *inpatient* in a ward or *semi-private room* in *a general hospital* for medical or surgical services, this *plan* covers hospital *services* for the number of days listed in the Summary of Benefits.

Related Exclusions

This *plan* does NOT cover extra *charges* for a private room.

3.18 House Calls

This *plan* covers doctor visits in your home if you have a condition resulting from an injury or illness which confines you to your home, requires special transportation, or requires the assistance of another person. See the Summary of Benefits for benefit limits and level of coverage.

3.19 Human Leukocyte Antigen Testing

This *plan* covers human leukocyte antigen testing for A, B, and DR antigens once per *member* per lifetime for utilization in bone marrow transplantation. The testing must be performed in a facility which is:

(a) accredited by the American Association of Blood Banks or its successors; and

(b) licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor program.

3.20 Infertility Services

Inpatient/Outpatient/In a Doctor's Office

This *plan* covers services for in vitro fertilization. This *plan* only covers in vitro fertilization services if:

- you are under the care of a gynecologist or an infertility specialist; and
- you are unable to conceive or sustain a pregnancy during a five (5) year period; or
- infertility is related to one or more of these medical conditions:
  (a) endometriosis;
  (b) exposure in utero to diethylstilbestrol (DES);
  (c) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy).

Coverage for infertility treatment is limited and Prior Authorization is required. Contact our Customer Service Department at 1-866-826-5335 or 808-954-8796 for additional information.

See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions

This *plan* does not cover infertility treatments other than in vitro fertilization.
This *plan* does NOT cover oral or injectable infertility drugs regardless of where dispensed.

This *plan* does NOT cover infertility treatment for an individual (either male or female partner) that previously had a voluntary sterilization procedure.

This *plan* does not cover infertility treatments if the female partner has had a hysterectomy.

This *plan* does NOT cover long term storage of sperm, oocytes or embryos.

3.21 Infusion Therapy

Inpatient

Inpatient infusion therapy services are covered as a *hospital service*. See Section 8.0 - definition of *hospital services.*

Outpatient

If you receive infusion therapy services in a *hospital's outpatient* unit, this *plan* covers the use of the treatment room, related supplies and solutions. For prescription drug coverage see Section 3.29 – Prescription drugs.

See the Summary of Benefits for benefit limits and level of coverage.

In a Doctor's Office

If you receive infusion therapy services in a *doctor's* office, this *plan* covers the related supplies and solutions. For prescription drug coverage see Section 3.29 - Prescription drugs.

See the Summary of Benefits for benefit limits and level of coverage.

In Your Home

This *plan* covers the following infusion therapy services as part of our *allowance* for home infusion therapy services when provided by an agency approved by us:

- nursing visits;
- administration of infusions for therapeutic delivery of drugs, biologicals, and hydration;
- infusions for total parenteral nutrition (including the infused TPN);
- related equipment; and
- supplies.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, home care equipment and supplies see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, radiation therapy or chemotherapy services see Section 3.30 - Radiation Therapy/Chemotherapy Services, and for prescription drugs see section 3.29 - Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions

This *plan* does NOT cover any homemaking, companion, or chronic (custodial) care services.

3.22 Lyme Disease Diagnosis and Treatment

This *plan* provides coverage for diagnostic testing and long-term antibiotic treatment of chronic Lyme disease when determined *medically necessary*. To qualify for payment, services must be ordered by your *doctor* after evaluation of your symptoms, diagnostic test results, and response to treatment. Benefit payment for Lyme disease treatment will not be denied solely because such treatment may be characterized as unproven, *experimental*, or *investigational*.

For coverage of specific services, refer to Sections 3.9 - Diagnostic Imaging, Lab, and Machine Tests, 3.24 - Office Visits, 3.21 Infusion Therapy, and 3.29 - Prescription Drugs.

3.23 Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices

Coverage is provided for *durable medical equipment*, *medical supplies,* and *prosthetic devices* that meet the minimum specifications which are *medically necessary*.

The *provider* must meet eligibility and/or credentialing requirements as defined by the *plan* to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT is equipment (and supplies necessary for the effective use of equipment) which:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) is not useful to a person in the absence of an illness or injury; and

(d) is for use in the home.

MEDICAL SUPPLIES means those consumable supplies which are disposable and not intended for re-use. Medical supplies require an order by a physician and are essential for the care or treatment of an illness, injury, or congenital defect.

PROSTHETIC DEVICES means devices (other than dental) which replace or substitute all or a part of an internal body part (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning body part necessary to alleviate functional loss or impairment due to an illness, injury or congenital defect.

Inpatient

Inpatient medically necessary durable medical equipment, medical supplies, enteral formula or food , and prosthetic devices you receive as an *inpatient* when provided and billed for by the *hospital* where you are an *inpatient* are covered as a *hospital service*. See Section 8.0 for the definition of *hospital services. Hospital Services* are covered up to the benefit limits and level of coverage shown in the Summary of Benefits.

When you are prescribed a *medically necessary prosthetic device* as an *inpatient* and it is billed by a *provider* other than the *hospital* where you are an *inpatient*, the benefit limits and level of coverage for Medical Equipment, Medical Supplies, and Prosthetic Devices, Outpatient, will apply, as shown in the Summary of Benefits.

Outpatient/In Your Home

See the Summary of Benefits for benefit limits and level of coverage. This *plan* will cover the following durable medical equipment, medical supplies, enteral formula or food, and prosthetic devices subject to our guidelines:

Durable Medical Equipment

A *durable medical equipment* (DME) item may be classified as a rental item or a purchased item, as determined by us. A DME rental item is billed on a monthly basis for a specific period of months, after which time the item is considered paid up to our *allowable.* Our *allowable* for a rental DME item will never exceed our *allowable* for a DME purchased item.
Prior Authorization is required for certain items. Repairs and supplies to rental equipment are included in our rental *allowable*. *Prior Authorization* is recommended for replacement and repairs of purchased *durable medical equipment*.

This *plan* will cover the following *durable medical equipment* subject to our guidelines:

(a) Wheelchairs, hospital beds, and other *durable medical equipment* used only for medical treatment;

(b) Replacement of purchased equipment which is required due to a change in your medical condition;

(c) Therapeutic/molded shoes for the prevention of amputation are covered for the treatment of diabetes; our *allowance* for molded shoes includes the initial inserts; Additional *medically necessary* inserts for custom-molded shoes are covered;

(d) External insulin infusion pumps and appurtenances thereto and insulin infusion devices only will be covered under this *plan* (see related exclusion);

(e) Appliances and devices for non-surgical treatment of temporomandibular joint dysfunctions.

Related Exclusion

Certain durable medical equipment for the treatment of insulin-treated diabetes, non-insulin-treated diabetes, and gestational diabetes can be purchased at a CVS Pharmacy and therefore is not covered under this *plan.* This includes, but is not limited to:

- blood glucose monitors (includes home monitors, disposable monitors, and monitors with an integrated voice synthesizer or integrated lancing/blood sample);
- blood glucose monitors for the legally blind;
- injection aids; and
- needle-free injection devices.

Medical Supplies

This *plan* will cover the following *medical supplies* subject to our guidelines:

(a) Essential accessories such as hoses, tubes and mouthpieces for use with *medically necessary durable medical equipment* (these accessories are included as part of the rental allowance for rented equipment);

(b) Catheters, colostomy and ileostomy supplies, irrigation trays and surgical dressings;

(c) Diaphragms supplied in a *doctor's* office

(d) Respiratory therapy equipment solutions.

Medical supplies provided during an office visit are included in our office visit *allowable*.

Related Exclusions

Certain supplies for the treatment of insulin-treated diabetes, non-insulin-treated diabetes and gestational diabetes can be purchased at a CVS Pharmacy and therefore are not covered under this *plan.* This includes, but is not limited to:

- insulin;
- needles and syringes when dispensed for use with insulin;
- insulin cartridges or insulin delivery devices, including reusable pens;
- test strips for glucose monitors and/or visual reading, test strips or tablets for urine testing, dextrostick or glucose test strips, and blood ketone test or reagent strips;
- lancets and spring-powered devices for lancets;
- platforms for home glucose monitors; and
- calibration liquid, calibrator solution/chips, and alcohol swabs.

Enteral Formulas or Food (Enteral Nutrition)

Enteral formula or food is nutrition that is absorbed through the intestinal tract, whether delivered through a tube for feeding or taken orally. The level of coverage differs depending on whether the enteral formula or food is the sole source of nutrition delivered through a feeding tube or taken orally.

This *plan* provides coverage for enteral formula and supplies to administer enteral formula when it is delivered through a feeding tube and is the sole source of nutrition. See the Summary of Medical Benefits for level of coverage. *Prior Authorization* is required.

This *plan* covers *medically necessary* enteral formula taken orally for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo obstruction, and inherited diseases of amino acids and organic acids. Enteral formula is covered when a *doctor* has issued a written order and must be for home use. Also, food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. *Prior Authorization* is required.

We will provide coverage for enteral formula up to the *maximum benefit.* You are responsible for paying the full amount due to the *provider.* If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 - How to File a Claim. We will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount indicated in the Summary of Medical Benefits. The benefit limit and level of coverage will apply as shown in the Summary of Medical Benefits.

Related Exclusions

This *plan* does not provide coverage for enteral formula taken orally without a written order from the *doctor* and unless for the treatment of the conditions listed above. This *plan* does not cover enteral formula taken orally unless for home use. Modified low protein food products are not covered unless for the treatment of the conditions listed above.

Prosthetic Devices

This *plan* provides coverage for covered *members* up to the benefit limit and level of coverage listed in the Summary of benefits. The *plan* will cover the following *prosthetic devices* subject to our guidelines:

(a) Prosthetic appliances such as artificial limbs, breasts, larynxes and eyes, including the replacement or adjustment of these appliances (replacement of a covered device will be allowed only if there is a change in your medical condition or if the device is not functional, no longer under warranty and cannot be repaired);

(b) Devices, accessories, batteries, and/or supplies necessary for attachment to and operation of *prosthetic devices*;

(c) Orthopedic braces (except corrective shoes and orthotic devices used in connection with footwear); and

(d) Initial and subsequent *prosthetic devices* following a mastectomy and pursuant to an order of a physician or surgeon.

This *plan* provides benefits for mastectomy-related prosthetics in accordance with the Women's Health and Cancer Rights Act of 1998. See Section 3.34 Surgery Services – Mastectomy.

Related Exclusions

Items typically found in the home that do not require a prescription and are easily obtainable such as, but not limited to, adhesive bandages, elastic bandages, gauze pads, and alcohol swabs are NOT covered under this *plan*.

This *plan* does NOT cover *durable medical equipment* and *medical supplies* prescribed primarily for the convenience of the *member* or the *member's* family, including but not limited to, duplicate *durable medical equipment* or *medical supplies* for use in multiple locations or any *durable medical equipment* or *medical supplies* used primarily to assist a caregiver. This *plan* does NOT cover *durable medical equipment* that does not directly improve the function of the *member*.

This *plan* does NOT cover pillows, batteries (except when used for the operation of *prosthetic devices*), or items whose sole function is to improve the quality of life or mental well being. See Section 5.26 for a list of personal appearance and/or service items NOT covered by this *plan*.

This *plan* does NOT cover repair or replacement of *durable medical equipment* when the equipment is under warranty, covered by the manufacturer, or during the rental period. This *plan* does NOT cover repair *charges* to repair rental items.

This *plan* does NOT cover hair prosthetics (wigs) when worn for any condition.

Hearing Aid Services
This *plan* provides hearing aid coverage for covered *members* up to the level of coverage listed in the Summary of Benefits.

We will provide coverage up to the *maximum benefit.* You are responsible for paying the full amount due to the *provider.* If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 - How to File a Claim. We will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount indicated in the Summary of Medical Benefits.

Related Exclusions

Hearing aid coverage does NOT include batteries, repairs, modifications, cords, and other assistive listening devices.

3.24 Office Visits
In a Doctor's Office

Our *allowable* for an office visit includes *medical supplies* provided as part of the office visit. See the Summary of Benefits for benefit limits and level of coverage for each service listed in this section.

Related Exclusions

Physical examinations and any services performed in conjunction with the exams, including but not limited to lab tests, machine tests, immunizations, are NOT covered when services are required for or related to employment, education, marriage, adoption, insurance purposes or when required by similar third parties.

Asthma Education

Medically necessary asthma education sessions are covered when the service is prescribed by a physician and performed by a certified asthma educator. The asthma education session can be rendered in a *doctor's* office, *outpatient* department of a *hospital*, or in a *hospital* based clinic. See the Summary of Benefits for benefit limits and level of coverage.

Other asthma related *covered health care services* including, but not limited to, office visits rendered by a *provider* (other than a certified asthma educator), medical equipment and supplies are subject to the benefit rules applicable to the specific services. For information regarding office visits See Section 3.24 - Office Visits, for medical equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies and Prosthetic Devices. See the Summary of Benefits for benefit limits and level of coverage for each section.

Diabetes Education

Diabetes education is covered when *medically necessary* and prescribed by a physician. Such education may be provided only by a physician or, upon his or her referral to, an appropriately licensed and certified diabetes educator. See the Summary of Benefits for benefit limits and level of coverage.

Hospital Based Clinic Visits

See the Summary of Benefits for benefit limits and level of coverage. Other *covered health care services* provided by a clinic, such as physical therapy or occupational therapy, are subject to the benefit rules applicable to the specific services.

Nutritional Counseling

Nutritional counseling is covered up to the number of visits shown in the Summary of Benefits. It must be prescribed by a physician and performed by a registered dietician/nutritionist. Nutritional counseling visits may be covered for healthy individuals seeking nutritional information or desiring weight loss or for the purpose of treating an illness. See the Summary of Benefits for benefit limits and level of coverage.

MinuteClinic

MinuteClinic visits are covered. The level of coverage for lab services rendered at a *MinuteClinic* is based on the type of service. See Section 3.9 - Diagnostic Imaging, Lab and Machine Tests.

Office Visits (Other Than Pediatric Office Visits)

This *plan* covers other *medically necessary* office visits, including visits to *urgent care centers* provided they are reasonable in number and in the scope of the services rendered for the following:

- office visits to *personal physician*;
- office visits to specialists;
- routine examinations;

- consultations; or
- medication visits for *outpatient* mental illness.

See the Summary of Benefits for benefit limits and level of coverage. For prescription drug coverage see Section 3.29 - Prescription Drugs. *Doctor* visits to your home, see Section 3.18 - House Calls.

Adult Immunizations/Vaccinations

Adult immunizations/vaccination are based on the most currently available guidelines and are subject to change. Adult preventive vaccinations/immunizations coverage includes, but is not limited to, the following:

- Diphtheria/Tetanus (or tetanus alone) - one dose every 10 years;
- Hepatitis B
- Influenza – annually; and
- Pneumonia polysaccharide vaccine – one dose beginning at age 65.

This plan also provides coverage for *medically necessary* adult immunizations in accordance with the guidelines established by the CDC. Adult immunization coverage includes, but is not limited to, the following:

- Hepatitis A - for those at risk;
- Meningitis – one dose if high risk;
- Pneumonia polysaccharide vaccine – for those at high risk;
- Varicella - for those at risk;
- Rabies - if exposed;
- Herpes Zoster (shingles) 1 dose for those over 60 years of age;
- Human Papillomavirus (HPV) vaccine as recommended by physician (series of 3 doses over 6 months between ages 9 to 12). Catch-up vaccine for ages 13 to 26 for those who did not receive it at a younger age; and
- The following vaccines for travel outside the country: Polio vaccine, live, inactivated (IPV), for subcutaneous or intramuscular use, Measles virus vaccine, live, for subcutaneous use, Yellow fever vaccine, live, for subcutaneous use, Hepatitis A vaccine, adult dosage, for intramuscular use, Hepatitis B vaccine, adult dosage, for intramuscular use, Hepatitis B vaccine for immunocompromised or dialysis patient, for intramuscular use, Hepatitis A and Hepatitis B vaccine, adult dosage, for intramuscular use, Typhoid vaccine, live oral, Typhoid vaccine, Vi capsular polysaccaride (ViCPs) for intramuscular use, Typhoid vaccine, heat and phenol-inactivated (H-P) for subcutaneous or intramuscular use, Meningococcal polysaccaride vaccine, any groups, for subcutaneous use, Meningococcal conjugate vaccine, serogroups A,C Y and W-135, for intramuscular use, Japanese encephalitis virus vaccine, for subcutaneous use.

Our allowable includes the administration and the vaccine. If any other *covered health care services* are rendered, including an office visit, the applicable *copayment, coinsurance,* and/or *deductible* for the covered service will apply. See the Summary of Medical Benefits for benefit limits and level of coverage.

Related Exclusions

This *plan* does NOT cover adult vaccinations/immunizations, Measles, Mumps, and Rubella. Immunizations for employment or educational purposes are NOT covered.

Pediatric Office Visits

Pediatric well child exams are covered in accordance with current guidelines and are subject to change. See the Summary of Benefits for benefit limits and level of coverage.

Pediatric Immunizations/Vaccinations and Screenings

Pediatric preventive immunizations/vaccinations are covered in accordance with the guidelines which are subject to change. As new vaccines are introduced the CDC schedules for catch-up immunizations will be followed for children older than the recommended starting vaccination age.

Pediatric preventive vaccinations/immunizations coverage includes, but is not limited to, the following:

- Diphtheria, tetanus, pertussis (DTaP) - 2, 4, and 6 months, 15-18 months, 4-6 years of age and tetanus, diphtheria, pertussis (Tdap - adolescent preparation) 11-12 years of age (6 doses);
- Haemophilus influenza type b (Hib) - 2, 4 and 6 months and between 12-15 months (4 doses);
- Hepatitis A - two doses separated by 6 months starting at age 12 months;
- Hepatitis B (HepB) – birth to 18 months (series of 3 or 4 doses);
- Influenza (flu) - annually starting at age 6 months;
- Measles, Mumps, Rubella (MMR) - 12-15 months and 4-6 years of age (2 doses)
- Meningitis – 11-12 years of age (one dose) and for high risk children;
- Pneumococcal conjugate vaccine (PCV) - 2, 4, and 6 months, and 12-18 months (4 doses);
- Polio (IPV) - 2 and 4 months, 6-18 months, and 4-6 years of age (4 doses);
- Varicella (chicken pox) - 12-18 months (1 dose) ;
- Human Papillomavirus (HPV) vaccine as recommended by physician (series of 3 doses over 6 months between ages 9 to 12). Catch-up vaccine for ages 13 to 26 for those who did not receive it at a younger age;
- Rotavirus (RV)**:** at 2, 4,and 6 months of age (series of 3 doses); and

- The following vaccines for travel outside the country: Polio vaccine, live, inactivated (IPV), for subcutaneous or intramuscular use, Measles virus vaccine, live, for subcutaneous use, Yellow fever vaccine, live, for subcutaneous use, Hepatitis B vaccine for immunocompromised or dialysis patient, for intramuscular use, Typhoid vaccine, live oral, Typhoid vaccine, Vi capsular polysaccaride (ViCPs) for intramuscular use, Typhoid vaccine, heat and phenol-inactivated (H-P) for subcutaneous or intramuscular use, Meningococcal polysaccaride vaccine, any groups, for subcutaneous use, Meningococcal conjugate vaccine, serogroups A,C Y and W-135, for intramuscular use, Japanese encephalitis virus vaccine, for subcutaneous use.

This plan provides coverage for *medically necessary* pediatric immunizations in accordance with the guidelines established by the CDC.

Our allowable includes the administration and the vaccine. If any other *covered health care services* are rendered, including an office visit, the applicable *copayment, coinsurance,* and/or *deductible* for the covered service will apply. See the Summary of Benefits for benefit limits and level of coverage.

Pediatric preventive screening coverage includes, but is not limited to, the following:

- Newborn screening for metabolic disorders such as congenital hypothyroidism and phenylketonuria (PKU) - within 7 days of birth;
- Lead levels - one at 9-12 months of age and 1 at 24 months of age.

Related Exclusions

Immunizations for employment or educational purposes are NOT covered.

You do not need *Prior Authorization* from us or from any other person (including a *personal physician*) in order to obtain access to obstetrical or gynecological care from a *network doctor* who specializes in obstetrics or gynecology. Your *doctor,* however, may be required to comply with certain procedures, including obtaining *Prior Authorization* for certain services [, following a pre-approved treatment plan, or procedures for making referrals.] For a list of *participating providers* who specialize in obstetrics or gynecology, contact our Customer Service Department.

3.25 Organ Transplants

Heart, heart-lung, lung, liver, small intestine, and pancreas transplants are included in the Additional Organ Transplant Coverage Section below.

Kidney, cornea, and bone marrow transplants are covered as surgical procedures. See Section 3.34 - Surgery Services.

Additional Organ Transplant Coverage

This *plan* covers organ transplants for heart, heart-lung, lung, liver, small intestine, and pancreas. *Prior Authorization* is required.

The transplant benefit period for the recipient begins five days before a covered organ transplant and continues through one year afterwards. During a benefit period we cover the following services:

- covered *hospital* expenses;
- professional services for surgical, medical and other services related to a covered organ transplant; and
- additional transplant *charges* for *medically necessary* services and supplies during a transplant benefit period.

When the recipient is a covered *member* under this *plan* the following services are covered:

- obtaining donated organs (including removal from a cadaver);
- donor medical and surgical expenses related to obtaining the organ that are integral to the harvesting or directly related to the donation and limited to treatment occurring during the same stay as the harvesting; and
- transportation of the organ from donor to the recipient.

Related Exclusions

This *plan* does NOT cover:

- services or supplies related to an excluded transplant procedure;
- services related to obtaining, storing, or other services performed for the potential future use of umbilical cord blood; or
- noncadaveric small bowel transplants.

3.26 Physical/Occupational Therapy

Physical and/or occupational therapy is covered only when a *program* is implemented to restore the highest level of independent functioning in the most timely manner possible and:

- physical or occupational therapy is received from a licensed physical or occupational therapist;
- the therapy will result in significant, sustained measurable functional/anatomical improvement of your condition; and
- such improvement will not diminish with the removal of the therapeutic agent or environment.

Inpatient

Medically necessary inpatient physical or occupational therapy is covered as a *hospital service* listed in Section 8.0. *Prior Authorization* is required.

Outpatient/In a Doctor's or Therapist's Office

This *plan* covers *medically necessary* physical and/or occupational therapy services. See the Summary of Benefits for benefit limits and level of coverage. *Prior Authorization* is required.

In Your Home

This *plan* does NOT cover physical or occupational therapy services received in your home unless received through a home care *program*. See Section 3.15 - Home Health Care. *Prior Authorization* is required.

Related Exclusions

This *plan* does NOT cover massage therapist services.

This *plan* does NOT cover these services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See applicable regulations governing the health of school children and the special education of children with disabilities or comparable requirements established by federal law.)

This plan does NOT cover maintenance therapy (rehabilitation activities that preserve present functional level and prevent regression).

3.27 Podiatrist Services

This *plan* covers office visits to the podiatrist. See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions

This *plan* does NOT cover routine foot care including the treatment of corns, bunions (except capsular or bone surgery) calluses, the trimming of nails, the treatment of simple ingrown nails and other preventive hygienic procedures, except when performed to treat diabetic related nerve and circulation disorders of the feet.

This *plan* does NOT cover the treatment of flat feet unless the treatment is surgical.

Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless related to the treatment of diabetes.

3.28 Pregnancy Services, Nursery Care and Interrupted Pregnancy Services

If you are covered as an individual under this *plan* you must notify your *employer/agent* and pay the appropriate family membership fee within thirty-one (31) days of delivery so that the newborn child will be covered beyond such thirty-one (31) day period. This *plan* does not cover services for a newborn child who remains hospitalized after thirty-one (31) days and has not been added to a family membership. See Section 2.2 - How to Enroll and When Your Coverage Begins - Special Enrollment.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain *Prior Authorization*. For information on *Prior Authorization*, contact our Customer Service Department at (808) 954-8796 or 1-866-826-5335.

Inpatient

This *plan* covers a minimum *inpatient hospital* stay of forty-eight (48) hours from the time of a vaginal delivery and ninety-six (96) hours from the time of a cesarean delivery.

- If the delivery occurs in a *hospital*, the *hospital* length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).
- If the delivery occurs outside a *hospital*, the *hospital* length of stay begins at the time the mother or newborn is admitted as a *hospital inpatient* in connection with childbirth.

Any decision to shorten these stays shall be made by the attending physician in consultation with and upon *plan* with you. In those instances where you and your infant participate in an early discharge, you will be eligible for:

- Up to two (2) home care visits by a skilled, specially trained registered nurse for you and/or your infant, (any additional visits must be reviewed for medical necessity); and
- A pediatric office visit within twenty-four (24) hours after discharge.

See Section 3.18 - House Calls and Section 3.24 - Office Visits to determine coverage of home and office visits.

Additional *hospital* days may be covered ONLY if additional *hospital* days are *medically necessary*.

This *plan* covers *hospital services* provided to you and your newborn child. Your newborn child is covered for services required to treat injury or sickness. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as well

as routine well-baby care. All services provided to you and your newborn are subject to the *coinsurance* and *deductible* as described in the Summary of Benefits.

Interrupted Pregnancy

This plan also covers medically indicated, elective/induced abortions. See Summary of Benefits for coverage and limits.

Related Exclusions

This *plan* does NOT cover genetic counseling, genetic screening, preimplantation genetic diagnosis (embryo screening), or parentage testing. This *plan* does NOT cover amniocentesis or any other service used to determine the sex of an infant before it is born.

Doctor Services

We cover *doctor* services (including the services of a licensed midwife) for prenatal, delivery, and postpartum services. If a *doctor* and midwife provide pregnancy services the *charges* will be combined and covered up to our *allowable*. We will not cover more than our *allowable*.

The initial office visit to diagnose pregnancy and office visits to an obstetrician or midwife unrelated to pregnancy are not included in prenatal services. They are covered as an office visit. See Section 3.24 - Office Visits.

3.29 Prescription Drugs and Diabetic Equipment/Supplies

A. Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy

With the exception of the drugs covered as a medical service listed below under Section 3.29 Subsection B, this *plan* does NOT cover prescription drugs when purchased at a retail, on-line, mail order, or specialty pharmacy.

B. Drugs Dispensed and Administered by a Licensed Health Care Provider (Other Than a Pharmacy)

Drugs we have approved that are dispensed and administered by a licensed health care *provider* (other than a pharmacy) are covered under this *plan* subject to the *copayment* and/or *deductible* listed in the Summary of Medical Benefits. The prescription must be dispensed at the proper place of service as determined by our Pharmacy and Therapeutics Committee. For example, certain drugs may only be covered when purchased at a pharmacy.

Inpatient

This *plan* covers *inpatient* drugs as a *hospital service*. See Section 8.0 – definition of *hospital services*.

Outpatient/In Your Doctor's Office/In Your Home

Drugs are covered at different benefit levels depending upon the route of administration. Our *allowable* for services rendered by the facilities, agencies, and professional *providers* may include the cost of the drugs administered and/or dispensed. We will determine coverage

based upon the route of administration that is customary and least invasive method to treat the condition. There are several ways to administer drugs into the body including:

- inhalation (into the lungs, usually through the mouth);
- intramuscular (injected into a muscle);
- intrathecal (injected into the space around the spinal cord);
- intravenous/infused/intra-arterial (into a vein or artery);
- nasal (sprayed into the nose);
- ocular (instilled in the eye);
- oral (by mouth);
- rectal or vaginal (inserted into the rectum or vagina);
- subcutaneous (injected beneath the skin);
- sublingual (under the tongue);
- topical (applied to the skin); OR
- transdermal (delivered through the skin by a patch).

INHALATION, NASAL, OCULAR, ORAL, RECTAL OR VAGINAL, SUBLINGUAL, TOPICAL, AND TRANSDERMAL DRUGS: The drug is included in our *allowable* for the medical service being rendered. If the sole service is drug dispensing, the drug is NOT covered.

INJECTED DRUGS: We use the term injected to include drugs approved by us given by intra muscular or subcutaneous injection or in the case of a body cavity by instillation. See the Summary of Medical Benefits for benefit limits and level of coverage. See Section 3.24 - Office Visits for immunization and vaccination coverage information.

INFUSED DRUGS: We use the term infused to include those drugs approved by us and administered into a vein or into an artery whether by mixing in fluids and administering intravenously or into an artery, direct injection, or by use of a pump that accesses the vein or artery. See the Summary of Medical Benefits for benefit limits and level of coverage.

ANTI-NEOPLASTIC (CHEMOTHERAPY) DRUGS WHEN USED FOR CANCER TREATMENT: Oral, injectable, and infused anti-neoplastic prescription drugs approved by us for the treatment of cancer are covered. This includes coverage for drugs that we designate as supportive, but not anti-neoplastic (e.g., anti-nausea drugs). See the Summary of Medical Benefits for benefit limits and level of coverage.

ANTI-NEOPLASTIC (CHEMOTHERAPY) DRUGS WHEN USED FOR OTHER THAN CANCER TREATMENT: Coverage varies depending on the route of administration refer to above sections for inhalation, nasal, ocular, oral, rectal or vaginal, sublingual, topical and transdermal, injected and infused drugs.

Related Exclusions

This *plan* does NOT cover prescription drugs when purchased at a pharmacy.

3.30 Radiation Therapy/Chemotherapy Services

Medically necessary high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* – Section 8.0.

Inpatient

Radiation therapy and Chemotherapy services are covered as a *hospital service*. See Section 8.0 - definition of *hospital services.*

Outpatient

See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy

This *plan* covers hospital and *doctor* services for *outpatient* radiation therapy. Radiation physics, dosimetry services, treatment devices, and *hospital services* are included in radiation treatment planning and therapy and are covered as part of our *allowable* for radiation therapy.

Chemotherapy Services

This *plan* covers the *doctor's* administration fee and associated *hospital* supplies.

For information regarding anti-neoplastic (chemotherapy) drug coverage see Section 3.29 - Prescription Drugs.

In Your Home

See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy

This *plan* does NOT cover radiation treatment services received in your home.

Chemotherapy Services

This *plan* covers the *doctor's* administration fee. For information regarding anti-neoplastic (chemotherapy) drug coverage see Section 3.29 - Prescription Drugs.

In a Doctor's Office

See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy

This *plan* covers doctor services for radiation therapy received in the *doctor's* office. Radiation physics, dosimetry services, and treatment devices are included in radiation treatment planning and therapy and are covered as part of our *allowable* for radiation therapy.

Chemotherapy Services

This *plan* covers the *doctor's* administration fee. For information regarding anti-neoplastic (chemotherapy) drug coverage see Section 3.29 - Prescription Drugs.

3.31 Respiratory Therapy

Inpatient

This *plan* covers inpatient respiratory therapy services as a *hospital service*. See Section 8.0 - definition of *hospital services*.

Outpatient/In a Doctor's Office

See the Summary of Benefits for benefit limits and level of coverage.

This *plan* covers outpatient respiratory therapy or respiratory therapy received in a *doctor's* office when your *doctor* orders the therapy under the following conditions:

- as part of a therapeutic *program* for up to fourteen (14) days before admitting you to the *hospital*; OR
- up to six (6) weeks after you have been discharged from the *hospital*.

In Your Home

Coverage is provided for durable medical equipment and oxygen at the same benefit limit and level of coverage as stated in the Summary of Benefits for medical equipment and medical supplies. See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices for coverage guidelines.

Related Exclusions

This *plan* does NOT cover respiratory therapy services when received in your home unless received through a home care *program* or hospice care *program*. See Section 3.15 - Home Health Care and Section 3.16 - Hospice Care.

3.32 Skilled Care In a Nursing Facility

Care in a skilled nursing facility is covered if:

- your condition requires skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- the services are required on a daily basis; AND
- this care can be provided ONLY in a skilled nursing facility.

Prior Authorization is required.

Related Exclusions

This *plan* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 5.5- Services Provided by Facilities We Have Not Approved.

3.33 Speech Therapy

Speech therapy is the treatment of communication impairment and swallowing disorders. Speech therapy services facilitate the development of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Inpatient

This *plan* covers inpatient *hospital* and skilled nursing facility speech therapy as a *hospital service*. See Section 8.0 - definition of *hospital services*.

Outpatient or In a Doctor's/Therapist's Office

This *plan* will cover speech therapy *rehabilitative services* when received from a registered therapist as part of a formal treatment plan for:

- speech or communication function loss;
- impairment as a result of an acute illness or injury; or
- an acute exacerbation of chronic disease.

Prior Authorization is required.

Services must relate to performing basic functional communication or to assessing and/or treating swallowing dysfunction.

See Summary of Benefits for benefit limits and level of coverage.

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.9 - Diagnostic Imaging, Lab, and Machine Tests and the Summary of Benefits for benefit limits and level of coverage for Diagnostic Imaging, Lab, and Machine Tests.

In Your Home

This *plan* does NOT cover speech therapy services received in your home unless it is part of a home care *program*.

Related Exclusions

This *plan* does NOT cover these services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See applicable regulations governing health of school children and the special education of children with disabilities or comparable requirements established by federal law.)

This *plan* does not cover *maintenance services.* This *plan* does not cover language and communication *developmental services* including but not limited to, psychosocial speech delay, expressive language delay, behavioral problems, attention disorders, conceptual handicap, mental retardation, autism, or developmental delay. Educational classes and services for impairments that are self-correcting are not covered.

3.34 Surgery Services

General Surgery

If you have an operation to treat a disease or injury, this *plan* covers it as long as the following conditions apply:

- the operation is not *experimental/investigational* or cosmetic in nature;
- the operation is being performed at the appropriate place of service; AND
- the *doctor* is licensed to perform the surgery.

Kidney, Cornea, and Bone Marrow Transplants

Kidney, cornea, and bone marrow transplants are considered general surgery procedures for purposes of coverage under this *plan*. *Medically necessary* high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* - Section 8.0. *Prior Authorization* is required.

Allogenic Bone Marrow transplant *covered health care services* include medical and surgical services for the matching participant donor and the recipient. Costs associated with donor searches are NOT covered. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Benefits, subject to certain conditions. For details see Section 3.19.

Multiple Surgeries

When a *doctor* performs more than one procedure in a day, there are rules that may reduce our *allowance* for the additional procedure. Our *allowable* may also include post-operative care and other procedures provided within specified time periods.

If More Than One Surgeon Operates

In addition to the type and purpose of surgery, our *allowable* differs depending on the number of surgeons involved, including assistant surgeons.

If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a *claim* reporting the procedure performed and the circumstances involved. These *claims* will then be evaluated for payment on an individual basis.

Related Exclusions

This *plan* does NOT cover the standby services of an assistant surgeon.

Mastectomy Services

This *plan* provides coverage for a minimum of forty-eight (48) hours in a *hospital* following a mastectomy and a minimum of twenty-four (24) hours in a *hospital* following an axillary node dissection. Any decision to shorten these minimum coverages shall be made by the attending physician in consultation with and upon *plan* with you. If you participate in an early discharge, defined as *inpatient* care following a mastectomy that is less than forty-eight (48) hours and *inpatient* care following an axillary node dissection that is less than twenty-four (24) hours, coverage shall include a minimum of one (1) home visit conducted by a physician or registered nurse.

This *plan* provides benefits for mastectomy surgery and mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998. For the *member* receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy, including lymphedema.

Surgery to Treat Functional Deformity or Impairment

Reconstructive surgery and procedures which are performed to correct a functional deformity resulting from a previous therapeutic process or to correct a documented functional impairment caused by trauma, congenital anomaly or disease are covered benefits under this *plan*. Functional indications for surgical correction do not include psychological, psychiatric or emotional reasons.

This *plan* covers some surgical procedures to treat functional impairments. This *plan* covers those procedures listed below to treat functional impairments when *medically necessary*:

- Abdominal wall surgery including Panniculectomy (other than an abdominoplasty) ;
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding (limited to one surgery per *member* per lifetime);
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Reduction Mammoplasty;
- Removal of Breast Implants;
- Removal/Treatment of Proliferative Vascular Lesions and Hemangiomas; or
- Treatment of Varicose Veins.

Determinations for coverage for the procedures listed above may require review of medical documentation including history and physical, preoperative diagnostic studies, previously attempted conservative medical therapy and photographs, or other medical records.

In addition, this *plan* covers mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998.

Related Exclusions

This *plan* does NOT cover the above listed procedures when not *medically necessary.*

This *plan* does NOT cover orthodontic services related to orthognathic surgery.

This *plan* does NOT cover cosmetic procedures. Cosmetic procedures are performed primarily to refine or reshape body structures that are not functionally impaired, to improve appearance or self-esteem or for other psychological, psychiatric or emotional reasons. Drugs, biological products, *hospital charges*, pathology, radiology fees and *charges* for surgeons, assistant surgeons, attending physicians and any other incidental services which are related to cosmetic surgery are NOT covered. The following procedures are NOT covered under this *plan*:

- Abdominoplasty;
- Cervicoplasty;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing and/or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Inverted nipple surgery;
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;
- Laser treatment for acne;
- Osteoplasty: Facial Bone Reduction;
- Otoplasty;
- Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants;
- Removal of Asymptomatic Benign Skin Lesions;

- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Rhinoplasty;
- Rhytidectomy;
- Scar Revision, regardless of symptoms;
- Sclerotherapy for Spider Veins;
- Subcutaneous Injection of Filling Material;
- Suction assisted Lipectomy;
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy); or
- Testicular prosthesis surgery.

This *plan* provides benefits for mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998.

Anesthesia Services

This *plan* covers medically *necessary* anesthesia services received from an anesthesiologist when the services are related to a covered procedure. Our *allowable* for the anesthesia service includes the anesthesia care during the procedure, time an anesthesiologist routinely spends with a patient in the recovery room, time spent preparing the patient for surgery, and for pre-operative consultations.

Our *allowable* for the surgical procedure includes local anesthesia.

Other than the pre-operative office visit, this *plan* covers office visits and/or office consultations to anesthesiologists as an office visit. See Section 3.24 - Office Visits.

Related Exclusions

This *plan* does NOT cover local anesthesia provided by an anesthesiologist or anesthesia administered by a surgeon, assistant surgeon, or obstetrician. This *plan* does NOT cover the services of a standby anesthesiologist. This *plan* does NOT cover patient controlled analgesia, also known as pain management.

3.35 Temporomandibular Joint Disorder (TMJ) Services

This *plan* covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes *medically necessary* treatment required as a result of accident, trauma, a congenital anomaly, developmental defect, or pathology.

For information regarding office visits see Section 3.24 - Office Visits, medical equipment and supplies see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, for surgery services see Section 3.34 – Surgery Services and for medications see Section 3.29 - Prescription Drugs.

3.36 Vision Care Services

Eye Examinations

This *plan* covers medically *necessary* eye examinations. See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions

This *plan* does not cover routine eye exams.

4.0 HOW YOUR COVERED HEALTH CARE SERVICES ARE PAID

Payments made to you are personal and you cannot transfer or assign any of your right to receive payments under this *plan* to another person or organization.

4.1 How Participating Providers Are Paid

Participating *providers* are paid directly for *covered health care services*. You are responsible for *copayments, coinsurance,* and/or *deductibles, and any state taxes off the allowable charge*, if any, which may apply to a *covered health care service*. *Participating providers* agree not to bill, charge, collect a deposit from, or in any way, seek reimbursement from you for a *covered health care service*, except for the *copayments*, *coinsurance, deductibles, any state taxes off the allowable charge,* and/or the difference between the *maximum benefit* and our *allowance*, if any, which may apply to a *covered health care service.* It is your obligation to pay a participating provider your *copayment, coinsurance deductible*, any state taxes off the allowable charge, and/or the difference between the *maximum benefit* and our *allowable*. If you do not pay the *participating provider*, the *provider* may decline to provide current or future services or may pursue payment from you. See Section 1.7 - Your Responsibility to Pay Your Providers for more information.

Not all of the individual *providers* at a *participating* facility will be *participating providers*. It is your responsibility to verify that each *provider* from whom you receive care is participating. However, if you receive certain types of services at a *participating* facility, and there are *covered health care services* provided by a *non-participating provider* outside of your control, you will be reimbursed for such *covered health care services* based upon our *allowance* at the *participating* level of benefits. The types of services this provision applies to are:

- *inpatient* admissions at a *participating* facility under the direction of a *participating* physician;
- *outpatient* services performed at a *participating* facility by a *participating* physician; AND
- emergency room services at a *participating* facility.

4.2 How Non-Participating Providers Are Paid

You are responsible for paying all *charges* from a *non-participating provider.* Generally you are reimbursed; however, the *plan* reserves the right to reimburse a *non-participating provider* directly. This *plan* reimburses you or a *non-participating provider* up to the *maximum benefit* or the *allowable*, less any *copayments, coinsurance* and/or *deductibles* which may apply to a *covered health care service* or procedure. You will be reimbursed for *non-participating provider* services according to the same guidelines we use to pay *participating providers*. Reimbursement for *non-participating provider* services will never be more than the amount paid for *participating provider* services. Benefits may not be assigned.

4.3 Coverage for Services Provided Outside of the Service Area
Out-of-Area Services

We have a variety of relationships with MultiPlan / HMN providers across the country. Whenever you obtain health care services outside of our service area, the *claims* for these services will be processed by HMA.

Typically, when accessing care outside our service area, you will obtain care from health care *providers* that have a contractual agreement (i.e., are *participating providers*) with MultiPlan / HMN. In some instances, you may obtain care from *non-participating* health care *providers*. Our payment practices in both instances are described below.

MultiPlan / HMN Network

Under the MultiPlan / HMN Network, when you access covered health care services outside our service area, we will remain responsible for fulfilling our contractual obligations.

Whenever you access covered health care services outside our service area the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that MultiPlan / HMN makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that MultiPlan / HMN pays to your health care *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your health care *provider* or *provider* group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care *providers* after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your *claim* because they will not be applied retroactively to *claims* already paid.

Laws in a small number of states may require MultiPlan / HMN to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Subscriber Liability Calculation

When covered health care services are provided outside of our service area by *non-participating* health care *providers*, the amount you pay for such services will generally be based on MultiPlan / HMN's established fee schedule. In these situations, you may be liable

for the difference between the amount that the *non-participating* health care *provider* bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, to determine the amount we will pay for services rendered by *non-participating* health care *providers*. In these situations, you may be liable for the difference between the amount that the *non-participating* health care *provider* bills and the payment we will make for the covered services as set forth in this paragraph.

5.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS PLAN

This *plan* does NOT cover health care services which:

- have not been assigned a CPT or other code;
- have not been finally approved by the FDA or other governing body;
- we have not reviewed; or
- we have not determined are eligible for coverage.

Not all health care services with an assigned CPT code, or that are approved by FDA or other governing body, are covered by this plan. If a service or category of service is not listed as covered, it is not covered under this *plan*.

This section lists many of the services or categories of services that are non-covered (excluded). In addition to this section, see Section 3.0 for *Covered Health Care Services* and their related exclusions; AND Section 1.0 and Section 3.0 for more information about how we identify *new services* and review and make coverage determinations.

5.1 Services Not Medically Necessary

This *plan* does NOT cover *hospital* care (admission tests, services, supplies, or continued care), medical care, rehabilitation, or any other treatment, procedure, facility, equipment, drug, device, supply or service which is NOT *medically necessary*. (See Section 8.0 – Glossary.) We will use any reasonable means to make a determination regarding the *medical necessity* of this care and we may examine *hospital* records, reports and *hospital utilization review* committee statements. Medical necessity is reviewed in accordance with our medical policies and related guidelines. You have the right to appeal our determination or to take legal action as described in Section 7.0.

We may deny payments if a *doctor* or *hospital* does not supply medical records required to determine medical necessity. We also may deny or reduce payment if the records supplied do not provide adequate justification for performing the service.

If the *hospital* performs routine screenings or tests which are not *medically necessary* for the diagnosis or treatment of your condition or which are not specifically ordered by the *doctor* who admits you, this *plan* does NOT cover them.

5.2 Services Not Listed in Section 3.0

This *plan* only covers services listed under Section 3.0 - *Covered Health Care Services.* This *plan* does NOT cover services that may in and of themselves otherwise be considered covered, when provided attendant to a non-covered course of service or as a component of a non-covered regimen of care.

5.3 Services Covered by the Government

This *plan* does NOT cover medical expenses for any condition, illness or disease which should be covered by the United States government or any of its agencies, Medicare, any state or

municipal government or any of its agencies (except *emergency* care when there is a legal responsibility to provide it). This *plan* does NOT cover services for military-related conditions and services or supplies required as a result of war, declared or undeclared, or any military action which takes place after your coverage becomes effective, to the extent permitted by law.

5.4 Services and Supplies Mandated by Laws in Other States

Any *charges* for services and supplies which are required under the laws of your state and which are not provided under this *plan* are NOT covered.

5.5 Services Provided by Facilities We Have Not Approved

This *plan* does NOT cover custodial care, rest care, day care, or non-skilled care in any facility. This *plan* does NOT cover care in convalescent/nursing homes, homes for the aged, halfway houses, or other residential facilities. This *plan* does NOT cover *hospital services* which are not performed in a *hospital* defined in Section 8.0 - Glossary.

5.6 Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed

This *plan* does NOT cover health care services performed in a facility or by a physician, surgeon or other person who is not legally qualified or licensed or who does not meet our credentialing requirements.

5.7 Services Performed by Naturopaths and Homeopaths

This plan does NOT cover health care services ordered or performed by naturopaths and homeopaths.

5.8 Services If You Leave the Hospital

If you leave the *hospital* for a day or portion of a day, this *plan* does NOT cover any *hospital services* for that day (unless you are leaving to receive treatment somewhere else or through a HMA approved *program*).

5.9 Benefits Available from Other Sources

This *plan* does NOT cover the cost of *covered health care services* provided to you when there is no charge to you or there would have been no charge to you absent this *plan*. This *plan* does NOT cover health care services when you can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if you choose not to assert your rights under these laws or if you fail to assert your rights under these laws.

This *plan* does NOT cover health care services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities.

5.10 Blood Services

This *plan* does NOT cover blood, except for those services specifically listed in Section 3.3 – Blood and Blood Products.

5.11 Charges for Administrative Services
This *plan* does NOT cover *charges* for missed appointments, *charges* for completion of *claim* forms or other administrative *charges*.

5.12 Christian Scientist Practitioners
This *plan* does NOT cover the services of Christian Scientist Practitioners.

5.13 Clerical Errors
If a clerical error or other mistake occurs, that error shall not deprive you of coverage under this *plan*. A clerical error also does not create a right to benefits. See Section 7.3- Our Right To Withhold Payments and Review Payments for further information on how CVS or HMA may recover funds paid to you in error.

5.14 Consultations - Telephone
This *plan* does NOT cover telephone consultations.

5.15 Deductibles and Copayments
This *plan* does NOT cover *deductibles* or *copayments*, if any.

5.16 Dental Services
This *plan* does NOT cover:

- general dental services such as extractions (including full mouth extractions), prostheses, braces, operative restorations, fillings, medical or surgical treatment of dental caries, gingivitis, impactions, periodontal surgery, gingivectomy;
- panorex X-rays or dental X-rays (except when ordered by a *doctor*/dentist to diagnose a condition due to an accident to your *sound natural teeth*. See Section 3.11 - Emergency Services for details);
- orthodontic services even if related to a covered surgery;
- dental appliances/devices (except when related to the treatment of temporomandibular joint dysfunction); and
- *hospital services*, *free-standing ambulatory surgi-center* services, and anesthesia services provided in connection with a dental service.

This *plan* does NOT cover any preparation of the mouth for dentures and/or dental or oral surgeries such as, but not limited to:

- apicoectomy, per tooth, first root;
- alveolectomy including curettage of osteitis or sequestrectomy;
- alveoplasty, each quadrant.
- complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- excision of feberous tuberosities;
- excision of hyperplastic alveolar mucosa, each quadrant;

- operculectomy excision periocoronal tissues;
- removal of partially bony impacted tooth;
- removal of completely bony impacted tooth, with or without unusual surgical complications;
- surgical removal of partial bony impaction;
- surgical removal of impacted maxillary tooth;
- surgical removal of residual tooth roots; or
- vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

5.17 Employment–Related Injuries and Injury or Illness Involving Third Parties

This *plan* does NOT cover health care services when performed to treat work-related illness, conditions, or injuries whether or not you are covered by Workers' Compensation law, unless; (1) you are self-employed, a sole stockholder of a corporation, or a member of a partnership; and (2) such work-related illnesses, conditions, or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; and (3) you are not enrolled as an employee under a group health plan sponsored by an employer other than the business or partnership described above.

In the event of a disputed worker's compensation claim, this *plan* may pay or provide for the medical services in accordance with the plan terms; however, if Worker's Compensation liability is established, then the plan shall be reimbursed by the Worker's Compensation carrier, in accordance with Section 7.4 – The Plan's Right of Subrogation and/or Reimbursement.

In addition, this *plan* does NOT cover health care services or supplies for an injury or illness where a Third Party is involved. Please see Section 7.4 The Plan's Right of Subrogation and/or Reimbursement for further information.

5.18 Eye Exercises

Eye exercises and visual training services are NOT covered.

5.19 Eyeglasses and Contact Lenses

Eyeglasses and contact lenses are NOT covered unless specifically listed as a *covered health care service* in this *plan*. This *plan* does not cover annual routine eye exams.

5.20 Food and Food Products

This plan does NOT cover food or food products, whether or not prescribed, unless specifically noted in this benefit booklet or delivered through a feeding tube as the sole source of nutrition.

5.21 Freezing and Storage of, Sperm, Gametes, Embryo and Other Specimens

This *plan* does NOT cover freezing and storage of gametes, sperm, embryos, or other tissues for future use.

5.22 Gene Therapy, Genetic Screening, Genetic Counseling, and Parentage Testing
This *plan* does NOT cover gene therapy, genetic screening, genetic counseling, or parentage testing.

5.23 Illegal Drugs and Chronic Addiction
Drugs which are dispensed in violation of state or federal law are NOT covered. Methadone dispensed to treat *chemical dependency* is NOT covered.

5.24 Infant Formula
This *plan* does NOT cover infant formula whether or not prescribed unless specifically noted in this benefit booklet or delivered through a feeding tube as the sole source of nutrition.

5.25 Marital Counseling
This *plan* does NOT cover marital counseling or training services.

5.26 Personal Appearance and/or Service Items
Services and supplies for your personal appearance and/or comfort whether or not prescribed by a *doctor* and regardless of your condition are NOT covered, such as, but not limited to, a radio, telephone, television, air conditioner, humidifier, air purifier, beauty and barber services and wigs. Travel expenses, whether or not prescribed by a *doctor*, are NOT covered. This *plan* does NOT cover items whose typical function is not medical such as, but not limited to, recliner lifts, air conditioners, humidifiers, or dehumidifiers. This *plan* does NOT cover items that do not meet the durable medical equipment, medical supplies, and prosthetic devices minimum specifications such as, but not limited to standers, raised toilet seats, toilet seat systems ,cribs, ramps, positioning wedges, wall or ceiling mounted lift systems, water circulating cold pads (cryo-cuffs), car seats (including any vest system) or car beds, bath or shower chair systems, trampolines, tricycles, therapy balls, or net swings with a positioning seat.

5.27 Private Duty Nursing
This plan does NOT cover private duty nursing services.

5.28 Psychoanalysis for Educational Purposes
Psychoanalysis services are NOT covered regardless of symptoms you may have. Psychotherapy services you receive which are credited towards a degree or to further your education or training, regardless of symptoms that you may have, are NOT covered.

5.29 Research Studies
This *plan* does NOT cover research studies.

5.30 Reversal of Voluntary Sterilization
This *plan* does NOT cover the reversal of voluntary sterilization or infertility treatment for an individual that previously had a voluntary sterilization procedure.

5.31 Services Provided by Relatives or Members of Your Household
This *plan* does NOT cover *charges* for any services provided to you by your parent, child or spouse.

5.32 Sex Transformations and Dysfunctions

Health care services related to sex transformations are NOT covered. Health care services related to sexual dysfunctions or inadequacies, except services approved by us and necessary for the treatment of a condition arising out of organic dysfunctions, are NOT covered. (i.e., Therapeutic services will be covered when the cause of the dysfunction is physiological, not psychological.) Silenafil citrate (e.g., Viagra) or any therapeutic equivalent is NOT covered.

5.33 Smoking Cessation

This *plan* does NOT cover smoking cessation drugs, aids or *programs* including, but not limited to, Nicotine Transdermal Patches and Nicotine Chewing Gums whether prescribed or not.

5.34 Surrogate Parenting

This *plan* does NOT cover services related to surrogate parenting, unless the surrogate is a member of this plan.

5.35 Therapies, Acupuncture and Acupuncturist Services, and Biofeedback

This *plan* does NOT cover recreational therapy, massage therapy, aqua therapy, maintenance therapy, and aromatherapy. Therapies, procedures, and services for the purpose of relieving stress are NOT covered. This *plan* does NOT cover acupuncture and acupuncturist services, unless acupuncture benefits are expressly set forth as being covered in the Summary of Benefits. This *plan* does NOT cover X-ray or laboratory services ordered by an acupuncturist. Pelvic floor electrical stimulation, pelvic floor magnetic stimulation, biofeedback training, pelvic floor exercise, and any other exercise therapy are NOT covered. This *plan* does NOT cover biofeedback by any modality for any condition.

5.36 Weight Loss Programs

This *plan* does NOT cover health care services, including drugs, related to *programs* designed for the purpose of weight loss, such as, but not limited to, commercial diet plans, weight loss *programs*, and any services in connection with such plans or *programs*.

6.0 HOW WE COORDINATE YOUR BENEFITS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN

6.1 Definitions

The definitions listed in this section apply only to Section 6 of this benefit booklet.

ALLOWABLE EXPENSE means the necessary, reasonable and customary item of expense for health care which is:

- covered at least in part under one or more plans covering the person for whom the *claim* is made; AND
- incurred while this agreement is in force.

When a plan provides health care benefits in the form of services, the reasonable cash value of each service is considered as both an *allowable expense* and a benefit paid.

BENEFITS means any treatment, facility, equipment, drug, device, supply or service for which you receive reimbursement under a plan.

CLAIM means a request that benefits of a plan be provided or paid.

PLAN means any *hospital* or medical service plan or health insurance benefit package provided by an organization. This includes the CVS-sponsored *plan* administered by HMA as well as:

(a) group insurance or group-type coverage, whether insured or self-insured, including group-type coverage through an HMO, other prepayment group practice or individual practice plan; AND

(b) coverage under a governmental plan or coverage required to be provided by law including Medicare, Medicaid or other types of government assistance.

If the term "*plan*" is in italics, the meaning given in Section 8.0 - Glossary applies instead of the above definition.

PRIMARY PLAN means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

SECONDARY PLAN means a plan which is not a primary plan.

If you or your covered dependents have health care benefits under another plan, *your* CVS-sponsored *plan* will be coordinated with the benefits of the other plan. HMA looks at the *claim* and determines how much the CVS *plan* would have paid. This amount is compared to what *your* other plan has paid. If the CVS benefit is greater, the CVS *plan* pays the difference. If it is less than or equal, no additional benefits are paid. This procedure is known as non-duplication of benefits. The level of benefits paid on this contract varies according to the plan option you select. Be sure to review the rules that govern *your* plans if *you* have coverage under both a

CVS *plan* and another benefit plan*. You* cannot be covered under CVS as both an employee and a dependent.

If you have any questions regarding these provisions, please call our Customer Service Department at 1-866-826-5335 or 808-954-8796.

If this provision applies, the order of benefit determination rules will determine whether we pay benefits on behalf of CVS before or after the benefits of another plan.

6.2 When You Are Covered by More Than One Insurer

When a Beneficiary Has Other Health Coverage (Coordination of Benefits).

(a) If a Beneficiary is covered by "this Plan" and any "other plan" that provides benefits for medical, surgical, Hospital or other services, the benefits of "this Plan" and those of the "other plan" will be coordinated so that the combined benefits are not more than the Eligible Charge for the covered service.

(i) "This Plan" shall mean this document.

(ii) "Other plan" shall mean the Federal Medicare Program, any "no-fault" or other type of motor vehicle insurance, or any group health plan including another group plan of the Employer. It shall not include any other nongroup health plan.

(b) Coordination of benefits rules are rules used by most group health plans to determine the order of payment of two (2) or more health plans and to determine the amount of payment. In coordinating the benefits of two (2) plans, one (1) plan (primary plan) pays its benefits in full and the other (secondary plan) normally pays reduced benefits. These rules help the plans to avoid unnecessary delay in deciding which plan is primary and also to avoid making costly duplicate payments.

(c) The Plan's determination of which health plan is primary is modeled according to the guidelines provided by the National Association of Insurance Commissioners (NAIC).

(d) Special Provisions Relating to Medicaid. In determining or making any payment for a Beneficiary hereunder, eligibility for, or provision of, State provided medical assistance shall not be taken into account.

(e) Special Provisions Regarding Medicare. The Federal Medicare Program will be considered the primary plan unless the Beneficiary is an active employee covered under an employer's health plan. Where an employee or Dependent is covered by both Medicare and an employer health plan, applicable Federal statutes will determine which plan is primary.

(f) Special Provisions Regarding Motor Vehicle Insurance Coverage.

(i) Any motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits for an Injury covered by motor vehicle insurance, the Beneficiary must provide the Claims Administrator with a list of the medical expenses that the motor vehicle insurance covered according to the date on which the expenses were incurred. The Claims Administrator will review the list of expenses to verify that benefit maximums are depleted. Upon verification of

depletion, covered services received by the Beneficiary will be eligible for benefits in accordance with this Plan.

(ii) If another person caused the motor vehicle accident and the Beneficiary may recover damages pursuant thereto, any benefits for which the Beneficiary may be eligible shall be subject to the provisions of Section 7.4, Injury or Illness Involving Third Parties. Under Section 7.4, the Plan is not liable to pay any benefits for injuries caused by another person. However, the Plan may assist the Beneficiary by making an interest-free loan in the form of benefit payments once motor vehicle insurance benefits have been depleted as described in subparagraph (f)(i) above.

(g) For the purposes of enforcing or determining the applicability of this Section 6.2, the Employee, on his or her own behalf or on behalf of his or her Dependents:

(i) will disclose all coverage under any "other plan";

(ii) consents to the Claims Administrator or Plan releasing to any party or obtaining from any party any information which the Claims Administrator or Plan deems necessary for such purposes;

(iii) authorizes direct reimbursement to or from the "other plan" when such direct payment is appropriate and necessary to facilitate the coordination and adjustments of this Plan's and "other plan's" payments under this section; and

(iv) will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.

6.3 Our Right to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right, exercisable alone at our own discretion, to pay those organizations the amounts we decide are necessary to satisfy the rules of this provision. These amounts are considered benefits provided under this *plan* and we are not liable for them.

If we have made payments for *allowable expenses* which are more than the maximum amount needed to satisfy the conditions of this provision, we have the right to recover the excess amounts from: the person to or for whom the payments were made; any other insurers; and/or any other organizations (as we decide). You and your dependents agree to pay back any excess amount, provide information and assistance, or do whatever is necessary to recover this excess amount. When determining the amount of payments made we include the reasonable cash value of any benefits provided in the form of services.

7.0 HOW TO FILE AND APPEAL A CLAIM

Only services provided by Clinical Laboratories, Home Health Agencies, Hospitals, Physicians (M.D., D.O., or D.P.M.), Psychiatrists, Psychologists, Licensed Mental Health and Substance Abuse Counselor, Marriage Family Therapist, Practice Registered Nurse, and Skilled Nursing Facilities who qualify as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render services within the lawful scope of their respective license, and are approved by the Claims Administrator or Employer, will be covered. Benefits may be available for services rendered by other providers as shown in specific sections of this Plan.

Submission of Claim. No claim for services covered by this Plan will be paid unless it is supported by the provider's report regarding the services rendered. The Employee is responsible for ensuring that the provider furnishes this report to the Claims Administrator, on the forms prescribed by the Claims Administrator, within one (1) year of the date the services are rendered.

Payment for Services.

- Participating Provider. When covered services are rendered by a Participating Provider, the Plan will pay benefits directly to the Participating Provider. Participating Providers have agreed to limit their charges to Beneficiaries to not more than a specified amount. In addition, Participating Providers have agreed not to collect from any Subscriber an amount exceeding the Subscriber's Copayment specified in this Plan, except for non-covered services.

  Payment of claims for services rendered by a Veterans Administration Medical Center and/or Uniformed Military Services Facility be adjudicated (processed) on a Participating Provider basis using the comparable Participating Provider Eligible Charge, but in no event shall the Plan pay the Veterans Administration Medical Center and/or Uniformed Military Services Facility any differently than the Plan's Participating Provider Eligible Charges, and payments are to be made directly to the Veterans Administration Medical Center and/or Uniformed Military Services Facility.

- Non-Participating Provider. The Claims Administrator or Employer has no agreement with Non-Participating Providers and they may charge the Plan's Beneficiaries more than the Eligible Charge for any service. The Plan's benefit payments for services rendered by Non-Participating Providers will be a specified portion or percentage of the Eligible Charge for the service. For services by a Non-Participating Provider, the benefit level may be a lower percentage of the Eligible Charge than the Plan would pay to a Participating Provider. The Subscriber is responsible for paying the specified Copayment plus any amount of the provider's charge which exceeds the Eligible Charge. Payment of claims for services covered by this Plan and rendered by a Non-Participating Provider:

  (i) are not assignable;

(ii) shall be made by the Plan, in its sole discretion, directly to the Employee or to the Dependent or, in the case of the Employee's death, to his or her executor, administrator, provider, Spouse, or relative; and

(iii) shall in no event exceed the amount which the Plan would pay to a comparable Participating Provider for like services rendered.

Reimbursement for Services. If a Subscriber has paid for services covered by this Plan the Employee will be reimbursed in accordance with the terms of this Plan. To receive payment for such services, an Employee must submit a claim within one (1) year after the last day on which such services were rendered.

Late Claims. No payment will be made on any claim submitted to the Claims Administrator more than one (1) year after the last day on which the services were rendered unless it shall be shown to the satisfaction of the Claims Administrator that there was unusual and justifiable cause for such late submission.

Medical Necessity of Services. This Plan covers only medically necessary services; the Plan will not cover any unnecessary services nor will the unnecessary portion of any charge be paid. The fact that a Physician may prescribe, order, recommend, or approve a service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. A Subscriber may ask a Physician to write to the Claims Administrator for a determination regarding the medical necessity of a service before it is performed. The Claims Administrator will determine the medical necessity of the test or treatment. To be considered medically necessary, a service must meet all of the following criteria:

(a) The service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.

(b) The service or treatment must not be "experimental," (e.g., used in research or on animals) or "investigative," (e.g., used only on a limited number of people or where the long-term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).

(c) If there is more than one (1) medically appropriate method of treating a Beneficiary, the Plan's benefit will be based on the least expensive method, even if the health care provider elects to treat the Beneficiary by a more expensive method. Similarly, if the services could be provided in more than one (1) type of facility or setting (e.g., Hospital or Physician's office), the Plan's benefits will be based on the least expensive facility or setting.

(d) The service or treatment is being covered by Federal government health plans.

Eligible Charges. The Plan's benefit payments and the Beneficiary's Copayments for services are based on the Eligible Charges for the services (i.e., the Beneficiary pays a specified percentage or portion of the Eligible Charge for each service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. A Subscriber is responsible for paying all taxes.

(a) Definition.

(i) The charge for a covered service made by a Participating Provider will be considered eligible when it complies with the fee schedule established by the Claims Administrator and the provisions contained in the agreement between the Claims Administrator and such Participating Provider.

(ii) The Eligible Charge for a covered service made by a Non-Participating Provider who is a Physician, Psychiatrist, Psychologist, or Clinical Laboratory will be the lowest of the following two (2) charges:

a. the charge established by the Claims Administrator, or

b. the actual charge for the service.

(iii) The Eligible Charge for a covered service rendered by a Non-Participating facility that is a Hospital, Skilled Nursing Facility, ambulatory surgical center, birthing center, Home Health Agency, or other similar facility will be the lowest of the following two (2) charges:

a. the charge established by the Claims Administrator, or

b. the actual charge for the service.

(b) Claims for Services Provided by Out-of-State Providers. Benefit payments for covered services rendered outside Hawaii are based on the Eligible Charges for the same or comparable services rendered in Hawaii. If services are received from Non-Participating Providers, the member will be responsible for the co-payment and any amount that exceeds the reasonable and customary charges and taxes.

Qualified Medical Child Support Orders. Any claim for benefits with respect to a Child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the Employee with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian.

Review of Claims. The Employer shall have discretionary authority to determine all questions of eligibility of Subscribers, to determine the amount and type of benefits payable to any Beneficiary or provider in accordance with the terms of this Plan, and related regulations, and to interpret the provisions of this Plan, as is necessary to determine benefits.

7.1 How to File a Claim

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Claims Administrator. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the deadline, it will not be covered unless you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Participating providers file *claims* for you and must do so within twelve (12) months of providing a *covered health care service* to you.

Non-participating providers may or may not file *claims* for you. If the *non-participating provider* does not file the *claim* on your behalf, you will need to file the *claim* yourself. To file a *claim*, please send us an itemized bill including the following:

- patient's name;
- your *member* identification number;
- the name, address, and telephone number of the *provider* who performed the service;
- date and description of the service; AND
- *charge* for that service.

Please mail the *claim* to:

HMA
Attention: Claims Department
P. O. Box 135005
Honolulu, HI 96801

7.2 Grievance and Administrative Appeal Procedures

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative. An "authorized representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Claim Denials and Appeals

If Your Claim Is Denied

If a claim for Benefits is denied in part or in whole, you will receive a written notice of the denial from the Claims Administrator within the time frames specified below. The notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide you with specific instructions for filing a *medical claim appeal*.

Medical claim appeal means a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because:

- the services were not *medically necessary*; or
- the services are *experimental* or *investigational*.

You may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals .This communication should include:

- the patient's name and ID number as shown on the ID card;
- the Provider's name;
- the date of medical service;
- the reason you disagree with the denial/payment; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

HMA
Attention: Grievance and Appeal Department
1440 Kapiolani Blvd., Suite 1020
Honolulu, HI 96814

For Urgent Care requests for Benefits that have been denied, you or your Provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Types of Claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand the type of claim. Following are the 4 types of claims:

- *Urgent care claim i*s a claim for medical care or treatment where delay could seriously jeopardize your life or health, or your ability to regain maximum function; or subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- *Pre-service claim* is a claim for a benefit that requires approval of the benefit in advance of obtain medical care (i.e. precertification).
- *Post-service claim* is a claim for a benefit that is not a pre-service claim; and for which the service has been rendered and billed.
- Concurrent claim is an oral or written request for assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. The request may be to extend, reduce, or terminate a course of treatment that was previously approved.

Review of an Appeal (Level 1 Appeal)

The Grievance and Appeal Coordinator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and

- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, the Grievance and Appeal Coordinator must notify you, in writing, of the appeal determination within 15 days after receiving the completed appeal for a pre-service claim and 30 days after receiving the completed appeal for a post-service claim. For a medical appeal related to a concurrent claim, depending on the circumstances, it may be treated as an urgent care claim or pre-service claim. If the Grievance and Appeal Coordinator upholds the denial, the written notification will include an explanation of the reasons and facts relating to the denial.

Filing a Second Appeal (Level 2 Appeal)

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Grievance and Appeal Coordinator within 60 days from receipt of the first level appeal determination.

The Grievance and Appeal Coordinator must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed appeal for a post-service denial. For a medical appeal related to a concurrent claim, depending on the circumstances, it may be treated as an urgent care claim or pre-service claim. If the Grievance and Appeal Coordinator upholds the denial, the written notification will include an explanation of the reasons and facts relating to the denial.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Grievance and Appeal Coordinator will review all claims in accordance with the rules established by the U.S. Department of Labor. The Grievance and Appeal Coordinator's decision will be final.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The tables on the following pages describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Claim or Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits information to the Claims Administrator within:	**48 hours** after receiving notice

Urgent Care Claim or Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
▪ if the initial request for Benefits is complete, within:	**72 hours**
▪ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**48 hours**.
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Grievance and Appeal Coordinator as soon as possible to appeal an Urgent Care request for Benefits. Your request for an expedited appeal may be submitted orally or in writing. All necessary information, including the Grievance and Appeal Coordinator's determination on appeal, may be transmitted by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim or Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, The Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, The Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days** after receiving an extension notice*
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
▪ if the initial request for Benefits is complete, within:	**15 days**
▪ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial

Pre-Service Claim or Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
The Grievance and Appeal Coordinator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Grievance and Appeal Coordinator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal*

*The Grievance and Appeal Coordinator may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving an extension notice*
If the Claims Administrator denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
The Grievance and Appeal Coordinator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Grievance and Appeal Coordinator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*The Grievance and Appeal Coordinator may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Grievance and Appeal Coordinator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may request an external review by an Independent Review Organization (IRO) if certain requirements are met, as discussed further below.

The External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you, provided your claim meets certain requirements, such as:

- your appeal relates to a rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- effective as of January 1, 2012, the Claims Administrator has not strictly followed all claim determination and appeal requirements under federal law, unless the violation was:

    (a) de minimis;

    (b) non-prejudicial;

    (c) attributable to good cause or matters beyond the plan's control;

    (d) in the context of an ongoing good-faith exchange of information; and

    (e) not reflective of a pattern or practice of non-compliance.

Further, this program only applies if the adverse benefit determination is based on:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

The External Review Program does ***not*** apply if the adverse benefit determination is based on an administrative determination, such as:

- your eligibility;
- explicit benefit exclusions; or
- defined benefit limits.

Standard External Review Procedure

Under the External Review Program, after you have exhausted your internal appeals, you may request an independent review of the adverse benefit determination, provided your claim meets certain requirements as listed above. An adverse benefit determination related to your failure to meet the Plan's eligibility requirements is not eligible for external review. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an external review must be made within 4 months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The Claims Administrator will review your request for an external review within 5 business days of the receipt of the request to determine whether:

- you were covered under the Plan at the time the service was requested or provided;
- the adverse determination does not relate to eligibility;
- you have exhausted the Plan's internal appeals process; and
- you have provided all paperwork necessary to complete the external review.

The Claims Administrator will notify you in writing within 1 business day of the completion of its review whether your adverse benefit determination is eligible for an external review and if any additional information is required. If additional information is required, you must supply the information by the later of:

(a) the last day of the 4-month filing period described above; or

(b) 48 hours after receipt of the Claims Administrator's notification.

If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an Independent Review Organization (IRO) with which the Plan has contracted. The (IRO) has been contracted by The Claims Administrator and has no material affiliation or interest with the Claims Administrator or CVS Caremark. The IRO will be chosen based on a rotating list of at least three (3) approved IROs. The IRO acts as a fiduciary of the Plan with respect to the external reviews that are delegated to the IRO.

The IRO will provide you with written notification that it has received and accepted your request for external review, and give you the opportunity to submit additional information within 10 business days, for a non-emergency (standard) external review. The Claims Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If you supply additional information to the IRO, the IRO will forward that

information to the Claims Administrator, at which point the Claims Administrator may reconsider its adverse benefit determination.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The IRO will review your claim without giving deference to the Claims Administrator's prior decisions, and will take into account any additional information you have supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, your medical records, your physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both you and the Plan. The notification will include:

1. a general description of the reason for the request for external review, including sufficient information to identify the claim;
2. the date the IRO received the request for external review and the date of its decision;
3. reference to the evidence or documentation considered in reaching its decision;
4. the reason(s) for its decision, including any evidence-based standards that were relied on;
5. a statement that the determination is binding except to the extent other remedies are available under state or federal law;
6. a statement that judicial review may be available; and,
7. current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Claims Administrator's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

Expedited External Review

Your adverse benefit determination may be eligible for an *expedited external review* if:

- you have received an adverse benefit determination which involves a medical condition for which the timeframe for completion of an expedited internal appeal (as described above) would seriously jeopardize your life or health, or your ability to regain maximum function and you have filed a request for an expedited internal appeal; or,
- you have received an adverse benefit determination which involves a medical condition where the timeframe or completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If you make a request for an expedited external review, the Claims Administrator will immediately review your request and provide you with written notice of whether your adverse benefit determination is eligible for external review. If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above under the *Standard External Review Procedures*, along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for an expedited external review. If the notice is not in writing, the IRO will provide a written confirmation of its decision to both you and the Plan within 48 hours thereafter.

Voluntary External Review

Your decision as to whether or not to submit a claim to this voluntary external review will have no effect on your right to benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting a decision maker and the circumstances, if any, that may affect the impartiality of the decision maker, such as financial or personal interests in the result of any past or present relationship with any party to the review process.

You will not have to pay any fees or costs as part of the voluntary external review.

If you choose not to submit a claim for a voluntary external review, the Plan will not assert that you failed to exhaust the administrative remedies under the Plan. If you submit a claim for voluntary external review, the Plan agrees that any statute of limitations applicable to pursuing your claim in court will be tolled.

Contact the Claims Administrator at the toll-free number on your ID card for more information regarding the voluntary external review process.

Limitation of Action

You cannot bring any legal action against CVS or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against CVS or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against CVS or The Claims Administrator.

You cannot bring any legal action against CVS or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against CVS or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against CVS or the Claims Administrator.

7.3 Our Right to Withhold Payments and Review Payments

We have the right to withhold payment during the period of investigation on any *claim* we receive that we have reason to believe might not be eligible for coverage. We will also conduct pre-payment review on a *claim* we have reason to believe has been submitted for a service not covered under this *plan*. We will make a final decision on these *claims* within sixty (60) days after the date you filed said *claim*.

We also have the right to perform post-payment reviews of *claims*. If we determine misrepresentation was used when you filed the *claim*, or if we determine that a *claim* or a portion of a *claim* should not have been paid for any reason (examples include but are not limited to (a) the amount paid to you is more than the *allowable,* (b) *a claim* was paid to an ineligible dependent, or (c) we reimbursed a *claim* when the *plan* had been terminated or amended, or (d) your coverage under the *plan* was retroactively terminated) we may take all necessary steps (including legal action) to recover funds paid to you or to a *provider*.

We may, in our own discretion, recoup the improperly paid *claim* through any methods of collection available, including any of the following:

- notification to you of the error, and an accompanying request that you immediately pay the amount of the improperly paid *claim*;
- offsetting the amount of the improperly paid *claim* against any other eligible *claim* payment (regardless of the *plan year* in which it is submitted); and
- if permissible under applicable law, CVS will withhold the amount of the improperly paid *claim* from your pay on a post-tax basis.
-

If we are unable to recover all or a portion of your debt, you may not be eligible to participate in this *plan* during the next Annual Enrollment period.

7.4 The Plan's Right of Subrogation and/or Reimbursement

Reimbursement means the *plan's* right to be reimbursed, up to the amount of any benefits paid from any payments, awards or settlements, which may be paid to the *subscriber* by any third party.

Subrogation means the *plan's* right to collect all or part of a debt or damages.

Injury or Illness Involving Third Parties. If an Injury or illness of a Beneficiary is or may have been caused by another person or party and the Beneficiary has or may have a right to recover damages pursuant thereto, or has or may have a right to recover damages or receive payment without regard to fault, the Plan shall not be liable to advance any benefits. However, the Plan may advance benefits in connection with such Injury or illness in the form of an interest-free loan if a Beneficiary complies with the following conditions and rules:

(a) The Beneficiary must notify the Plan of any actual or potential legal action (including any claim, demand or legal proceeding) which the Beneficiary anticipates bringing or has brought against any third party or other source of recovery in connection with the illness or Injury, not later than 30 calendar days subsequent to submitting or filing a claim, demand or legal action against the third party or other source or recovery.

(b) The Beneficiary must promptly execute and deliver to the Plan all liens, assignments or other documents which the Plan determines are necessary to secure the Plan's rights of reimbursement (and the Beneficiary shall authorize and direct person making any payment on account of any such injury or illness to pay to the Plan so must of such payment as necessary to discharge the Beneficiary's obligation; and

(c) The Beneficiary must cooperate in protecting the Plan's interest under these rules. The interest free loan is made without waiver of the Plan's rights of reimbursement and the other rules described in Right of Reimbursement below.

Right of Reimbursement.

(a) The Beneficiary must repay the interest free loan from any recovery received from or on behalf of the third party, including, but not limited to, proceeds from any:

(i) Motor vehicle insurance, including the Beneficiary's underinsured or uninsured motorist coverage;

(ii) Property and casualty insurance;

(iii) Medical malpractice coverage;

(iv) Settlement, judgment, or award;

(v) Workers' compensation insurance or other employer liability program; or other insurance.

(b) The Plan shall have a first lien on such proceeds, up to the amount of the total benefits the Plan paid related to such injury or illness. The Beneficiary must repay the interest free loan even if the proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

(i) Do not specifically include medical expenses,

(ii) Are stated to be for general damages only,

(iii) Are for less than the actual loss or alleged loss suffered by the Beneficiary due to the injury or illness,

(iv) Are obtained on the Beneficiary's behalf by the Beneficiary's estate, legal representative or parent,

(v) Are without any admission of liability, fault, or causation by the third party or payor.

The Plan will have the same rights of lien and reimbursement described above even if the Beneficiary does not sign any documents, to the extent of any payments made by the Plan on the Beneficiary's behalf for any charges related to the illness or injury.

The rights of reimbursement are in addition to any equitable subrogation rights and/or statutory lien rights the Plan may have for reimbursement of these payments.

The Plan's lien may be filed with any third party responsible for such illness or injury, their agent or insurance company, the Beneficiary's legal representative or the court.

Once the Beneficiary has: (1) complied with the requirements above; (2) received a recovery relating to the injury or illness; and (3) paid the Plan's lien as described above (or any lesser amount the Plan agrees is satisfactory if your proceeds are less than the Plan's lien), then the Plan will pay future benefits related to the injury or illness, to the extent that medical treatment subsequent to these events would otherwise be a covered benefit payable under the Plan, but only to the extent that future eligible charges exceed the amount of any net recovery obtained by or on behalf of the Beneficiary (including by the Beneficiary's estate, legal representative, or parent). Net recovery means the total proceeds recovered minus only attorneys' fees, costs and liens directly related to or arising from the injury or illness and actually paid from the recovery.

If the Beneficiary has complied with the above conditions and rules and has made reasonable efforts to obtain recovery for the Beneficiary's illness or injury, but have received a final dismissal or denial of the Beneficiary's legal action without recovering any proceeds for the illness or injury, then the Employer will forgive any loan made under these rules, and will provide benefits for the illness or injury to the extent that they would otherwise be a covered benefit payable under the Plan.

For any payment made by the Plan under these rules, the Beneficiary is still responsible for copayments, deductibles, and timeliness in submission of claims, and other obligations under the Plan.

Release of Information.

By accepting benefits described in this Plan, the Beneficiary agrees that the Claims Administrator or Employer may examine and copy the Beneficiary's medical records, including records containing mental health, substance abuse, and AIDS related information, for the purposes of:

(a) administering the Plan between the Employer and the Beneficiary;

(b) complying with government requirements; and

(c) bona fide research or education.

8.0 GLOSSARY

ALLOWABLE means the maximum amount determined to be acceptable for *covered health care services.* The *allowable* for a *covered health care* service may include payment for other related services. See Section 4.0- How We Pay For Your Covered Health Care Services and the Summary of Benefits for services subject to *copayments*, *coinsurance, deductibles,* and/or *maximum benefits.*

- **HMN ALLOWABLE** is the negotiated price a HMN PPO *participating* provider has agreed to accept for a *covered health care* service or procedure. See section 4.1 for details.
- **MULTIPLAN ALLOWABLE** is the maximum amount a MultiPlan *participating* provider has agreed to accept for a *covered health care* service. See Section 4.1 for details.
- **NON-PARTICIPATING ALLOWABLE** is the maximum amount HMA determines to be acceptable or negotiates for *covered health care services* rendered from a *non-participating provider.* You are responsible up pay the *provider's charge.* Our reimbursement is based on the lesser of the *non-participating allowable,* the *non-participating provider's charge,* or the *maximum benefit* less any *copayments, coinsurance,* and/or *deductibles.* See section 4.2 for details.

CHARGES means the amount billed by any health care *provider* (e.g., *hospital*, *doctor*, laboratory, etc.) for *covered health care services* without the application of any discount or negotiated fee arrangement.

CHEMICAL DEPENDENCY means the chronic abuse of alcohol or other drugs characterized by impaired functioning, debilitating physical condition, the inability to keep from or reduce consuming the substance, or the need for daily use of the chemical in order to function. The term "chemical" includes alcohol and addictive drugs, but not caffeine or tobacco.

CHEMICAL DEPENDENCY TREATMENT FACILITY means a *hospital* or facility which is licensed by the state in which it is located as a *hospital* or as a community residential facility for *chemical dependency* and *chemical dependency* treatment, unless we can establish through a pre-admission certification process that services are not available at a facility that meets these requirements.

COPAYMENT/(COINSURANCE) means

Copayment - a flat dollar amount that you must pay per service for *covered health care services*. For purposes of this benefit booklet, a *copayment* may be either a flat dollar amount or a percentage.

Coinsurance - the percentage of our *allowable* which you must pay for *covered health care services*.

COVERED HEALTH CARE SERVICES means any service, treatment, procedure, facility, equipment, drug, device, supply or service which we have reviewed and determined is eligible for reimbursement under this *plan*.

DEDUCTIBLE means the amount of covered health care expenses that you must pay per *plan year* before this *plan* provides benefits. Covered health care expenses are calculated based on our *allowance* and not on *charges*.

See the Summary of Benefits for your *plan year deductible* limits.

DOCTOR means any person licensed and registered as an allopathic or osteopathic physician (i.e. a D.O or M.D.). For purposes of this benefit booklet, the term *doctor* also includes a licensed dentist, podiatrist, or chiropractic physician.

ELIGIBLE CHARGE amount is the maximum allowed payment for that particular health care service or the Provider's actual charge, whichever is less.

EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

EMPLOYER/AGENT means the corporation that pays for some or all of your membership and benefits as described in this *plan*. This company is separate from us.

EXPERIMENTAL/INVESTIGATIONAL means any health care service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See Section 3.12 for a more detailed description of the type of health care services we consider *experimental/investigational*.

FREE-STANDING AMBULATORY SURGI-CENTER means a state licensed facility which is equipped to surgically treat patients on an *outpatient* basis.

FREE-STANDING EMERGENCY MEDICAL CENTER means a health care center physically separate from a *hospital* or other institution with which it is affiliated OR an independently operated and owned health care center. These centers are also referred to as " urgent centers" or "walk-in" centers.

HMN, Inc. is the entity that administers healthcare benefits on behalf of the Plan sponsor. The Plan sponsor is CVS Pharmacy, Inc.

HOSPITAL means any facility worldwide that provides medical and surgical care for patients who have acute illnesses or injuries AND is either listed as a *hospital* by the American Hospital Association (AHA) OR accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "*Hospital"* does not refer to convalescent homes, rest homes, nursing homes, homes for the aged, school/college infirmaries, halfway houses or residential facilities, long-term care facilities, *free-standing emergency medical centers* or *free-standing ambulatory surgi-centers*, facilities providing primarily custodial, educational or rehabilitative care, or

sections of *hospitals* used for those purposes, even if accredited by the JCAHO or listed in the AHA directory.

A GENERAL HOSPITAL means a *hospital* which is designed to care for medical and surgical patients with acute illness or injury.

A SPECIALTY HOSPITAL means a *hospital* or the specialty unit of *a general hospital* which is licensed by the State and designed to care for patients with injuries or special illnesses, including but not limited to, a mental health or rehabilitation unit or *hospital*.

HOSPITAL SERVICES are the following in-*hospital services*:

- anesthesia supplies;
- blood services including: administration, typing, cross matching, drawing, maintenance of donor room, and *charges* for plasma and derivatives;
- cardiac pacemakers;
- computerized axial tomography (CAT or CT scan) and magnetic resonance imaging (MRI);
- diagnostic X-rays, radiotherapy and diagnostic and therapeutic radioisotopic services;
- drugs and medications as currently listed in the National Formulary or the U.S. Pharmacopoeia;
- electrocardiograms (EKGs) and electroencephalogram (EEG);
- general nursing care;
- hearing evaluation;
- hemodialysis - use of machine and other physical equipment;
- inhalation and oxygen therapy;
- insulin and electroconvulsive therapy;
- laboratory examinations and pulmonary function tests;
- mammogram;
- meals and other dietary services;
- medical and surgical supplies;
- occupational therapy;
- original prosthetic and initial prosthesis when provided and billed for by the *hospital* where you are an *inpatient* or the *hospital* where you return within a reasonable period of time for an initial prosthesis or original prosthetic, providing the prosthesis or the prosthetic is related to the original *hospital* stay;
- pap smear;
- physical therapy;
- recovery room;
- room accommodations in a ward or *semi-private room*;
- services performed in intensive care units;
- services of a licensed clinical psychologist when ordered by a *doctor* and billed by a

hospital;

- speech evaluation and therapy;
- ultrasonography (ultrasounds);
- use of the operating room; and
- other *hospital services* necessary for your treatment which we have approved.

INPATIENT is a patient admitted, at least overnight, to a *hospital* or other health care facility.

LEGEND DRUG is a drug that federal law prohibits the dispensing of without a prescription.

MAXIMUM BENEFIT means the total benefit allowed under this *plan* for *covered health care services* associated with a particular condition or service.

When you receive *covered health care services* from a *participating provider*, the *provider* has agreed to accept our *allowable* as payment in full. You will be responsible to pay the difference between the *maximum benefit* and our *allowable,* and any applicable *copayments*, *coinsurance*, and *deductibles.*

When you receive *covered health care services* from a *non-participating provider*, you will be responsible for the *provider's charge.* Our reimbursement will be based on the lesser of our *allowable,* the *non-participating provider's charge,* or the *maximum benefit,* less any *copayments*, *coinsurance,* and/or *deductibles*.

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount of *coinsurance* that you must pay each *plan year* for *covered health care services* provided by *participating and non-participating hospitals*, facilities, *doctors* and other health care *providers.*

This *plan* will pay up to 100% of our *allowable* for the remainder of the *plan year* once you have paid the *maximum out-of-pocket expense*.

***Copayment* amounts you pay for the services marked with a double asterisk (**) in the Summary of Benefits will NOT be applied to the *maximum out-of-pocket expense*. *Our allowable* will never increase for these services.**

See the Summary of Benefits for your *maximum out-of-pocket expenses.*

MEDICALLY NECESSARY means that the health care services provided to treat your illness or injury, upon review by HMA are:

- appropriate and effective for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed;
- appropriate with regard to generally accepted standards of medical practice within the medical community;
- not primarily for the convenience of the *member*, the *member's* family or *provider* of such *member;* AND

- the most appropriate supplies or level of service which can safely be provided to the *member*, i.e. no less expensive professionally acceptable alternative is available.

We will make a determination whether a health care service is *medically necessary.* You will have the right to appeal our determination or to take legal action as described in Section 7.0. We review medical necessity on a case-by-case basis. THE FACT THAT YOUR *DOCTOR* PERFORMED OR PRESCRIBED A PROCEDURE DOES NOT MEAN THAT IT IS *MEDICALLY NECESSARY*. We determine medical necessity solely for purposes of *claims* payment under this *plan*.

MINUTECLINIC® means the specific *provider* named *MinuteClinic*. *MinuteClinics* are health care facilities designed to offer an alternative to a physician's office visit for treatment of unscheduled and/or non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. The clinics also offer administration of certain vaccines or immunizations. *MinuteClinics* are not designed to be an alternative for emergency services or the ongoing care of your physician.

Clinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners and have a physician on call at all times who also sets protocol for clinical policies, guidelines and decisions.
MinuteClinic is a registered trademark of MinuteClinic, L.L.C., a Delaware corporation.

MULTIPLAN / HMN is a national network which HMA plans participate that benefits *subscribers* who receive *covered health care services* outside their own plan's service area. See Section 4.1 for details.

PARTICIPATING/NETWORK PROVIDER (PARTICIPATING/NETWORK) is a *provider* that has entered into an agreement with us or MultiPlan/HMN.

NEW SERVICE means a service we have not previously reviewed to determine whether the service is eligible for coverage under this *plan*.

NON-PARTICIPATING/NON-NETWORK PROVIDER (NON-PARTICIPATING/NON-NETWORK) is a *provider* that has not entered into an agreement with us or MultiPlan/HMN.

OUTPATIENT is a patient receiving ambulatory care at a *hospital* or other health care facility without being admitted overnight.

PLAN, other than when used in Section 6, means the group health care *plan* offered by the plan sponsor. The *plan* name is The CVS Caremark Welfare Benefit Plan and the plan sponsor is CVS Pharmacy, Inc.

PLAN YEAR means the one-year period that begins on June 1st of one year and continues until May 31st of the following year.

PRIOR AUTHORIZATION is a process that determines if a health care service qualifies for benefit payment. *Prior Authorization* is not a guarantee of payment, as the process does not take benefit limits into account.

Prior Authorization is the approval that we advise you to seek before receiving certain *covered health care services. Prior Authorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Participating providers* are responsible for obtaining *Prior Authorization* for all applicable *covered health care services*.
You are responsible for obtaining *Prior Authorization* when the *provider* is *non-participating*. If you do not obtain *Prior Authorization* and the services are determined to either be (1) not *medically necessary* or (2) performed in a facility or by a physician, surgeon or other person that is not legally qualified or licensed or who does not meet our credentialing requirements this *plan* will not cover these services/facilities.

You may request information regarding *Prior Authorization* by telephoning us at 1-866-826-5335 or 808-954-8796 for medical/surgical services and behavioral health services. A completed Prior Authorization Form must be submitted to the HMA Health Services Department. We encourage you to contact us at least two (2) working days before you receive any *covered health care service* for which *Prior Authorization* is required. Services for which *Prior Authorization* is required are marked with an asterisk (*) in the Summary of Benefits.

PREVENTIVE CARE SERVICES means *covered health care services* performed to prevent the occurrence of disease. For the purpose of coverage under this benefit booklet *preventive care services* include adult preventive immunizations, pediatric preventive immunizations, and those services listed in Section 3.9 when performed for routine screening.

PRIMARY CARE PHYSICIAN (PCP) – For the purpose of coverage under this benefit booklet, a PCP is a physician who specializes in internal medicine, family practice, pediatrics, or obstetrics/gynecology, including a physician's assistant (PA) or nurse practitioner (NP) working under the license of one of the above listed primary care physicians.

PROGRAM means a collection of *covered health care services*, billed by a single *provider*, which can be administered in a variety of settings and by different *providers*. This *plan* does NOT cover *programs* unless specifically listed as covered. See Section 3.0 - *Covered Health Care Services* to determine if a *program* is covered under this *plan*.

PROVIDER means an individual or entity licensed under the laws of the state in which services are provided to furnish health care services. For purposes of this benefit booklet the term *provider* includes a *doctor* and a *hospital* as well those individuals whose services we are required to cover such as midwives, certified registered nurse practitioners, psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a licensed physician, counselors in mental health, and therapists in marriage and family practice.

SEMI-PRIVATE ROOM means a *hospital* room with two or more patient beds.

SERVICE AREA is the State of Hawaii.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

TREATMENT PLAN is also known as a Behavioral Health Treatment Plan/Interpretive Summary. It consists of the member's symptoms, current medications, history, diagnosis, goals, treatment modalities, and frequency of treatments.

SUBSCRIBER/MEMBER means you and each *eligible person* listed on your application who is enrolled in the *plan* sponsor's health plan.

UTILIZATION REVIEW means the prospective (prior to), concurrent (during) or retrospective (after) review of any service to determine whether such service was properly authorized, constitutes a *medically necessary* service for purposes of benefit payment, and is a *covered health care service* under this *plan*.

Prospective Review is a review conducted prior to services being rendered.

Concurrent Review is a review conducted during a patient's *hospital* stay or course of treatment.

Retrospective Review is a review conducted after services have been rendered.

WE, US, and **OUR** means HMA. We are located at 1440 Kapiolani Blvd., Suite 1020, Honolulu, Hawaii 96814. HMA is the entity that administers healthcare benefits on behalf of the *plan* sponsor. The *plan* sponsor is CVS Pharmacy, Inc. For the purpose of this benefit booklet WE, US, or OUR will have the same meaning whether italicized or not.

YOU and **YOUR** means the individual who is subscribing to the *plan* sponsor's health plan. For the purpose of this benefit booklet YOU and YOUR will have the same meaning whether italicized or not.

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Custom/NoRx/

CVS ADDENDUM

The information in this CVS Addendum is provided by the plan sponsor (CVS). If you have questions about any law or requirement referenced in this section, contact the Plan Administrator at the phone number and/or address noted in this Addendum.

The defined terms used in Sections 1-8 of the Benefit Booklet are not applicable to this CVS Addendum.

Women's Health and Cancer Rights Act

The Plan complies with the Women's Health and Cancer Rights Act of 1998. That law mandates that all group health plans providing coverage for mastectomies also cover:

- all stages of reconstruction of the breast on which a mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications through all stages of a mastectomy, including lymph edemas; and
- coverage in a manner that is determined in consultation with the attending physician and patient.

A health plan cannot penalize, reduce, or limit reimbursement of providers because they provided care under the terms of this law.

Your Privacy Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your health information is private, and we are committed to maintaining the privacy of your medical information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you certain rights to privacy concerning your health information. The Plan will follow the policies below to help ensure that your health information (or "protected health information" ("PHI")) is protected and remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your PHI. In general, the Plan will only use or disclose your PHI without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by CVS and HMA acting on the Plan's behalf.. As a result, PHI used or disclosed by the Plan (as discussed below) necessarily means that CVS and HMA, as applicable, are using or disclosing the PHI on behalf of the Plan. As a result, references to the Plan in this section shall also be construed as references to CVS and HMA to the extent necessary to carry out the actions of the Plan.

Permitted Uses and Disclosures

The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

The Plan may use or disclose your PHI for the following reasons:

- for treatment, payment, and health care operations (including disclosures to the Plan's Business Associates to carry out these functions);
- to family members, relatives, and close personal friends involved in your care or payment for your care (but only to the extent of their involvement);
- as required by law;
- to avert a serious threat to your health and safety or the health and safety of the public or another person;
- for purposes of organ or tissue donation;
- as required by military command authorities, if you are a member of the armed forces;
- for workers' compensation or similar programs;
- for public health activities (for example, to prevent or control disease, injury, or disability, to report reactions to medications or problems with products, etc);
- for certain health oversight activities (for example, audit and inspection to monitor the health care system);
- in response to a court or administrative order or subpoena or discovery request;
- to the Department of Health and Human Services for purposes of determining the Plan's compliance with these privacy rules;
- to coroners, medical examiners, and funeral directors (for example, to identify a deceased person or determine the cause of death);
- for national security and intelligence activities; and
- if you are an inmate of a correctional institution for specified reasons such as the protection of your health and safety.

Disclosures to CVS.

The Plan will disclose your PHI to CVS for Plan administration purposes only upon receipt of a certification from CVS that the Plan sets forth the permitted uses and disclosures of PHI by CVS on behalf of the Plan, and that CVS has agreed to the following assurances:

- CVS shall implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- CVS shall not further use or disclose your PHI other than as permitted or required by the Plan documents or as required by law;
- CVS shall ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to CVS with respect to such information and agree to implement reasonable and appropriate security measures to protect such information;
- CVS shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of CVS;
- CVS shall report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses and disclosures, including any security incidents, of which it becomes

aware;

- CVS shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- CVS shall, if feasible, return or destroy all PHI received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- CVS shall ensure that there is adequate separation between the Plan and CVS (as described below) and that the separation is supported by reasonable and appropriate security measures;
- CVS shall make your PHI available to you (as described below);
- CVS shall make your PHI available to you for amendment and incorporate any amendment into your PHI (as described below); and
- CVS shall make available the information required to provide you an accounting of disclosures (as described below).

Access to PHI

The Plan will make your PHI available to you for inspection and copying upon your written request to HMA. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

Amendment of Medical Information

If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to HMA. In addition, you must provide a reason that supports your request.

HMA may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, HMA may deny your request if you ask HMA to amend information that is not part of the medical information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Accounting of Disclosures

If you wish to know to whom your PHI has been disclosed for any purpose other than (a) treatment, payment, or health care operations, (b) pursuant to your written authorization, and (c) for certain other purposes, you may make a written request to the applicable HMA department. Your request must state a time period which may not be longer than six years Your request should indicate in what form you want the list (for example, paper or electronic).

The first list you request within a 12-month period will be free. The accounting will not include disclosure for the purposes of treatment, payment, or health care operations. In addition, the accounting will not include disclosures which you have authorized in writing.

Separation Between the Plan and CVS

Only employees of CVS who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include the following individuals: employees of the Human Resources Department and the Legal and Employee Relations Departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, CVS will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

Other Uses of PHI

Any other uses and disclosures of your PHI will be made only with your written authorization. If you provide the Plan authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization.

If you have a question about your rights under the HIPAA regulations, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan And Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court subsequent to exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Department of Labor's Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

General Plan Information

This section provides administrative information for the Plan, but is subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official documents differ, the official plan documents or insurance booklets/contracts are the final authority. This description of administrative information is not an employment contract or any type of employment guarantee.

The Plan is a welfare benefit plan. The Plan provides medical benefits that are self-insured and administered by HMA on behalf of CVS Caremark.

The Plan Administrator will help resolve any problem you might have about your rights to benefits. The official plan documents, benefits booklet, and related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Labor Management Services Administration, Department of Labor, you will need to provide the information contained in this section to identify the plan properly.

Formal Plan Name

The CVS Caremark Welfare Benefit Plan

Plan Year

The Plan's records are kept on a 12-month period beginning June 1 and ending May 31.

Employer/Plan Sponsor

CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

Employer and Plan Identification Number

The employer identification number assigned to the Employer/Plan Sponsor by the Internal Revenue Service (IRS) is 05-0494040.

The Plan number assigned to the Plan is 510.

Plan Administrator

The Plan Administrator is the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Communications to the Plan Administrator should be directed as follows:

Attn: Lisa Bisaccia
Senior Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

The Plan Administrator has delegated authority to HMA to determine all claims under the Plan. Such discretionary authority is intended to include, but is not limited to, the determination of whether a person is entitled to benefits under the Plan and the computation of any and all benefit payments. The Plan Administrator also delegates to HMA the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by a claimant or his or her duly authorized representative.

Except with regard to administrative authority delegated to HMA, the Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan (such as whether an individual is eligible for coverage under the Plan), and shall determine all questions arising in the administration, interpretation and application of the Plan. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

Agent for Service of Legal Process

CT Corporation System
155 South Main Street, Suite 301
Providence, Rhode Island 02903

Process may also be served on the Plan Administrator.

Named Fiduciary

Attn: Lisa Bisaccia
Senior Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

The “Named Fiduciary” is the one named in the Plan, which is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. To

the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will generally not be liable for any act or omission of such person.

Claims Fiduciary

While the Plan Administrator is the Named Fiduciary, HMA, is the Plan fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the Plan.

Claims Administrator

As Claims Administrator, HMA receives, processes, and pays for the benefits under the Plan. With regard to administrative authority delegated to the Claims Administrator, the Claims Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan. All determinations of the Claims Administrator shall be conclusive and binding on all parties.

COBRA Administrator

Aon Hewitt
myHR
P.O. Box 563927
Charlotte, NC 28256
(888) 694-7287

Future of the Plans

The continued maintenance of the Plan is completely voluntary on the part of CVS and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. While CVS expects to continue the Plan indefinitely, CVS reserves the right at any time and for any reason, in its sole discretion, to curtail benefits under, otherwise amend, modify, or terminate the Plan or any portion thereof without notice, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of employees or dependents eligible for benefits under the Plan. The Plan may be amended by the board of Directors of CVS Caremark Corporation, by the Management Planning and Development Committee or, in certain circumstances, by approval of the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Any claims requested after the effective date of termination, modification, or amendment are payable in accordance with the respective Plan documents. However, no amendment or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the date of amendment or termination. In the event the Plan terminates, you will be informed of any termination rights you may have.