EXPRESS SCRIPTS®

Nemours Prescription Drug Program

WELCOME

Thank you for choosing an Express Scripts prescription drug plan.

This booklet explains the benefits for the Nemours Foundation's covered fulltime and part time Associates and family members. Please read this booklet carefully and keep it handy. Use the *Table of Contents* to find topics. A list of terms is given in the back of the book.

This plan pays only "covered services." See the *Schedule of Benefits* for a list.

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in a group contract with your employer. Your employer holds a copy of the contract.

This booklet explains the benefits in effect as of January 1, 2025.

HINTS TO GET THE MOST FROM YOUR PRESCRIPTION DRUG PLAN

- Always show your ID card when you need care.
- Always follow Express Scripts Managed Care Guidelines.
- Read this booklet.
- Call us if you have any questions!

WHEN YOU HAVE QUESTIONS

Our Customer Service staff is ready to answer your questions. Here are reasons you may need to call us:

- asking about your prescription drug plan
- reporting a lost or stolen ID card
- ordering a new ID card
- asking about a claim

You may call, write, email or visit with your questions.

To Reach Us by Phone

1-844-394-2932

- To talk to a Customer Service Representative, call anytime – we are open 24 hours a day, 7 days a week.

To Reach Us by Letter

Write to:

Express Scripts Inc.
Attn: Corporate Quality
One Express Way
St. Louis, MO 63121

To Reach Us on the Internet

URL Address: www.express-scripts.com

TABLE OF CONTENTS

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

In this section, we describe how the plan works. Please read these rules carefully. Call us if you have any questions.

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive benefits, go to an In-Network pharmacy to fill your prescriptions. In-Network pharmacies are available online. You may sign into Express Scripts directly, or you may access our website from the homepage of your benefits website (www.nemoursbenefits.com). **If you fill a script at an Out-of-Network pharmacy, your prescription will not be covered.**

You must also follow Express Scripts Managed Care Guidelines to avoid penalties.

EXCEPTION FOR OUT-OF-NETWORK BENEFITS AT AN OVERNIGHT PHARMACY

An exception may be made for an out-of-network claim that must be filled at an overnight pharmacy if no overnight pharmacy is available in your area. The script may not be for a maintenance medication. To fill the script at an Out-of-Network pharmacy, you must pay out-of-pocket and then file a claim for reimbursement.

A GUIDE TO CLAIMS

Claims must be filed within 12 months from the time you fill a script. Claims filed beyond 12 months will not be paid.

HOW TO FILL A SCRIPT

In most cases, you will simply present your ID card to the participating pharmacist and pay the applicable copay or coinsurance.

You may also choose to use our convenient Mail Order Program. The Mail Order program is described later in this booklet.

If you take medication for a chronic condition, you may fill a script after 50% of your current prescription has been taken. For example, if you have a 30-day supply of a medication, you may fill your next script after 15 days have elapsed from the last time you filled a script.

HOW TO FILE CLAIMS

In most cases, claims are filed for you by your pharmacy.

Always be sure to show your Express Scripts ID card when you fill a script!

IF YOU NEED TO FILE A PAPER CLAIM

You may need to file a claim in the unlikely event that your enrollment in Express Scripts has not yet been processed.

To file a claim, you'll need a claim form. To obtain a form, call Customer Service. Let us know how many forms you need. We'll send your forms right away. Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

Attn: Claims Department
Express Scripts
PO Box 66773
St. Louis, MO 63166-6773

BENEFITS APPEAL

Here are the steps you need to follow if you disagree with how we processed a claim or a Prior Authorization:

HOW TO APPEAL A DECISION

Express Scripts members have the right to a full and fair review of all benefit and authorization denials. If you wish to appeal a decision, you may represent yourself or appoint someone else, including your physician or provider, to represent you. At any time during the appeal process, you may submit written comments, documents or other information relevant to the appeal. You may submit your appeal by writing or faxing to:

Express Scripts, Inc.
Attn: Pharmacy Appeals
6625 West 78th Street, Mail Route BL0390

Bloomington, MN 55439
Fax: 1-877-852-4070

If, however, the appeal involves urgent care and the member has not actually received the requested drug or supply before submission of the appeal, either the member, the member's authorized representative, or the member's physician may submit the urgent care appeal by calling: 1-800-887-1044.

Here's how the Express Scripts appeal process works:

EXPRESS SCRIPTS' APPEAL PROCESS

- To appeal an Express Scripts decision, contact Pharmacy Appeals within 180 calendar days from the date you received the benefit decision. There is no cost to you to appeal. Please explain why the claim was not paid correctly or why you believe the request for service was inappropriately denied and provide any additional information relevant to the decision.
- An appeals representative or qualified reviewer who did not participate in the initial decision will be appointed to conduct the review. A qualified physician reviewer will participate in all decisions involving issues of medical judgment.

POST-APPEAL OPTIONS

If your health plan is subject to the Employee Retirement Income Security Act (ERISA) and you have already completed the Express Scripts appeal process, you have the right to file a civil action under Section 502(A) of ERISA. To determine whether ERISA applies to your plan, please contact your employer or plan administrator.

If you would like more information on this process, please call the Express Scripts Prior Authorization Department at 1-800-417-8164.

SCHEDULE OF BENEFITS

The next pages describe what's covered under your Prescription Drug benefits. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your prescription drug plan.

Pharmacy Plan included in Red, Blue and White Medical Plans Applicable Programs: Generic Preferred, Drug Quantity Management, Prior Authorization, Step Therapy, SaveOnSP Copay Assistance & Accredo		
Drug Type	**Retail (34-day supply)**	**Smart90 Walgreens / Mail Order (90-day supply)****
ACA Preventive Medicines	$0.00	N/A
Non-Preventive Medicines		
Generic	$10.00	$25.00
Preferred Brand	20% coinsurance minimum $30, maximum $60	20% coinsurance minimum $75, maximum $150
Non-Preferred Brand	40% coinsurance minimum $60, maximum $120	40% coinsurance minimum $150, maximum $300
Specialty*	20% coinsurance minimum $100, maximum $200	N/A

*Specialty medications included on the SaveOnSP drug list may be filled through the SaveOnSP program at significant cost savings. Please note that manufacturer assistance for the drugs on the SaveOnSP list requires program enrollment and will not be used to satisfy the deductible and out-of-pocket maximum

Green Plan (High Deductible Plan) Applicable Programs: Generic Preferred, Drug Quantity Management, Prior Authorization, Step Therapy & Accredo		
Drug Type	**Retail (34-day supply)**	**Smart90 Walgreens / Mail Order (90-day supply)****
ACA Preventive Medicines	$0.00	N/A
Non-ACA Preventive Medicines Generics Preferred and Non-Preferred Brands	 $10.00 20% coinsurance, after deductible	 $25.00 20% coinsurance, after deductible
Non-Preventive Medicines:		
Generic	20% coinsurance, after deductible	20% coinsurance, after deductible
Preferred Brand	20% coinsurance, after deductible	20% coinsurance, after deductible
Non-Preferred Brand	20% coinsurance, after deductible	20% coinsurance, after deductible

Note: Copay assistance dollars for Specialty Rx will lower the medication cost. Please note the manufacturer copay assistance will not be used to satisfy the deductible and out- of-pocket maximum in the Green plan

Note: (**) Cost share for a 90-day supply of maintenance medications at Nemours Onsite Pharmacies is 2x the retail cost share.

Some prescription drugs have quantity limits set by the FDA. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.

There is no lifetime benefit maximum.

Preventive Drugs Covered at 100%

To comply with the Patient Protection and Affordable Care Act (ACA), the Prescription Benefit Plan covers certain drugs at 100%. A comprehensive list of the preventive medications covered at 100% as required under the ACA can be found on the Patient Protection and Affordable Care Act (PPACA) Preventative Drug List. Coverage of any medication requires a prescription from a licensed health care provider. Then you may proceed to use your prescription drug card to fill the script. This list is subject to change as ACA guidelines are updated or modified.

Special Preventive Drug Provisions for the Green Plan (HDHP)

If you are covered under the Green Plan, the Prescription Benefit Plan covers some additional preventive drugs that will be subject to a $10 copay if generic with the deductible waived or a 20% co-insurance after deductible if a preferred or non-preferred brand. A comprehensive list of the preventive medications covered for the Green Plan participants can be found on the **Standard Plus Preventative Drug List**. (Please note, that if you are covered under the Red Plan, these drugs are subject to regular generic, preferred and non-preferred cost sharing.)

OUT OF POCKET COSTS

In the *Schedule of Benefits*, we refer to copayments and coinsurance. These amounts are your share of payment. These terms are described below.

COPAYMENTS AND COINSURANCE

A copayment and or coinsurance is an amount you pay at the time you fill a prescription drug. After the copayment or coinsurance, a prescription drug is paid at 100%, unless the prescription drug is subject to the Generic Preferred Program.

Your copayment and or coinsurance will fall into the Generic, Preferred or Non-Preferred Tiers.

Generic: An FDA approved equivalent of a brand name drug. Generic drugs have been approved by the U.S. Food & Drug Administration (FDA) for quality and safety, and are absorbed into the bloodstream in the same manner as a brand name drug.

- Chemically Equivalent: have the same active ingredients, in the same quantities, as a Brand Name drug. The only differences are fillers and dyes.

- Therapeutically Equivalent: treat the same conditions as brand name drugs, but do not contain the same ingredients.

Preferred Brand: Members will pay a coinsurance for preferred brand name drugs which are drugs still protected by patents (meaning no chemically equivalent generic equivalent is available). The U.S. Food & Drug Administration (FDA) has approved these higher-cost drugs after trials show they are safe and effective. When a generic drug is introduced for a preferred brand name drug, the brand name will automatically move from Preferred Brand to Non-Preferred Brand. Check our carrier links regularly for updates.

Non-Preferred Brand: Members will pay the higher coinsurance (except Green plan) as applicable for non-preferred brand name drugs. These drugs may have been excluded because there are other, lower-cost brand name drug(s) that are just as effective, or because there is a chemically equivalent generic drug available.

A listing of the most common Preferred Brand list (otherwise known as a Formulary List) is available from Express Scripts, and on your benefits website and intranet.

Copayments and coinsurance should be paid at the time you fill a script.

GENERIC PREFERRED PROGRAM

If you fill a script for a brand name drug for which a *chemically equivalent* generic drug is available, you will be asked to pay the difference in cost between the generic and the brand name drug, in addition to the preferred or non-preferred copay or coinsurance. You will never be asked to pay more than the cost of the drug itself.

To ensure that you pay the lowest cost possible, ask your doctor to write "substitution allowed" on your script. This will allow the pharmacist to fill a script for a chemically equivalent generic, instead of a brand name, drug.

If your doctor writes "Dispense as Written"

- You may still request that the pharmacist fill the script with a generic drug rather than the brand name drug, but the pharmacist will first need to check with your doctor before filling the script as you request.

- If you fill a script for the brand name drug, you will still be required to pay the difference in cost between the generic and the brand name drug.

If you have a contraindication or other concern with taking a generic alternative in lieu of the chemically equivalent brand name drug, you may request that Express Scripts review your history. Express Scripts *may* provide you with a prior authorization to fill the brand name drug without requiring you to pay the difference in cost between the generic and brand name. To request this review, please ask your provider to contact the Express Scripts Prior Authorization Department at 1-800-417-8164.

Visit the Express-Scripts sponsored website www.drugdigest.org to determine if your brand name prescription drug has a chemically equivalent generic alternative. "Search" for the name of your brand name drug. Look for the heading "Generic Alternative." You may get a quote for your out-of-pocket costs either online or by calling Express-Scripts.

The difference in cost between the generic & brand name must be paid at the time you fill a script.

PRIOR AUTHORIZATION

Prior Authorization guidelines are administered by the Express Scripts Prior Authorization department. The Prior Authorization department helps you and your doctor make sure that prescriptions you receive are appropriate for your condition.

The Prior Authorization review is performed by Express Scripts. The criterion was developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with Express Scripts – which manages our pharmacy benefit plan – these experts review the most current research on thousands of drugs tested and approved by the U.S. Food & Drug Administration (FDA) as safe and effective. This criterion is consistent with the manufacturers' recommended guidelines.

The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. To find out whether a medication requires a coverage review, log in to www.express-scripts.com anytime.

Prior authorizations, when approved, are typically approved for a one-year period, unless otherwise noted.

To obtain a Prior Authorization for one of the above medications, you may ask your doctor to call Express Scripts Prior Authorization Department at the number listed below. Only your doctor (or sometimes a pharmacist who knows your history) can give Express Scripts the information needed to see if your drug can be covered.

Express Scripts' Prior Authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made right away. Your doctor or pharmacist will be asked questions about your specific condition. If the information provided meets our plan's requirements, you pay the plan's copayment or coinsurance at the pharmacy.

If your Prior Authorization is denied, you may still fill your script, but you will be responsible for the entire cost of the prescription.

Express Script's Physician Prior Authorization line is 800-417-8164.

Step Therapy Requirements

Step therapy is a program designed to help you save money by using the most cost-effective treatments if you have certain health conditions that require maintenance medications. It requires that you try a first line alternative ("Step 1"), often a generic medication, to treat your medical condition.

Then, based on your doctor's review, if necessary, you may be able to move to a preferred or non-preferred brand-name drug ("Step 2"). However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization as described in the "Prior Authorization" section fall into this step therapy program.

Please contact Express Scripts Member Services at 1-844-394-2932 or visit www.express-scripts.com for more specific information on the program.

CASE MANAGEMENT

When you need certain care, Aetna (your Case Management vendor) may choose to provide optional benefits not normally included under your plan. These optional benefits will replace or minimize the need for existing prescription drug plan benefits. Such benefits may include modification to copayments, coinsurance, or covered services. We work with you and your doctor when considering optional benefits.

APPEALS

You may disagree with a decision the Prior Authorization department makes. If so, you may file a written appeal with us. See the section, *Benefits Appeal*, for more information.

RETAIL PHARMACIES

Express Scripts has contracted with thousands of retail pharmacies, including most major drug stores. These retail pharmacies in the Express Scripts network are referred to as "participating pharmacies." To locate a participating pharmacy close to your home or other location, you can call Express Scripts Member Services at 1-844-394-2932 or check Express Scripts' website at www.Express-Scripts.com.

You can purchase up to a 30-day supply of a covered prescription at one time at any participating retail pharmacy or a 90-day supply at a Smart 90 Walgreens or Nemours Onsite Pharmacy.

MAIL ORDER / HOME DELIVERY

The convenient Mail Order / Home Delivery program through Express Scripts allows you to receive a 90-day supply of your maintenance medication for the cost of only a 75-day supply. Express Scripts will send your script directly to your home. Prescriptions are delivered to member's homes within 14 days from the time the prescription is mailed by the member. The Mail Order Pharmacy operates under the same laws as a retail pharmacy, with registered Pharmacists checking and confirming accuracy. This service is available for new and refill prescriptions.

INSTRUCTIONS FOR USING EXPRESS SCRIPTS MAIL ORDER

New Prescription

1. When visiting your physician ask for two prescriptions,
    a. One for a 30-day supply to be filled at your local pharmacy,
    b. One for a 90-day supply to be filled through Express Scripts mail service.
2. AFTER filling your 30-day supply at your local pharmacy, submit to Express Scripts your prescription for a 90-day supply plus refills (if applicable).
3. There are three methods to order a NEW prescription through the mail service:
    a. Your DOCTOR can phone in a prescription
    b. Your DOCTOR can fax in a prescription
    c. You can MAIL your prescription to Express Scripts using the mail service mailers
4. To MAIL your Prescription:
    a. Include your original prescription
    b. Fill out and print the Mail Service Profile available on the Express Scripts website.
    c. Include your payment. Your payment will be 2.5x what you paid at the retail pharmacy for your 30-day supply

Refill Prescription

For Refill prescriptions – Ordering a refill(s) can be accomplished by one of three methods:

1. Internet – www.express-scripts.com (there are separate instructions for ordering refills through the internet)
2. Phone – 1-844-394-2932
3. Mail – Use the refill form sent with your previous order in your mail service mailer (a new mail service mailer is included with every order).
   Within 14 days from the time the Mail Order prescription is sent to Express Scripts, your prescription will be delivered to your home.

You may also choose to set up an automatic refill of your prescription; if you do so, refills will be filled 34 days prior to running out of your last refill. You may contact Express Scripts by phone or via the internet to set up auto-refill.

MISCELLANEOUS

If Express Scripts does not have credit card on file for you, they will notify you if your order exceeds $150. If Express Scripts has a credit card on file for you, they will notify you if your order exceeds $500.

Prescriptions filled through Accredo are not eligible for the Mail Order Program.

ACCREDO PROGRAM

Your prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy. The Accredo Program is a Specialty Mail Order Pharmacy. If you or a covered dependent are taking a Specialty Medication, you should contact Accredo prior to your first fill. Your specialty medication fill will trigger the Accredo Program, and you will be proactively contacted by Express Scripts with instructions for enrolling in Accredo. Thereafter, your specialty medication must be filled through Accredo.

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Express Scripts defines specialty medications as injectable and non-injectable drugs having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability, and distribution
- Require specialized product handling and / or administrative requirements
- Cost in excess of $500 for a 30-day supply

Through the Accredo Program, you will be eligible to receive:

- Proactive Prescription Fulfillment
- Comprehensive Print Materials
- Ongoing Clinical Support
- Integrated Patient Education
- Side-Effect Management
- Disease-Specific Programs
- Continuing Coordination of Care
- Compliance Monitoring
- Support from Social Workers
- Financial Assistance

Effective January 1, 2023, you are no longer covered for specialty medications through your medical benefit. The list of medications subject to this program is available by calling the number on your prescription drug ID card. If you are currently using specialty medications affected by the program and you do not obtain them through Accredo, you will be required to transfer those prescriptions to Accredo. If you continue to purchase your medications from your doctor or another pharmacy, you will be responsible for their full cost. When you order a covered specialty medication through Accredo, your out-of-pocket cost will be limited to the applicable specialty copay mail-order cost share. If you are on a covered specialty medication through Accredo, Accredo may reach out to you and your provider to assist in the transition to Accredo pharmacy.

If you have an extenuating medical condition that prevents you from transitioning to the pharmacy benefit, you may be granted an override and continue on your medical benefit as long as there is a reviewed medical reason not to transition.

The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication.

COPAY ASSISTANCE PROGRAM

Nemours is partnering with Express Scripts' program, SaveOnSP, to help you save money on certain specialty medications. Specialty medications included on the SaveOnSP drug list may be filled through the SaveOnSP program. If your specialty medication is noted on the SaveOnSP Drug List, you must participate in the SaveOnSP program to receive your medications at no cost to you. Your prescriptions will be filled through approved specialty pharmacy.

If you do not participate in the SaveOnSP program, you will be responsible for the copay listed on the attached SaveOnSP Drug list.

The cost of these medications will not count towards your deductible or out-of-pocket maximums.

WHAT IS NOT COVERED

The following services and items are not covered.

- OTC (Over the Counter) Products, unless covered under the Preventive Medicines list
- Legend Homeopathic Medications
- DME (Durable Medical Equipment)
- Photo Age Skin Products
- Hair Growth Agents
- Yohimbine (Impotence)
- Fertility Medication
- Serums
- Toxoids
- Vaccines, unless covered under the Preventive Medicines list

COORDINATION OF BENEFITS

There is no Coordination of Benefits feature in your Prescription Drug Program.

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You, if you're a regular full or part-time Associate
- Your spouse
- Your children under 26

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Self** for you only
- **Self and Child(ren)** for you and your children (this coverage does not include your spouse)
- **Self and Spouse** for you and your spouse
- **Family** for you, your spouse and your children

CHILDREN

Dependent Children may be covered up to the age of 26. A dependent child is defined as a biological child **of an Associate**, an adopted child or a child placed for adoption **with an Associate**, a stepchild (defined as the child of your legal spouse), foster child (up to the age of 18 only), a legal ward, or a child for whom **an Associate** has a Qualified Medical Support Order.

- **Disabled Child:** must be certified as disabled when covered on the plan prior to the age of 26 AND must be primarily supported by Associate.
- **Foster Child:** May only be covered until the age of 18, AND must have a letter of placement

Nemours may require proof of dependency.

ENROLLMENT

ENROLLMENT DATE

Your enrollment date is the later of

- the date that falls within the first 30 days of your date of hire (if you're a full-time or regular part-time Associate), or
- the date you move to an Associate class that is eligible for health coverage (such as going from part-time to full-time Associate), or
- the date coverage begins if you're a Special Enrollee or a Late Enrollee.

HOW TO ENROLL

You may enroll yourself and your dependents by enrolling online (if within 30 days of your date of hire or change to an eligible status).

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You may decline coverage during the online enrollment process.

WHEN COVERAGE BEGINS

When your coverage begins is determined by

- when you are eligible for coverage, and
- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a

- Timely Enrollee, or
- Special Enrollee, or
- Late Enrollee

TIMELY ENROLLEES

Who Can Be a Timely Enrollee?

You are a Timely Enrollee if you enroll within 30 days of when the Associate is first eligible to be covered.

When Coverage Begins

Coverage for new Associates (and their dependents) begins on the first day of the month following or coinciding with the date of hire.

SPECIAL ENROLLEES

Who Can Be a Special Enrollee?

You are a Special Enrollee if you enroll within the 30-day enrollment period. The enrollment period is within 30 days of

- losing other health coverage under certain conditions, or
- obtaining a new dependent because of marriage, birth, adoption or placement in the home for adoption, or court ordered support.

Associates or dependents may qualify as Special Enrollees if the following requirements are met:

- *Associates*: if you're not already enrolled in this plan, you must
  - be eligible to enroll in this plan, and
  - enroll at the same time you enroll a dependent.

- *Spouses and Children*: you're a dependent of an Associate
  - who is already enrolled or is eligible to enroll in this plan, and
  - who enrolls at the same time you enroll.

If you don't enroll within the 30-day enrollment period, you are a Late Enrollee.

Loss of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the Associate or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this plan (such as at the last annual enrollment period), and

- when this plan was previously offered, you declined coverage under this plan because you had other coverage, and

- the other coverage was either:
  - COBRA continuation coverage that is exhausted, or
  - other (non-COBRA) coverage that was lost because
    you are no longer eligible, or
    the employer stopped contributing, and
    you enrolled within 30 days of the date
      COBRA continuation coverage is exhausted, or
      the other (non-COBRA) coverage was lost because
        - you lost eligibility, or
        - the employer stopped contributing, and

- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

New Dependents

You (Associate or dependent) are a Special Enrollee if the Associate gets a new dependent because of

- marriage, or
- adoption, or
- legal guardianship, or
- placement of a child in the home for adoption, or
- court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows if we receive the application and premium before the end of the 30-day enrollment period.

- *Associates*: the first day of the month after you enroll
- *Spouses*: the first day of the month after you enroll
- *Children*: either
  - the date of birth of birth, or the date of adoption or placement in the home for adoption; or
  - the first day of the month after you enroll if
    you lost coverage under a prior plan, or
      - your parent got married.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be a Late Enrollee?

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an annual enrollment period.

Spouses and children are Late Enrollees if they were not enrolled within 30 days of

- marriage, or marriage of the parent, or
- birth
- adoption, or
- placement in the home for adoption.

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

CHANGES IN ENROLLMENT

You can change your enrollment because of one of the reasons described below.

MARRIAGE

You may add your spouse when you get married. You must enroll within 30 days after the marriage. If added premium is due, you must pay when you enroll. If you enroll within the 30-day period, your spouse will be a Special Enrollee. If you don't enroll within the 30-day period, your spouse will be a Late Enrollee.

NEWBORNS

You may add your newborn child. Hospital nursery care is covered for infants when the mother is having hospital obstetrical care. If a sick baby must stay in the hospital, the baby remains covered if:

- You have *Individual and Child(ren)* or *Family* coverage. You must enroll within 30 days of the child's birth.

- You have *Individual* coverage that doesn't cover dependent children and you enroll for *Individual and Child(ren)* or *Family* coverage. You must enroll within 30 days of the child's birth by completing the Life Event enrollment on the benefits portal. If added premium is due, you must pay it when you enroll.

If you enroll within the 30-day period, the newborn will be a Special Enrollee. If you don't enroll within the 30-day period, the child will be a Late Enrollee.

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption. You must enroll within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't enroll within the 30-day period, the child will be a Late Enrollee. To enroll the child, complete the Life Event enrollment on the benefits portal.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a stepchild. The child must be enrolled within 30 days of the date the child became eligible in order to be a Special Enrollee. If you don't enroll within the 30-day period, the child will be a Late Enrollee. To enroll the child, complete the Life Event enrollment on the benefits portal.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may enroll in this plan within 30 days. If you enroll within the 30-day period, you will be a Special Enrollee. If you don't enroll within the 30-day period, you will be a Late Enrollee.

MEDICARE ELIGIBILITY

At age 65 you become eligible for Medicare. Medicare is a health insurance program administered by the federal government. If you are still working you may choose to either

- Continue your coverage under the Nemours Foundation plan, but you may also enroll in Medicare. Medicare will be secondary and pay benefits after benefits are paid under this plan.
- Enroll in Medicare as your primary coverage instead. You will then no longer be eligible for benefits under the Nemours plan.

WHEN COVERAGE ENDS

Under COBRA, you may extend coverage after you lose coverage under this plan. Please read the section, *Continuing you Coverage Under COBRA*, to see how you may extend your coverage. You are eligible to receive a *Certificate of Coverage* after you lose coverage under COBRA.

Coverage ends the last day of the month in which you lose eligibility because of one of the events below:

DIVORCE

Former spouses are not covered. You must complete a Life Event enrollment on the benefits portal with 30 days of the date the divorce is final. Your spouse's coverage under this plan ends at the end of the month in which the divorce is finalized.

LEAVE YOUR JOB

Coverage ends at the end of the month in which you leave your job.

DEATH

Coverage ends for your dependents at the end of the month in which you die.

CHANGE IN YOUR JOB STATUS

Coverage ends at the end of the month in which you are no longer eligible through your job. This might happen if you begin to work fewer hours, etc.

CHANGE IN CHILD'S STATUS

Your child's coverage ends the earlier of:

- The end of the month in which the child reaches age 26

THE PLAN IS CANCELLED

Coverage ends the day your employer's contract with Express Scripts ends.

GENERAL CONDITIONS

RELEASING NEEDED RECORDS

Your providers have information about you that we need to apply benefits. When you applied for coverage, you agreed to let providers give us information we need. This includes the diagnosis and history of your care. This applies to any condition or symptom you had or for which you sought care. It may also include other information. We'll keep these records private as allowed by law.

When you applied for coverage, you authorized us to share records of your health when needed. We'll only share your records to apply your benefits. We may share your records with:

- a medical review board
- a utilization review board or company
- any other health benefit plan
- any other insurance company

If the records relate to fraud or other illegal act, we may disclose them to legal authorities. We may also use them in legal actions.

We may charge a fee for making copies of claim records.

TIME LIMITS

Claims must be filed within 12 months after you receive care. We won't pay claims filed past the 12-month limit.

DENIAL OF LIABILITY

We're not responsible for the quality of care you receive from a pharmacist. Your coverage doesn't give you any claim, right or cause of action against us based on care by a provider.

NON-ASSIGNABILITY

Any right you have to care is personal and cannot be assigned. Any right you have to payments is personal. Your payment rights cannot be assigned without our written approval.

SUBROGATION

Subrogation applies when:

- you have a right of recovery against a party (a person or organization), and
- your right of recovery is based on a legal claim, and
- the legal action involves a medical cost we paid.

When this happens, we are **subrogated** to your rights of recovery from that party. This applies whether or not you assert your claim. This means we are entitled to receive payment from that party.

You are required to assist us. This includes filling out and giving us any needed documents we request. You cannot settle or compromise your claim for medical costs without our written consent. We may cancel your coverage if you don't comply.

LEGAL ACTION

There is a 2-year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

POLICIES AND PROCEDURES

To make sure this plan functions as it should, we may adopt any reasonable:

- policies,
- procedures,
- rules, and
- interpretations.

You agree to abide by these rules. If you don't, we may cancel your coverage.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

- Statements you made were untrue or not complete. This applies to when you applied and after you applied.
- You received or tried to receive benefits under this plan through misrepresentation, fraud or other intentional misconduct.
- You helped someone else in either of the acts as noted above.

PLAN AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to terminate the plan at any time. Any covered claims or expenses that were incurred prior to the termination of the plan shall be covered to the extent provided in the plan. Any claims or expenses incurred after the plan is terminated are covered as specified in "Benefits After Your Coverage Ends" in the section, *A Guide to Enrollment Information.* The Plan Sponsor also reserves the right to suspend, withdraw, amend, or change the plan in whole or in part at any time. For example, this means that copayments, coinsurance, deductibles, or limits may change; the services or procedures covered or excluded may change; or the In-Network and Out-of-Network procedures or providers may change. Any covered claims or expenses that were incurred prior to such suspension, withdrawal, amendment or change shall be covered to the extent provided in the plan. Any claims or expenses that were incurred after such suspension, withdrawal, amendment or change and are not covered by the plan as changed, shall not be covered.

The company reserves the right, in its sole discretion, to terminate the plan or amend the plan in any manner, in whole or in part, at any time. The company's right to amend the plan shall include, without limitation, the right to eliminate or revise the availability of any benefit provided under the plan, to revise eligibility requirements, to increase the amounts required to be paid or contributed by retirees, or to decrease benefits payable under the plan. Any such amendment or termination may be made by written instrument signed by the company. Unless otherwise specified, an amendment to or termination of the plan shall apply to individuals who are participants under the plan at the time of the amendment or termination, as well as to future plan participants, and shall apply to all events occurring after the effective date of the amendment or termination.

CONTINUING YOUR COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments, the Nemours Foundation (the "company") is required to offer Associates and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the company health plan would otherwise end. This section is intended to inform you of your rights and obligations under COBRA.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; your coverage may be terminated retroactively if you are later discovered ineligible. However, under COBRA, you have to pay all (up to 102% initially and 150% in some cases) or part of the premium for your continuation coverage. There is a grace period of 30 days for the regularly scheduled premium.

If you are an Associate of the company covered by the company health plan, you have the right to choose this continuation coverage if you lose group health coverage under the company health plan for any of the following reasons:

- the death of your spouse;
- a termination of your spouse's employment (for reasons other than gross misconduct) or reduction of your spouse's hours of employment;
- divorce or legal separation from your spouse; or
- your spouse becomes entitled to Medicare.

In the case of a dependent child of an individual covered by the company health plan, including a newborn infant or a newly adopted child, the dependent has the right to continuation coverage if group health coverage under the company health plan is lost for any of the following five reasons:

- the death of a parent;
- the termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the company;
- parent's divorce or legal separation;
- a parent becomes entitled to Medicare; or
- the dependent ceases to be a "dependent child" under the company health plan.

Under COBRA, the Associate or a family member has the responsibility to inform the company of a divorce, legal separation, or a child losing dependent status within 60 days of the later of the date of the event or the date on which coverage would be lost because of the event. Rights similar to those described above may apply to retirees, spouses and dependents if the employer commences a bankruptcy proceeding and these individuals lose coverage.

When the company is notified that one of these events has happened, the company will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have 60 days from the later of the date coverage ends or the date the COBRA qualifying event notice is given to complete and return the election form to the company indicating you want COBRA coverage. If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, the Company is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Associates or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

The 18-month period may be extended to 36 months if other events (for example, divorce, legal separation, or death) occur during that 18-month period. In no event will COBRA coverage last beyond 36 months from the date of the event that originally made you eligible for coverage.

In addition, the 18-month period may be extended to 29 months under the following circumstances: (i) COBRA coverage arose because of your termination of employment or the termination of your family member's employment, (ii) you or a family member is determined to have been disabled (for Social Security disability purposes) at any time during the first 60 days of the 18-month coverage period, and (iii) you or a family member notifies the company of the disability determination within 60 days of the date on which the Social Security Administration makes its determination and before the end of the 18-month coverage period. The company must also be notified within 30 days of any final determination that you or your family member is no longer disabled. During this 11-month extension period, you must pay 150% of the premium.

However, COBRA also provides that your continuation coverage may cease for any of the following five reasons:

- the company no longer sponsors any Associate health plan;
- the premium for your continuation coverage is not paid on time;
- you become covered under another group health plan that does not contain any exclusion or limitation for any preexisting condition you may have;
- you become entitled to Medicare; or
- for the 11-month extension in the case of disability, if it is determined that you or your family member is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits. If you become covered by another group health plan and that plan contains a preexisting condition limitation, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the company may terminate your COBRA coverage.

If you have any questions or need to notify the Plan of an event, please contact your company's COBRA Administrator bswift at 866-365-2413.

ERISA INFORMATION

As a participant in the Nemours Foundation health care plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

THE ERISA PLAN ADMINISTRATOR AND PLAN SPONSOR

The plan is administered through the Nemours Foundation, 10140 Centurion Parkway North Jacksonville, FL 32256. You may get information about the plan from your Operating Division's Human Resources Department.

AGENT FOR SERVICE OF LEGAL PROCESS

You may have a dispute under the ERISA Plan. Service of legal process is made upon the ERISA Plan Administrator. This is done through Human Resources of the above address.

TYPE OF PLAN

The ERISA Plan is a welfare benefit plan, funded through a predetermined withholding of the Associate portion on a monthly basis, which is combined with a predetermined Foundation portion. Monthly payment to Express Scripts is made upon receipt of invoices for fixed fees and actual claims.

TYPE OF ADMINISTRATION

The Plan is administered through a group contract issued by Express Scripts.

PLAN ID NUMBERS

The following are the plan ID numbers. The numbers are filed with the Federal government.

Employer Identification Number: 59-0634433
Plan Number: 513

ERISA RIGHTS

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administration may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for

such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Associate benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Questions

If you have any questions about the Plan:

- contact the ERISA Plan Administrator

If you have questions about this statement or your ERISA rights, you can either:

- contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (the address and phone are listed in your phone book), or contact the following:

Division of Technical Assistance & Inquiries
Room N-5625
200 Constitution Ave., N.W.
Washington, DC 20210
Phone: (202) 219-8776

DEFINITIONS

Annual Enrollment Period: The time when you may make changes to your coverage.

Copayment/Coinsurance: The amount you pay at the time of service.

Doctor or Physician: A licensed physician, osteopath, podiatrist, chiropractor, or dentist. Such a provider must be acting within the scope of his or her license.

Medically Necessary: Care, required to identify or treat a condition, which is:

- consistent with the symptoms or treatment of the condition
- meets the standards of accepted practice
- not solely for anyone's convenience
- the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.

Prescription Drugs: Drugs which are:

- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary
- approved by the Food & Drug Administration

Provider: The organization or person giving care, supplies or drugs.

We, Us or Our: Refers to Express Scripts.

You and Your: Refers to the Associate or any of the Associate's eligible dependents enrolled in this plan.