EXPLANATION OF COVERAGE
FOR THE
MANAGED PHARMACY BENEFIT PROGRAM
OF THE
UNIVERSITY OF NOTRE DAME DU LAC
GROUP BENEFITS AND PLAN

JANUARY 1, 2015
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>3</td>
</tr>
<tr>
<td>PHARMACY BENEFITS</td>
<td>4</td>
</tr>
<tr>
<td>DEFINED TERMS</td>
<td>6</td>
</tr>
<tr>
<td>HOW TO SUBMIT A CLAIM</td>
<td>11</td>
</tr>
<tr>
<td>CLAIMS PROCEDURE</td>
<td>13</td>
</tr>
</tbody>
</table>
INTRODUCTION

This document is a description of the managed pharmacy benefit program that is part of your medical coverage under the University of Notre Dame du Lac Group Benefits Plan (the Plan). The managed pharmacy benefit program is designed to protect Plan Participants against certain catastrophic pharmacy expenses.

By enrolling in a University medical plan, the prescription drug benefit is offered through Express Scripts with their network of participating retail pharmacies and the Express Scripts Home Delivery Pharmacy Service.

Under this program, prescriptions are filled at a network pharmacy for a percentage of the drug cost. There are no claim forms to fill out. Over 90% of pharmacies nationwide belong to the network. There is also a home delivery service for maintenance medication.

Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy any waiting period and eligibility requirements of the Plan. The eligibility, waiting period and enrollment requirements for this prescription drug program are the same as those that apply to medical coverage under the Plan. The prescription drug program’s waiting period and eligibility requirements are explained in the Summary Plan Description for the Plan. The prescription drug program’s enrollment requirements are described in the Explanation of Coverage for the Plan’s medical benefits. Coverage remains in effect for eligible employees and their eligible dependents as long as medical coverage remains in effect.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to covered charges incurred before termination, amendment or elimination.

Effective January 2015 all out-of-pocket expenses (medical and prescription drug) incurred will be applied to the maximum out of pocket for the medical plans.

This document summarizes the Plan rights and benefits for covered employees and their dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.
How to Submit a Claim. Explains the rules for filing claims.

Claims Procedures. Explains the claims filing and appeals process.
SCHEDULE OF BENEFITS

Verification of Eligibility 1 800-711-0917

Call this number to verify eligibility for Plan benefits before the charge is incurred.

PHARMACY BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator’s determination that the prescription is Medically Necessary; that charges are Usual and Reasonable; and that the prescription is not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan has entered into an agreement with certain pharmacies, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-participating Provider is used. It is the Covered Person’s choice as to which Provider to use.

The prescription plan includes a formulary, which is a list of drugs that are considered preferred drugs. This list includes a wide selection of drugs and is preferred because it offers choice while keeping the cost of the drug benefit affordable. Each drug is approved by the Food and Drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and effectiveness.

Co-payments payable by Plan Participants

Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

<table>
<thead>
<tr>
<th></th>
<th>Participating Retail Pharmacy Up to a 30-day supply</th>
<th>Mail Service Up to a 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$5</td>
<td>$12</td>
</tr>
<tr>
<td>Brand formulary</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Brand non-formulary</td>
<td>$45</td>
<td>$90</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$100</td>
<td>$200*</td>
</tr>
</tbody>
</table>

* When clinically appropriate

Mail Service Requirement:

You may receive your first three refills for long-term or maintenance medications under the retail network service. Your fourth and future refills must be obtained through the mail service to avoid higher co-payments. Long-term or maintenance medications filled at retail after the first three refills will be subject to double the retail co-payments for up to a 30-day supply ($10 for generic, $60 for brand, or $90 for brand non-formulary).
PHARMACY BENEFITS

Pharmacy Benefits apply when Covered Charges are incurred by a Covered Person for prescriptions for an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the supply is furnished.

Covered Drugs: Federal Legend Drugs, State Restricted Drugs, Compounded Medications of which at least one ingredient is a legend drug, insulin, needles and syringes, OTC Diabetic Supplies, Inhaler assisted devices, Relenza, Tamiflu, Retin-A & Co brands through age 35 (cream form only), Legend Vitamins, Legend Smoking Deterrents (lifetime max 3 month supply with prior authorization).

Health Care Reform Preventive Drug List: The affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing (i.e., copayments) when they are delivered by a network provider. This includes the following:

- Aspirin for men aged 45 to 79 and women aged 55 to 79
- Fluoride for children aged 6 months to 5 years
- Folic Acid for women younger than 51 years of age
- Iron for children aged 6 to 12 months
- Smoking cessation for adults older than 18 years of age
- Vitamin D2 or D3 for men and women over 65 years of age
- Bowel preps for men and women between the ages of 50 and 75
- Breast cancer medications for primary prevention for women over 35 years of age

Quantity Level Limits: Drugs to treat Impotency for males only age 18 and over limited to 30 days or 8 units, whichever is lesser per claim.
Specialty Medications: Some conditions for complex disease states such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis are treated with specialty medications which are distributed via Express Script’s Special Care Pharmacy.

Step Therapy Requirement: Preferred PPI (Nexium) for gastroesophageal reflux disease (GERD)

Client Prior Authorization: Prior authorization is required for the following:

- Drug treatment for correction of existing pathologies of the reproductive system.

- For oral and injectable infertility drugs administered in conjunction with IUI or GIFT when the treatment assists normal reproductive processes to achieve pregnancy if the sperm is collected during normal sexual relations through the use of a perforated condom and if approved by the University after a review of the facts and circumstances.

- Legend Smoking Deterrents

Limitation:

No payment will be made for expenses incurred:

- For oral contraceptives or contraceptive devices, except when specifically requested by a physician based on medical necessity and for purposes other than contraception. Implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs.

- For oral and injectable infertility drugs administered in conjunction with in-vitro fertilization (IVF), PROST/ZIFT, ICSI, artificial insemination or any other treatment (other than IUI or GIFT) designed to replace normal reproductive processes to achieve pregnancy.

- For oral and injectable infertility drugs administered in conjunction with IUI or GIFT when the treatment replaces normal reproductive processes to achieve pregnancy because the sperm is not collected during normal sexual relations or if not approved by the University after a review of the facts and circumstances.

Traditional Prior Authorization: Gleevec, Tarceva

Exclusions: The following are excluded from coverage: Non-Federal Legend Drugs: Anti-Obesity Preparation, Topical Fluoroide Products, Contraceptive jellies, creams, foams, devices implants: Therapeutic devices or appliance Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®, Vaniqa®, Tri-Luma and Botox Cosmetic), Allergy Serums, Biologicals, Immunization agents or Vaccines; Blood or blood plasma products; Drugs labeled “Caution-limited by Federal law to investigational use; or experimental drugs, even though a charge is made to the individual, Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member; Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent
hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals; Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician’s original order; Charges for the administration or injection of any drug.

**Dispensing Limits:** Retail: The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30 day supply. Long term medications purchased at the retail pharmacy are subject to a higher copay after the third fill.

**UTILIZATION REVIEW**

Utilization review is a program designed to help insure that all Covered Persons receive appropriate drugs while avoiding unnecessary expenses

The program consists of:

(a) **Concurrent DUR** - proactively warns the dispensing pharmacist of potential drug issues. Online edits are also provided

(b) **Seniors DUR** - targets drugs that are commonly misused by seniors or mis-prescribed to them

(c) **Physician Profiling** - provides information on prescribing patterns of individual doctors and Informs doctors about their prescribing patterns

**DEFINED TERMS**

The following terms have special meanings and when used in this Plan will be capitalized. Active Employee is an Employee who has an appointment with the University.

**Allergy Serums** means extracts of biological substances that cause allergic reactions in sensitive individuals. These are used to desensitize the patient over time and primarily administered in the allergist's office (routine allergy shots).

**Anti-Obesity Medications** (Meridia®, Xenical®, Par-mine®, Adipost®) Bilogicals/Vaccines/Immunization Agents are non self-injectable products that are generally classifieds vaccinations and are covered under the medical plan.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Contraceptive devices** (diaphragms, IUDs) are birth control devices that prevent contraception through a barrier method.

**Contraceptives, Implantable** (Norplant) - Systemic contraceptives contain progestin only or a combination of estrogen and progestin. Systemic contraceptives inhibit ovulation or prevent a fertilized egg from being implanted and are used to prevent pregnancy. They may also be used to treat endometriosis and abnormal menstruation.
Contraceptives Emergency Kit (PREVEN, Plan B®) - the “morning-after” pills that are taken orally once.

Contraceptives, Injectable (Depo-Provera®) - This is a quarterly birth-control injection that is administered in a doctor's office.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health/pharmacy coverage, such as coverage under a group health/pharmacy plan (including COBRA continuation coverage), HMO membership, and individual health/pharmacy insurance policy. Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Dependent means a person who is a dependent of an Employee and who is eligible for coverage under the Plan.

Employee means a person who is an employee eligible for coverage under the Plan.

Employer is University of Notre Dame.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means an expense for a treatment, procedure, device or drug that meets one or more of the following:

• It is within research, investigational or experimental stage.

• It involves the use of a drug, substance or device that has not been approved by the United States FDA or has been labeled as “Caution: Limited by Federal Law to Investigational Use” or has not successfully completed Stage 3 clinical trials for the intended treatment or disease.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Federal Legend Drugs are all drugs regulated as prescription drugs by the FDA.

Fertility Medications (oral, injectible) are used to induce ovulation or to stimulate follicle development in patients undergoing Assisted Reproductive Technology (ART) (e.g., in-vitro fertilization).

Generic Prescription Drug or Medicine is a Prescription Drug which is not protected by trademark registration, but is produced and sold under chemical formulation name.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify
mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Gleevac™** is an oral cancer treatment for use in patients with chronic myeloid leukemia who have failed other treatments.

**Glucagon Emergency Kit** is used by diabetics whose blood sugar has fallen to a dangerously low level.

**Growth Hormones (Protropin®, Somatropin®, Humatrope®, Somatrem®)** are self-injectable medications used to treat AIDS wasting and growth failure.

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

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Inhaler Assisting Devices** - devices that help children and adults use their asthma inhalers more effectively.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Home Delivery Pharmacy** is an establishment where Prescription Drugs are legally dispensed by mail.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes, and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.
**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

**OTC Drugs** - drugs purchased over-the-counter that do not require a prescription and often are less expensive than a typical member co-payment.

**OTC Diabetic Supplies and Insulin** are necessary testing and administering supplies for people with diabetes. Diabetic supplies include: Alcohol Swabs, Lancets Only, Urine/Blood Test Strips and Tapes Only, Blood Glucose Testing Monitors Only, Insulin Syringes w/wo Needles, and Insulin.

**Pharmacy** is an establishment where Prescription Drugs are legally dispensed.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: “Caution: federal law prohibits dispensing without prescription”: injectible insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Self-Injectible Medications (Enbrel®, Sandostatin®, Neumega®, Heparin®)** are self-administered injectibles including those medications that are available in paranteral (injectible) form and considered suitable for patient self-administration.

**Sickness** is a person's Illness, disease or Pregnancy (including complications).

**Smoking Deterrents (Rx) Zyban®, Nasal** are products that control cigarette cravings on an as needed basis.

**Smoking Deterrents (OTC) Patches, Gum** - Transdermal patches provide continuous nicotine replacement through the skin.

**State Restricted Drugs** - some states require prescriptions for certain non-Federal Legend drugs.

**Step Therapy** is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.
**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Tarceva™** is an oral cancer treatment for use in patients with chronic pancreatic cancer and non-small cell lung cancer.

**Therapeutic Vitamins** are vitamins that are used to supplement important nutritional needs of certain populations. Some are also used to treat certain types of anemia.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the pharmacist and does not exceed the usual charge made by most pharmacists of like service in the same area. This test will consider the nature and severity of the condition being treated.

**Vaccines/Immunization Agents** are injections generally given in a clinic setting or doctor's office. The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.
HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Human Resources Office or the Plan Administrator.

(2) Complete the Member/Subscriber Information and Patient Information portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Pharmacy complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Group No.
- Member ID
- Member Name
- Street Address, City, State, ZIP
- Patient Name
- Patient Date of Birth (Month/Day/Year)
- Sex
- Relation to Plan member
- Name of Pharmacy
- Street Address, City, State, Zip
- Telephone
- Signature of Pharmacist (Optional)
- NABP Number
- Patient's Signature

Send the above to the Claims Administrator at this address:
Claims should be filed with the Claims Administrator within 90 days of the date of purchase. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(b) it's not reasonably possible to submit the claim in that time; and

(c) the claim is submitted by the end of the calendar year following that which the claim was incurred. This period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.
CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances.

“Days” means calendar days.

• Medical Prescription drug ID card should always be presented at the participating retail pharmacy

• Claims are only submitted when the member has paid a pharmacy full price for a prescription drug order because
  • The pharmacy does not accept member's Prescription Member ID card, or O Member has not received their Prescription Member ID card
  • A separate claim form must be completed for each pharmacy used and for each patient

• Receipts must be complete and contain:
  • Date prescription filled
  • Name and address of pharmacy
  • Doctor name or ID number
  • NDC number (Drug number)
  • Name of drug and strength
  • Quantity and days' supply
  • Prescription number (Rx number)
  • DAW (Dispense As Written)
  • Amount Paid

• Plan member must read acknowledgement carefully, sign and date the form.