PRESCRIPTION DRUG PLAN

SUMMARY PLAN DESCRIPTION

CINNAMINSON TOWNSHIP BOARD OF EDUCATION

2022

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INTRODUCTION

This is the Summary Plan Description for the prescription drug benefit plan provided by the CINNAMINSON TOWNSHIP BOARD OF EDUCATION (the "Employer") through the Schools Health Insurance Fund (the "Fund").

The Fund is a joint self-insurance fund established pursuant to New Jersey statutes (N.J.S.A. 18A:18B-1 et. seq.) consisting of Boards of Education that have elected to participate in a school board insurance group, referred to as the Fund, (each a "Member" or collectively "Members") in order to provide for contributory or non-contributory group health insurance to employees, and their dependents, of the Members through self-insurance, the purchase of commercial insurance or reinsurance, or any combination thereof.

The Fund contracts with various third-party providers in order to make available to its Members a comprehensive program of health care which provides health care services and benefits to the eligible employees, and their dependents, of Fund Members. The Fund has contracted with EXPRESS SCRIPTS, INC. (hereinafter "ESI" or "Administrator") to provide certain administrative services to the Fund and to process the payment of claims for the prescription drugs provided to Participants (as hereinafter defined) pursuant to the terms of CINNAMINSON TOWNSHIP BOARD OF EDUCATION Prescription Drug Plan.

This Summary Plan Description ("SPD"), and the attachments, exhibits and schedules attached to this SPD and incorporated herein by reference outline the services and benefits and other rights and privileges which are available to eligible employees and their dependents. Every effort has been made to ensure the accuracy of this SPD, which describes eligibility for, and the prescription drug plan provided through, the Fund. The Fund is subject to New Jersey State law and regulations. In the event there are inconsistencies or discrepancies between the information presented in this SPD and/or plan documents and the laws, regulations, or contracts governing the Fund, the latter will govern.

The rights and conditions with respect to the amounts payable by the Administrator for the prescription drug benefits to be provided under this Prescription Drug Plan shall be determined by the Administrator in accordance with their agreement with the Fund and their contracts with service providers, the terms of which are incorporated herein by reference. In the event of a conflict between the terms of this SPD and the terms and conditions of the agreements with the Administrator, the terms of the Administrator's agreements shall control. Your Employer establishes the criteria for determining the persons eligible for coverage under the Prescription Drug Plan, the dates of their eligibility, and the benefits Participants are entitled to receive and the circumstances under which their eligibility terminates.

The purpose of this SPD is to provide you with information about your Prescription Drug Plan (hereinafter sometimes referred to as the "Plan"). In the event that you have questions after reading this SPD, please contact your Employer's personnel/human resources department or use the contact information in this SPD or on your prescription drug plan identification (ID) card to contact the

appropriate representative. Furthermore, if you are unsure whether a drug is covered, contact ESI before you order or purchase the prescription and/or receive services to avoid any denial of coverage issues that could result.

Prescription drugs are available at designated copayment levels only when a participating licensed pharmacy is used. A prescription drug plan identification card is provided and use of the ID card is required to obtain medications at a participating retail pharmacy for the designated copayment.

Your Prescription Drug Plan is self-funded by your Employer through the Fund and is administered by ESI. The Fund and your Employer reserve the right to amend or terminate this Prescription Drug Plan, in whole or in part, at any time, subject to applicable law. In the event that your Employer has implemented a Section 125 Plan as provided under the Internal Revenue Code of 1986, as amended, (the "Code") your participation in this Prescription Drug Plan may require that you agree to reduce your compensation or to forego all or part of an increase, if applicable, in your compensation and to have such amounts contributed by your Employer on your behalf to the payment of the cost of your coverage under the Prescription Drug Plan.

CINNAMINSON TOWNSHIP BOARD OF EDUCATION PRESCRIPTION DRUG PLAN

DEFINITIONS

This section defines certain words and phrases that appear in this Summary Plan Description of the Prescription Drug Plan. Capitalized terms not defined in this Summary Plan Description will have the meaning given to them in the applicable documents attached to or incorporated in this Summary Plan Description.

Accredo Specialty Pharmacy — A duly licensed pharmacy owned or operated by ESI or its subsidiaries where Specialty Products are dispensed for, and delivered to, Participants.

Civil Union Partner* — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment.

Copayment — The amount charged to the eligible participant by a retail pharmacy, the ESI mail order pharmacy, or the ESI Accredo Specialty Pharmacy for each prescription drug order or authorized refill, whether as a copayment, coinsurance and/or deductible.

Covered Drug(s) — Those prescription drugs, supplies, and other items that are covered under this Prescription Drug Plan as indicated on the EBD.

Drug Enforcement Agency (DEA) Number — A number assigned by the Drug Enforcement Agency to each physician in the United States who prescribes medications.

Dependents — The eligible dependents of an eligible participant are a spouse, (see page 15) and children under age 26 without regard to marital or financial dependency status. (This includes children who are away at school or are not living with you.) Grandchildren, unless

adopted by an eligible participant or the subject of a legal guardianship with an eligible participant are not eligible dependents. If you are a single parent, divorced (either from the bonds of matrimony and/or from bed and board), or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Dispensing Quantity Limit — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).

Domestic Partner* — For health benefits eligibility, a domestic partner is defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by registering with the local registrar and receiving a *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners. On and after February 19, 2007, same sex or opposite sex persons, if both are age 62 or older, may form a domestic partnership. Domestic partner coverage is only available in the event your Employer has adopted a resolution to participate in health benefits coverage under the Domestic Partnership Act. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer for more information).

Dose Optimization — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.

Drug Utilization Review (DUR) — Drug utilization reviews are performed by ESI to determine a prescription's suitability in light of the patient's health, drug history, drug-to-drug interactions, and drug contraindications.

Employee — For purposes of this Prescription Drug Plan, an employee is a full-time employee receiving a salary and working for the Employer. An Eligible Employee means a full-

time Employee who satisfies the definition/requirements for eligibility set forth under Eligibility on Page 6 of this document.

Employer — is the CINNAMINSON TOWNSHIP BOARD OF EDUCATION.

ESI — The pharmaceutical benefits management company that administers this Prescription Drug Plan.

ESI Benefit Design or EBD — Any prescription drug benefit summary form or document that ESI has provided to the Fund and the Employer which describes the essential features of the Prescription Drug Plan.

Federal Legend Drug — A drug that, by law, can be obtained only by prescription and bears the label, "Caution: Federal law prohibits dispensing without a prescription."

ID Card — A standard single purpose printed identification card containing information about the prescription drug benefits to which a Participant is entitled and the applicable ESI pharmacy network logos or other method of identifying the fact that ESI is the provider of prescription drug benefit services.

Mail Order Pharmacy or Mail Service Pharmacy — A duly licensed pharmacy operated by ESI or its subsidiaries, where prescriptions are filled and delivered to Participants via the mail service.

Mail Order Prescription — A prescription which is dispensed by the designated mail order pharmacy.

Medical Necessity and Appropriateness — Medical necessity and appropriateness criteria and guidelines are established and approved by the National Pharmacy and Therapeutics Committee ("NP&T Committee"), which consists of practicing physicians and pharmacists. Eligible prescription drugs must meet federal Food and Drug Administration (FDA) approved indications and be safe and effective for their intended use. Drugs administered by a medical professional are not eligible under this plan.

A prescription drug is medically necessary and appropriate if, as recommended by the treating practitioner and as determined by the NP&T Committee or designee(s) it is all of the following:

- A health intervention for the purpose of treating a medical condition;
- The most appropriate intervention, considering potential benefits and harms to the patient;
- Known to be effective in improving health outcomes (For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence; then if necessary, by professional standards; then, if necessary, by expert opinion);
- Cost effective for the applicable condition, compared to alternative interventions, including no intervention. "Cost effective" does not mean lowest price.

The fact that an attending practitioner prescribes, orders, recommends, or approves the intervention, or length of treatment time, does not make the intervention "medically necessary and appropriate."

National Association of Boards of Pharmacy (NABP) Number — Number assigned by the National Association of Boards of Pharmacy to identify the pharmacy. The National Association of Boards of Pharmacy is an independent association that assists its member boards and jurisdictions in developing, implementing, and enforcing uniform standards for the purpose of protecting the public health.

National Drug Code Number (NDC) — A universal drug identification number assigned by the Food and Drug Administration (FDA).

Non-federal Legend Drug — A drug that does not require a prescription and is available "over-the-counter."

Non-participating Pharmacy — Any pharmacy that does not have an agreement with ESI or the Fund.

Participant or Plan Participant — Any individual who has properly enrolled in, and who participates in this Prescription Drug Plan in accordance with the terms and conditions established for the Prescription Drug Plan, and who has not for any reason become ineligible to participate further in such Plan. Participation (Eligibility Requirements) are described at page 6 of this document and Schedule A of the CINNAMINSON TOWNSHIP BOARD OF EDUCATION Health Benefit Plan Supplemental Summary Plan Description.

Participating Pharmacy — Any licensed retail pharmacy which has entered into an agreement with ESI or the Fund to provide Covered Drugs to Participants.

Participating Pharmacy Allowance — The maximum amount a retail pharmacy will be reimbursed by ESI for a particular medication. The participating pharmacy allowance is specified in the contract participating pharmacies enter into with ESI.

Pharmacist — A person licensed to practice the profession of pharmacy and who practices in a pharmacy.

Pharmacy — Any place of business which meets these conditions: 1) It is registered as a pharmacy with the appropriate state licensing agency and 2) prescription drugs are compounded and dispensed by a pharmacist. This definition does not include a physician who dispenses drugs, pharmacies or drug centers maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group. It also does not include pharmacies maintained by hospitals, nursing homes, or similar institutions.

Plan — The CINNAMINSON TOWNSHIP BOARD OF EDUCATION Prescription Drug Plan, as amended from time to time.

Prescription — The request for drugs issued by a physician licensed to make the request in the course of his professional practice or other duly licensed professional authorized to prescribe medications.

Prior Authorization — A mechanism to screen a drug/drug class by specific criteria along with a patient's medical history to determine if the drug is covered under the Plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the Plan.

Protected Health Information or PHI — A Participant's name, address and social security number, date of birth, Participant-specific medical or prescription information and any other Participant-identifiable demographic information which may be deemed to be confidential from time to time under federal or state law.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Specialty Pharmaceuticals or Specialty Products — Oral or injectable drugs that have unique production, administration, or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while undergoing treatment.

Specialty Pharmaceutical Provider — A provider that dispenses Specialty Pharmaceuticals.

ELIGIBILITY

The **Prescription Drug Plan** is offered to:

- Eligible employees of the Employer (and eligible dependents) as more particularly described in Schedule "A-1" attached to the CINNAMINSON TOWNSHIP BOARD OF EDUCATION Health Benefit Plan Supplemental Summary Plan Description and made a part hereof.

PLAN BENEFITS

Plan benefits are available through a participating pharmacy**,** the plan's designated mail order service, the Accredo Specialty Pharmacy, or from a participating specialty pharmaceutical provider for infertility drugs.

Retail pharmacy

Normally, retail pharmacy copayment amounts are for a 30-day supply of prescription drugs for one copayment (see page 7 for copayment information). Additional information about purchasing prescription drugs at a retail pharmacy begins on page 8.

Mail Order Service

Mail order benefits are available where participants can receive up to a 90-day supply of prescription drugs for one copayment (see page 7 for copayment information). Additional information about using the mail order service begins on page 9.

Specialty pharmaceutical provider

Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. Examples of prescription drugs that qualify as specialty pharmaceuticals include, but are not limited to, those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; or Gaucher's Disease.

Specialty pharmaceuticals are provided through Accredo Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for this Prescription Drug Plan.

If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy and the pharmacy representative will advise you to contact Accredo Specialty Pharmacy at 1-800-803-2523. When calling, identify yourself as a Schools Health Insurance Fund CINNAMINSON TOWNSHIP BOARD OF EDUCATION prescription drug plan participant. ESI will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

The copayment for up to a 30-day supply of the specialty medication is the same as the retail copayment for preferred brand name or non-preferred brand name drugs under the plan in which you are a participant.

COPAYMENT AMOUNTS

For the current Plan Year, copayments for eligible employees, and their eligible dependents, are as follows:

- **Retail pharmacy** copayment for up to the greater of a 34-day supply or 100 units is $10.00 for generic drugs*, $15.00 for preferred brand name drugs and $15.00 for non-preferred brand name drugs. Prescription out-of-pocket maximum $3,000/$6,000. Paired with Aetna QPOS Pat V and Premier plans.
- **Mail order** for up to a 90-day supply $10.00 for generic drugs*, $15.00 for preferred brand name drugs and $15.00 for non-preferred brand name drugs. Paired with Aetna QPOS Pat V and Premier plans. (See "Mail Order Services" on page 9 for more information).

- **Retail pharmacy** copayment for up to a 30-day supply is $15.00 for generic drugs*, $35.00 for preferred brand name drugs and $50.00 for non-preferred brand name drugs. Prescription out-of-pocket maximum $3,000/$6,000. Paired with Aetna Choice POS II Core plan.
- **Mail order** copayment for a 90-day supply of prescription drugs is $30.00 for generic drugs*, $70.00 for preferred brand name drugs and $100.00 for non-preferred brand name drugs. Paired with Aetna Choice POS II Core plan. (See "Mail Order Services" on page 9 for more information)

- **Retail pharmacy** copayment for up to a 30-day supply is $10.00 for generic drugs*, $35.00 for preferred brand name drugs and $50.00 for non-preferred brand name drugs.

$200.00 $400.00 deductible applicable to preferred and non-preferred brand name drugs. Paired with Aetna Choice POS II MVP plan.

- **Mail order** copayment for a 90-day supply of prescription drugs is $20.00 for generic drugs*, $70.00 for preferred brand name drugs and $100.00 for non-preferred brand name drugs (See "Mail Order Services" on page 9 for more information). Paired with Aetna Choice POS II MVP plan.

- **Retail pharmacy** copayment for up to a 90-day supply is 20% co-insurance payment of the retail price for generic drugs*, preferred brand name drugs and for non-preferred brand name drugs. Paired with Aetna Choice POS II HDHP Plan.
- **Mail order** copayment for a 90-day supply of prescription drugs is 20% of the mail order price for generic drugs*, preferred brand name drugs and for non-preferred brand name drugs (See "Mail Order Services" on page 9 for more information). Paired with Aetna Choice POS II HDHP Plans.

See page 12 for additional information about generic drugs.

PURCHASING YOUR PRESCRIPTION DRUGS AT A PHARMACY

To purchase a prescription drug at a retail pharmacy, present your identification card and prescription to the pharmacist. Prescription drug refills are also covered as long as the prescription is used within one year of the original prescription date, authorized by your physician, and permitted by law.

Participating pharmacies

If you use a participating pharmacy, you will pay the appropriate copayment for the purchase of up to a 34-day supply. Almost all New Jersey pharmacies have elected to participate with the Prescription Drug Plan offered through the Fund and administered by ESI. To identify a participating pharmacy in your area you may contact ESI, toll free, at 1-800-282-2881 or check on the Internet at: www.express-scripts.com. Once at the ESI home page, you will be prompted to "activate your account", click on that link and complete the registration information. Once registered you will have full access to the secure participant section of the ESI website.

When using a participating pharmacy, present your identification card and prescription(s). The pharmacist will complete all the necessary paperwork and process your prescription as written. The submission of a claim form is not required. You will be asked only to pay the appropriate copayment(s).

If you have forgotten your identification card, you may have to pay the full cost of the prescription drug to the pharmacist. However, you will still be entitled to the benefits of this plan. Simply obtain a detailed pharmacy receipt for each prescription and forward it along with a claim form to ESI for reimbursement. Your reimbursement will be based on the participating pharmacy allowance less your copayment (see "How to File a Claim for Reimbursement" below).

Non-participating pharmacies

A majority of New Jersey pharmacies as well as other pharmacies located throughout the United States participate with ESI. However, some pharmacies in New Jersey and in other states do not have agreements with ESI and do not accept ID cards from this Prescription Drug Plan. When using a non-participating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist. You then must file a claim for reimbursement with ESI.

Your reimbursement will be based on the participating pharmacy allowance for the cost of the medication less your copayment. **If the non-participating pharmacy charges more than the allowance for a participating pharmacy, you will not be reimbursed for the difference.**

How to File a Claim for Reimbursement

1. If you have to file a claim for reimbursement, obtain a detailed pharmacy receipt for each prescription which includes the:

- Patient's first and last name;
- Prescription number;
- Date the prescription was filled;
- Name, address, and NABP number of the pharmacy;
- National Drug Code number;
- Name and strength of the drug or NDC number;
- Quantity and form;
- Days of supply;
- "Dispense as written" or "Substituted for";
- Doctor's name and DEA number; and
- Cost of the prescription drug.

2. Obtain a *Prescription Reimbursement Claim Form* from the www.express-scripts.com website (see page 28), or by calling ESI Customer Service at 1-800-282-2881.

3. Send the completed *Prescription Reimbursement Claim Form*, along with your pharmacy receipt(s), to the address on the claim form.

Claims should be filed as soon as possible. The filing deadline is 1 year and 90-days following the end of the calendar year of the dispensing date. Information about claims or coverage can be obtained by calling ESI Customer Service at 1-800-282-2881**.**

MAIL ORDER SERVICES

The Mail Order Service is designed for participants taking medication on an ongoing basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any chronic health condition. All Mail Order Service prescriptions are filled by registered pharmacists who are

available for emergency consultations 24 hours a day, seven days a week by contacting ESI Customer Service at 1-800-282-2881.

How the Mail Order Service Works

Mail Order Service is designed for maintenance drugs that you take on a regular basis. When you order by mail, you get larger quantities of medication at one time up to a 90-day supply for only one mail-order copayment per prescription**.**

If you have an immediate need for your initial prescription, it is suggested that you ask your physician to provide you with two prescriptions, one for a 90-day supply of needed medications plus refills, the second for a 30-day supply of the medication. The 30-day prescription should be filled at your local pharmacy for your use while your mail order prescription is being processed.

Note: Certain prescription drugs, including drugs requiring special handling are not available through the mail order pharmacy and should be obtained from the Accredo Specialty Pharmacy or from a participating specialty pharmaceutical provider for infertility drugs (see page 7). Specialty drugs obtained from retail or specialty providers are subject to a copayment per 30-day supply of medication.

If this is the first time you are using the mail order service, you will need to complete the patient profile information on the back of the *Mail Service Order Form* with each family member's first order.

Your personal patient profile data will be stored and referenced each time a new prescription is processed to assure against drug reactions. Be sure to provide answers to all of the information requested.

A ESI *Mail Service Order Form* is required with your prescription. You may obtain a Mail Service Order Form from the ESI website: www.express-scripts.com or (see page 29), by calling ESI Customer Service at 1-800-4282-2881.

Mail your prescription along with your completed *Mail Service Order Form* and the appropriate copayment, to the address on the order form. You may pay by Visa®, MasterCard®, Discover®, American Express®, or by check or money order. Please do not send cash.

Your mail order prescription is reviewed by a pharmacist, dispensed by the pharmacist, and verified through the Mail Order Service Quality Control Department prior to mailing.

Your order will be processed and your medications will be sent to you in plain, tamper-evident packaging for security and confidentiality via First Class U.S. Mail, UPS®, or Federal Express®, along with reorder instructions and a postage paid envelope for future prescription drugs and/or refills. Express shipping is available for an additional charge.

Transfer an Existing Prescription

For a fast and easy way to use mail order, call ESI Customer Service at 1-800-282-2881. Tell the representative that you would like to transfer your prescription from your retail pharmacy to the Mail Order Service. Have your prescription drug container handy. You will need

information off the label along with your medical history and the prescribing physician's name and telephone number. Your Mail Order Service pharmacist will contact your doctor to authorize a new prescription on your behalf.

New Prescriptions Submitted by Phone from Your Doctor

You can ask your doctor to call ESI's Provider Line at 1-888-468-5539 to order a new prescription through the Mail Order Service.

Please note: *This phone number is for physicians only and is not to be used by patients.*

You may also ask your doctor to fax your new prescription directly to ESI at 1-800-636-9494. To obtain a *Physician's Fax Form* on behalf of your doctor, call ESI Customer Service at 1-800-282-2881. **ESI cannot accept faxes from members.**

New Prescriptions Submitted by Phone from the Member

You can request a new prescription — provided that you have obtained the actual prescription from your physician — over the phone, toll-free at 1-800-282-2881. Provide the Customer Care representative with the following information:

- Member ID number (on your prescription benefit card);
- Medication name;
- Prescribing doctor's name and phone number;
- Shipping address; and
- Credit card number and expiration date.

The representative will contact your doctor to complete the order.

Online Access

The Mail Order Service is available over the Internet at: www.express-scripts.com where you can:

- Refill your Mail Order Service prescriptions.
- Check the status of a refill order.
- Obtain Mail Order Service forms.

Obtaining Refills Through the Mail Order Service

To help ensure you never run short of your prescription medication, you should reorder when you have 14 days of medication left. The proper copayment amount will be billed to the credit card on file with ESI provided you designated the card to be billed on your prior order.

There are three ways to order refills:

By Telephone: Simply call ESI Customer Service at 1-800-282-2881, 24 hours a day, 7 days a week. Have your refill slip with your prescription information ready. Use the

simple voice instructions to enter your member ID number and the 7- digit prescription number of the medication that you are requesting. Your prescription medication will be sent to your home.

Over the Internet: If you have Internet access, you may refill your prescription online. Go to the ESI Web site at: www.express-scripts.com. Enter your login information (preregistration is required click on "activate your account") and you will then be linked to the secure participant website and be able to refill your prescription after you enter the prescription number of your medication. You will see a detailed summary of your order, including costs. Review the information and then click on the shopping cart next to the medication to refill your prescription.

By Mail: With your original prescription medication, you will receive a pre-addressed envelope and a notice showing the number of times it may be refilled. Mail this refill notice with your copayment to ESI in the envelope provided.

Note: Prescriptions for perishable drugs and those sensitive to heat and cold should be processed at a participating pharmacy nearest your home. If processed through the Mail Order Service or Accredo's Specialty Pharmacy, you will be advised prior to shipment of the mailing date to ensure someone is home to receive the delivery.

INFORMATION ABOUT GENERIC DRUGS

What are Generic Drugs?

In many instances, consumers have a choice between brand name drugs and generic drugs. A brand name drug is a medication manufactured by a drug company that has developed and patented the drug. After the drug patent expires, other manufacturers who can meet the FDA production standards may produce and market an equivalent product. These medications, known as generic drugs, are chemically and therapeutically equivalent to their brand name counterparts.

Substitution of drugs in New Jersey is regulated by law. The law stipulates that when a physician indicates "substitution permissible" or gives no indication at all on the prescription, the pharmacist must substitute a generic drug, unless otherwise advised by the patient or prescribing physician that substitution is not permissible.

Who Determines if a Participant can Receive Generic Drugs?

Your physician determines whether a brand name or generic product is dispensed to you. You can take full advantage of the cost savings offered by this Prescription Drug Plan by asking your physician to prescribe a generic drug or write a prescription which allows substitution of a generic drug whenever it is legally permissible.

If your physician writes a prescription that allows only for a brand name drug, the pharmacist will be required to dispense that drug, and you will be required to pay the appropriate higher copayment. If you are interested in taking advantage of the cost savings, be sure to inform

your physician of your preference for a generic substitute when he or she is prescribing medications for you and your family.

COVERAGE AND SERVICES PROVIDED BY THIS PRESCRIPTION DRUG PLAN

Your Prescription Drug Plan helps meet the cost of drugs prescribed for you and your covered dependents for use when you are not hospitalized or a patient at a medical facility, i.e. outside of hospitals, skilled nursing facilities, or other institutions. As required by Federal Law, covered drugs can be dispensed only upon a written prescription ordered by a physician.

The following are covered benefits, subject to applicable plan terms and conditions, unless listed as an exclusion:

- Federal legend drugs.
- Compounded medications.
- Over-the-counter equivalents.
- Diabetic Supplies.
- Oral and injectable contraception but excepting IUDs, diaphragms and contraceptive devices.
- Erectile Dysfunction.

Dispensing Limits

The maximum amount of a drug which is allowed to be dispensed per prescription or refill:

- Retail Pharmacy — up to a 30-day supply for one copayment or up to the greater of a 34-day supply or 100 units dependent upon the plan.
- Mail Order Service — up to a 90-day supply.

Prescription drugs obtained from a retail pharmacy are not eligible to be refilled until 75 percent of the last ordered and dispensed supply period has passed. (i.e. a refill for a 30-day supply will be honored after 23 days have passed.) In the case of mail order prescription drugs, they may be refilled after 60 percent of the last ordered and dispensed supply period has passed.

The Fund and ESI reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, and the Specialty Pharmacy Program, as described below, may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions currently apply to certain drugs.

Utilization Management

This Prescription Drug Plan includes various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use

of cost-effective drugs. Through these efforts, plan participants benefit by obtaining appropriate prescription drugs in a cost-effective manner. Among the programs utilized are the following.

• **Dispensing Quantity Limit** — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).
- **Step Therapy** — Step Therapy encourages the trial of less costly first-line prescription drugs before the use of more costly second line agents or other prescription drugs with no greater effectiveness. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.
- **Dose Optimization Program** — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.
- **Prior Authorization** — A mechanism to screen a drug class by specific criteria along with a patient's medical history to determine if the drug is covered under the plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the plan.
- **Member Utilization Management Program** — Pharmacy claims (along with supporting medical data) are evaluated on a periodic basis to identify, document, and correct or deter cases of excessive or abusive utilization. The program may also identify members who are candidates for case management.

Under certain circumstances, a pharmacy may not be able to determine at the point of sale, whether a prescription drug is covered. For example, the information on the prescription order may not be sufficient to determine medical necessity and appropriateness. In those circumstances, a member may elect to receive a 96-hour supply of the prescription drug, as a covered benefit, until the determination is made. Alternatively, the member may decide to purchase the prescription drug and submit a claim for benefits. If the claim is denied, no charge in excess of the charge for the 96-hour supply will be covered for that prescription drug or any refill(s) of it.

WHAT THE PRESCRIPTION DRUG PLAN DOES NOT COVER

The following services or supplies are not covered under this plan:

- Non-Federal Legend Drugs.
- State Restricted Drugs.
- Fertility Drugs (injectable forms).
- "Over-the-Counter" drugs or drugs that do not require a prescription written by a licensed practitioner.
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent, except insulin.
- Anorexiants (Diet Medication).
- Respiratory Therapy supplies, peak flow meters and ostomy supplies.
- Cosmetic only products (e.g. Renova, Avage) or hair growth agents.
- Coinsurance or copayments from another prescription plan.
- Coordination of benefits with prescription and medical plans.
- Serums, toxoids and vaccines unless covered vaccines under ACA guidelines
- Drugs dispensed or administered in an outpatient setting, including but not limited to, outpatient hospital facilities and physician offices.
- Drugs dispensed by or while confined in a hospital, skilled nursing facility, sanitarium, or similar facility.
- Infusion drugs and drugs that are administered intravenously (IV), except those that are self-administered subcutaneously or intramuscularly.
- Drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by another Drug or Medical Service for which no charge is made to the member.
- Drugs prescribed for experimental or investigational indications.
- Drugs supplied in Unit Dose packaging except when that is the only form distributed to pharmacies.
- Drugs dispensed by an unlicensed pharmacy.
- Prescription drugs which lack U.S. Food and Drug Administration (FDA) approval, or which are approved but prescribed for other than a FDA approved use, or in a dosage other than that approved by the FDA.
- Prescription drugs which do not meet medical necessity and appropriateness criteria.

- Professional charges in connection with administering, injecting, or dispensing of drugs.
- Prescription drugs to enhance normal functions such as growth hormones for anti- aging, steroids to improve athletic performance, or memory enhancing drugs.
- Prescription drugs used primarily for cosmetics purposes & cosmetics and health or beauty aids.
- Select classes of drugs where non-preferred medications that have therapeutic alternatives have shown no added benefit regarding efficacy or side effects over preferred drugs.
- Herbal, nutritional, and dietary supplements.
- Quantities in excess of dispensing limits.
- Early refills, i.e. a refill of a prescription drug at a retail pharmacy before 75 percent of the last ordered and dispensed supply period has passed (60 percent for mail order).

ENROLLING IN THE EMPLOYEE PRESCRIPTION DRUG PLAN

Levels of Coverage

You may enroll under one of the following levels of prescription drug coverage:

- **Single** — coverage for yourself only.
- **Member/Spouse or Partner*** — coverage for you and your spouse (or eligible "civil union partner"*) provided that the relationship is continuing and has not been terminated by divorce, (e.g. divorce from the bonds of matrimony or divorce from bed and board), legal separation, annulment or other similar proceeding.
- **Family** — coverage for you, your spouse or eligible "civil union partner"* and eligible children.
- **Parent and Child**(ren) — coverage for you and your eligible children (but not your spouse, if married, or a partner).

When you enroll in the Employee Prescription Drug Plan you will be mailed identification cards indicating your level of coverage.

When Coverage Begins

For all eligible employees, coverage for you and your eligible dependents generally begins on the same date as your health plan coverage. Please refer to Schedule A attached to your Health Benefit Plans Supplemental Summary Plan Description for additional eligibility, enrollment and coverage information (see your Employer for information on how to obtain a copy). If your Employer has elected to participate in this Employee Prescription Drug Plan at a later date than

when they first offered health benefits, coverage for you and your dependents will begin as of the date your Employer commenced participation in this Prescription Drug Plan.

Leave of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness.
- Approved leave of absence other than illness (see your employer for details).
- Family Leave Act (federal and State).
- Furlough.
- Workers' Compensation.
- Suspension (COBRA continuation only — see page 18).

While you are on an approved leave of absence, you may reduce your level of coverage (for financial reasons) for the duration of your leave and increase it again when you return from leave. For example, you can reduce "Family" coverage to either "Parent and Child" or "Single" coverage. Please note that it is necessary to complete a Schools Health Insurance Fund Prescription Benefits Application to decrease your coverage and also to reinstate it once you return to work.

Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence.

Note: When a leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of enrolling for benefits under the provisions of COBRA (see page 18).

When Coverage Ends

Coverage for you and your dependents will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- Your hours are reduced so you no longer qualify for coverage;
- You do not make required premium payments;
- You enter the Armed Forces and are eligible for government-sponsored health services;
- Your employer ceases to participate in the Fund; or
- The Fund is dissolved or discontinued.

Coverage for your dependents will end if:

- Your coverage ceases for any of the reasons listed above;
- You die (dependent coverage terminates the 1st day of the month following the date of death);

- Your dependent is no longer eligible for coverage (divorce of a spouse, legal separation, divorce from bed and board, annulment; dissolution of a civil union or domestic partnership; children turn age 26 unless the dependent child qualifies for continuance of coverage due to disability; or
- Your enrolled dependent enters the Armed Forces.

If your participation in this Prescription Drug Plan ends, you may be eligible to continue to participate in the Prescription Drug Plan for a limited period of time under the provisions of the federal COBRA law (see page 18).

You cannot convert Prescription Drug Plan participation to a private plan.

COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see "Duration of Coverage" on page 19), and the member must pay the full cost of the coverage plus an administrative fee. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA you may elect to enroll in any or all of the coverages that you had as an active employee or dependent (health, prescription drug, dental, and vision), and may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that were covered while an active employee, or delete dependents from coverage however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, civil union, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Effective for plan years beginning on and after January 1, 2014, a dependent child who would otherwise be eligible for coverage as a full-time student but is on a medically necessary leave of absence from a post-secondary educational institution may receive up to one year of continued coverage subject to the terms and conditions otherwise applicable to COBRA continuation coverage as set forth below.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the

U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. Also, other health insurance coverage options may be available to you through the Health Insurance Marketplace described on page 21. For more information about the Marketplace visit www.Healthcare.gov.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce (from the bonds of matrimony or from bed and board, or annulment), legal separation, dissolution of a civil union or same-sex domestic partnership (makes spouse or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because **of termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or same-sex domestic partnership,** or he or she becomes ineligible for continued group coverage because of **marriage, civil union, domestic partnership, attaining age 26**, or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse/partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the Fund and ESI within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- Notify your employer (even if you are retired) that a divorce, legal separation, dissolution of a civil union or same-sex domestic partnership, or your death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause. Beginning in 2014 plans will not be able to have pre-existing condition exclusions.)

- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you. As of January 2014, individual policies may not impose pre-existing condition exclusions.

- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you. In addition, you will be able to buy coverage through the Health Insurance Marketplace, also known as the Health Insurance Exchange (the "Marketplace"). In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments) right away and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan does not accept late enrollees, if you request enrollment within 30 days (a "special enrollment period"). Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;

- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the Fund; or
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

CLAIM APPEAL PROCEDURES

If you believe an error has been made in processing your prescription drug claim you may call ESI Customer Service at 1-800-282-2881, or write to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873

Please include the following information in your letter:

- Names and addresses of patient and employee;
- Your prescription drug plan identification number (on your prescription drug ID card);
- Your group number and group name as shown on your prescription drug ID card;
- Employer's name;
- Payment voucher number and date;
- Claim number, if available;
- Date the prescription was filled;
- Pharmacy's name;
- Name of the medication;
- Strength of the medication;
- Quantity prescribed;
- Prescription number;
- Amount billed; and
- Amount you paid.

If your drug claim has been denied and you think the claim should be reconsidered, appeals must be made within 12 months of the date you were first notified of the action being taken to deny your claim. When your appeal is received, the claim will be researched and reviewed. ESI will notify you in writing of the decision on your appeal within 60 days after the appeal is received. Special circumstances, such as delays by you or the provider in submitting necessary

information, may require an extension of this 60-day period. The decision on the review will include the specific reason(s) for the decision and refer to specific provisions of the plan on which the decision is based.

After you have exhausted the ESI internal appeal process, if still dissatisfied with the decision, you or your legal representative may appeal the decision, in writing, to the Fund.

If you are dissatisfied with the decision of ESI, you or your representative may appeal, in writing, ESI's decision to the Fund's Executive Committee and, at your written request, the appeal may be made with your identity revealed. Your identity will be revealed only upon your specific written request. A copy of this communication with your name shall be sent to the Fund's Program Manager.

a. You may appeal an adverse determination concerning a claim to the Executive Committee by forwarding a copy of the determination letter issued by ESI to the Fund's Program Manager, who shall place it on the agenda for a closed session discussion at the next regularly scheduled meeting of the Fund, unless the appeal is received seven (7) business days or fewer prior to the next meeting, in which case it shall be placed on the ensuing meeting agenda. Prior to distribution of any writing concerning the appeal, all personal references to you or your Employer shall be stricken, unless you specifically request in writing that the identities be revealed. The Fund's Program Manager shall review the claim and make a written recommendation to the Executive Committee prior to their deliberation regarding same. Whenever practical, the Executive Committee shall render its decision upon conclusion of the discussion at the appeal meeting, and if you are not present, provide you with written notice of the determination and the reasons therefore within five (5) business days.

b. If you are dissatisfied with the Executive Committee's determination, you may appeal the Executive Committee's determination to the independent appeal organization designated by the Fund annually for a non-binding determination pursuant to fair, informal procedures adopted from time to time.

c. If you are dissatisfied with the determination of the independent appeal agency, you may exercise any remedies provided by law.

HIPAA PRIVACY

This Prescription Drug Plan, the Fund and your Employer are required by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and New Jersey laws to maintain the privacy of any personal information relating to the physical or mental health of Participants. The Plan, the Fund and your Employer make every effort to safeguard the health information of Participants and to comply with the privacy provisions of HIPAA. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. This notice is effective as of January 1, 2022 and additional information about HIPAA can be found at www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html or contact your employer's privacy official listed in the Appendix to this document.

For purposes of this Section the following capitalized terms shall have the following meanings:

Authorization means an authorization by an individual that permits the Plan to use or disclose Protected Health Information that complies with the requirements of Federal medical privacy regulations.

HIPAA means the federal law identified as the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder, which requires certain non-federal governmental group health plans to implement certain provisions contained in HIPAA or notify its Participants of filings made by the group health plan to exempt itself from certain of the provisions of HIPAA as well as implement certain provisions to prevent the disclosure of Protected Health Information.

Plan Administration Functions means administration functions performed by ESI, the Fund and/or the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any of its other benefits or benefit plans.

Protected Health Information ("PHI") means individually identifiable health information of the Plan that is (i) transmitted by electronic media, (ii) maintained in any medium described as electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" does not include individually identifiable health information in education records covered by the Family Educational Right and Privacy Act.

Summary Health Information means information, that may be individually identifiable health information, and (i) that summarizes the claims history, claims expense, or type of claims experienced by individuals for whom the Employer has provided health benefits under a Group Health Plan; and (ii) which contains no information which could be used to individually identify the person to whom the health information pertains inclusive of any unique identifying number, characteristic, or code except a code or other means of de-identifying and re-identifying information permitted under HIPAA.

Use and Disclosure of Protected Health Information

The Plan is permitted to use and disclose PHI under certain specific circumstances such as to permit Participants to obtain treatment or payment for prescription benefits or to conduct the administrative activities needed to operate the Plan, in each case without your specific authorization. The Plan, except as specifically provided in this section or as authorized under a valid Authorization, shall restrict uses and disclosures of such information by the Employer consistent with the requirements set forth in this HIPAA Privacy Section. You may request a list (accounting) of the times we have shared your health information, to whom and why it was shared.

We can also share your health information to: prevent disease, help with product recalls, report adverse drug reactions, report suspected abuse, neglect or domestic violence, prevent or reduce a serious threat to anyone's health or safety, to foster health research or in order to comply with

state or federal laws, including sharing with Department of Health and Human Services, when requested.

We can share health information about you with organ procurement organizations and with a coroner, medical examiner, or funeral director when an individual dies.

We can share or use health information about you: for workers' compensation claims; for law enforcement purposes or with an official; with health oversight agencies for authorized purposes; for military, national security and presidential protective services and in response to a court or administrative order or in response to a subpoena.

Separation Between Administrator and Employer

Any employee or person who receives Protected Health Information relating to payment under, health care operation of, or other matters pertaining to the Plan in the ordinary course of business shall be restricted to the Plan Administration Functions that the Employer performs for the Plan.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference you can tell us to share information with your family, close friends, or others involved in payment for your care or to share information in a disaster relief situation. If you are unable to inform us of a preference, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We will never share your information for marketing purposes nor sell your information without your written consent.

Participant Rights

Participants in the Plan have the following rights with respect to Protected Health Information:

Right to Inspect & Copy. Subject to certain limitations, Participants have the right to inspect and/or obtain a copy of their health and claims records and other health information that we have which relates to you. You may ask us how to obtain a copy. We will provide a copy or summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Correct or Amend. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may refuse your request, but we must provide you with a written explanation of why we won't make the change within 60 days after the receipt of your request.

The Plan cannot amend demographic information, treatment records or any other information created by others. If Participants would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a Participant must contact the treating physician, facility, or other provider that created and/or maintains these records.

Right to an Accounting of Disclosures. Participants have the right to receive a list (accounting) of the times we have shared your health information during the six-year period prior to the date of your request. We will provide the Participant with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting. We will provide one accounting a year without charge but will charge a reasonable, cost-based fee, if you ask for another report within 12 months.

Right to Request Restrictions. A Participant has the right to request that the Plan place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Plan is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if the Plan does agree to a restriction, the consent will always be in writing and signed by the Privacy Officer. A Participant's request for restrictions must be in writing.

Right to Request Confidential Communications. You can ask us to contact you in a specific way (for example by phone at your home or office) or to send mail to a specific address or alternative location. We will consider all reasonable requests, and must consent if you tell us you would be in danger if we do not.

Copies. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose a Representative. If you have given someone a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Complaints. You can complain if you feel we have violated your rights by contacting us using the information on the back page of this document. See below for additional information.

Questions and Complaints

If you have questions or concerns, please contact your Employer's HIPAA Privacy Officer.

If Participants think the Plan may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Plan communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W.,

Washington, D.C. 20201 or call 1-800-368-1019 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or contact the privacy official listed in the Appendix. We will not retaliate against you for filing a complaint.

The Plan supports Participant rights to protect the privacy of PHI. It is your right to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this Plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A Certification of Coverage form, which verifies group health plan enrollment and termination dates, is available through the Employer's personnel office, should there be a termination of coverage

Nondiscrimination and Accessibility

The Fund and the Plan comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Nor do they exclude people or treat them differently because of race, color, national origin, age, disability, or sex. When necessary, free aids and services will be provided a permit people with disabilities to communicated effectively with us, such as qualified sign language interpreters, written information in large print, accessible electronic formats and other formats to facilitate reading and free language services such as qualified interpreters and translations of written text when your primary language is not English. If you need any of these services please contact your Employer's Human Resources or Benefits Manager. If you believe the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Program Manager at: PERMA c/o Conner Strong Companies, Inc., Triad Centre, 2 Cooper Street, Camden, NJ 08102, Telephone #: 856-552-4914; Fax #856-552-4919; e-mail: cbailey@connerstrong.com. If you need help filing a grievance Thomas W. Egan, Jr. is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 phone 1-800-368-1019; 800-537-7697(TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html..

APPENDIX

CONTACT INFORMATION

ADDRESSES

Express Scripts, Inc.	**Express Scripts, Inc.** **PO Box 390873, Bloomington, MN 55439-0873** **Web Address: www.express-scripts.com**
Accredo, Inc.:	**Express Scripts Specialty Pharmacy** **4865 Dixie Highway** **Fairfield, OH 45014**
Employer address:	**Cinnaminson Township Board of Education** **2195 Riverton Road** **Cinnaminson, NJ 08077** **Privacy Official: Thomas W. Egan, Jr.**
Program Manager:	**Conner Strong Companies, Inc.** **Triad Centre, 2 Cooper Street, Camden, NJ 08102** **Mailing address: P.O. Box 99106, Camden, NJ 08101**
Fund Mailing address:	**Schools Health Insurance Fund** **9 Campus Drive, Ste. 216, Parsippany, NJ 07054**

Telephone Numbers

Express Scripts Customer Service:	**1-800-282-2881**
Accredo Specialty Pharmacy	**1-800-803-2523**