A Guide to Your Benefits and Enrollment

New Mexico Institute of Mining & Technology

MERITAIN™ HEALTH

An Aetna Company

Bring Healthy Balance Back to Your Life

Finding your perfect balance

At Meritain Health, we know how important it is for you to understand how your benefits work.

That's why this packet contains:

Useful information about your benefits plan.

Everything you need to choose the best options for you and your family.

Instructions on how to enroll, and to begin using your new benefits.

Why do we feel this is important? Because, let's face it, living today can be larger than life. Getting through the day at top speed is a sign of our hurry-up, drive-through times. Many people put themselves at the bottom of their *to-do* lists, giving everything else the best of their energy.

In this way, life gets out of balance. Most of us can keep juggling it all until one day health and well-being begin to pay the price.

Take a deep breath, step back and see the big picture. Help yourself. Put that life on pause for a few minutes, and take the time to read this packet. You'll see that your employer provides tools, resources and benefits to help you regain your best life and make smart healthcare decisions.

We want to help you get the most from your benefits—so you can live a life that's balanced and informed.

A balanced life means a healthier you.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (575) 835-5643. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $1,000 person / $2,000 family For non-participating providers: $2,000 person / $4,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For participating providers: Preventive care (all providers), diagnostic tests, emergency medical transportation (ground), emergency room care, urgent care (all providers), office visits, outpatient mental health and prenatal/postnatal services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 individual /Up to 2 deductibles (family) for dental coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers: $3,000 person / $6,000 family (medical deductible, medical copays and coinsurance) For non-participating providers: $6,000 person / $12,000 family (medical deductible, medical copays and coinsurance) For prescription drugs: $3,000 person / $6,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalty amounts, dental and vision benefits other than those paid under the medical plan, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	$50 copay/visit	40% coinsurance	
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/visit	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay (30-day retail)/ $20 copay (90-day mail order)/$30 copay (90-day retail)	$10 copay (30-day retail)/ $30 copay (90-day retail)	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (for mail order prescription and maintenance medications), 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Mandatory generic provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. There is no charge for diabetic supplies purchased through the Diabetic Sense Diabetes Management Program.
	Formulary drugs	$30 copay (30-day retail)/ $60 copay (90-day mail order)/$90 copay (90-day retail)	$30 copay (30-day retail)/ $90 copay (90-day retail)	
	Non-Formulary drugs	$60 copay (30-day retail)/ $120 copay (90-day mail order)/$180 copay (90-day retail)	$60 copay (30-day retail)/ $180 copay (90-day retail)	
	Specialty drugs	20% copay up to a maximum of $400 per prescription	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	Non-participating providers paid at the participating provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	$200 copay/trip (ground) /20% coinsurance (air)/20% coinsurance (non-emergency services)	40% coinsurance	----------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit (outpatient mental health)/ Not Covered (substance use disorders)	40% coinsurance (outpatient mental health)/ Not Covered (substance use disorders)	Substance use disorders are not covered.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If you are pregnant	Office visits	No Charge (prenatal)/$30 copay/visit (postnatal)	0% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense;
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per year. Preauthorization recommended. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, speech & occupational therapy limited to 52 visits per each type of therapy per year.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization recommended.
	Hospice services	20% coinsurance	40% coinsurance	Limited to a lifetime maximum of 6 months. Bereavement counseling is covered. Preauthorization required for inpatient. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to 1 exam per calendar year. Dollar maximums do not apply to children under age 19.
	Children's glasses	No Charge	No Charge	
	Children's dental check-up	No Charge	No Charge	Limited to 2 check-ups per year. Dollar maximums do not apply to children under age 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Habilitation services • Long-term care	• Routine foot care (except for metabolic or peripheral vascular disease) • Substance use disorders

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery (for the treatment of morbid obesity only) • Chiropractic care	• Dental care (Adult & Child) • Glasses (Adult & Child) • Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult & Child) • Weight loss programs (when medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov, or New Mexico Institute of Mining & Technology at (575) 835-5643. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact New Mexico Institute of Mining & Technology at (575) 835-5643 or Meritain at (800) 925-2272.

Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Public Regulation Commission, Consumer Relations Division at (855) 857-0972 or (888) 427-5772.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Primary care physician coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$610
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,495

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,520
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,921

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) copayment	$200
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$256
Copayments	$750
Coinsurance	$64
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,070

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $1,500 person / $3,000 family For non-participating providers: $3,000 person / $6,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For participating providers: Preventive care (all providers), diagnostic tests, emergency medical transportation (ground), emergency room care, urgent care (all providers), office visits, outpatient mental health and prenatal/postnatal services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 individual /Up to 2 deductibles (family) for dental coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers: $3,500 person / $7,000 family (medical deductible, medical copays and coinsurance) For non-participating providers: $7,000 person / $14,000 family (medical deductible, medical copays and coinsurance) For prescription drugs: $3,000 person / $6,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalty amounts, dental and vision benefits other than those paid under the medical plan, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	$50 copay/visit	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/visit	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay (30-day retail)/ $20 copay (90-day mail order)/$30 copay (90-day retail)	$10 copay (30-day retail)/ $30 copay (90-day retail)	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (for mail order prescription and maintenance medications), 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Mandatory generic provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. There is no charge for diabetic supplies purchased through the Diabetic Sense Diabetes Management Program.
	Formulary drugs	$30 copay (30-day retail)/ $60 copay (90-day mail order)/$90 copay (90-day retail)	$30 copay (30-day retail)/ $90 copay (90-day retail)	
	Non-Formulary drugs	$60 copay (30-day retail)/ $120 copay (90-day mail order)/$180 copay (90-day retail)	$60 copay (30-day retail)/ $180 copay (90-day retail)	
	Specialty drugs	20% copay up to a maximum of $400 per prescription	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	Non-participating providers paid at the participating provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	$200 copay/trip (ground) /20% coinsurance (air)/20% coinsurance (non-emergency services)	40% coinsurance	----------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit (outpatient mental health)/ Not Covered (substance use disorders)	40% coinsurance (outpatient mental health)/ Not Covered (substance use disorders)	Substance use disorders are not covered.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If you are pregnant	Office visits	No Charge (prenatal)/$30 copay/visit (postnatal)	0% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per year. Preauthorization recommended. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, speech & occupational therapy limited to 52 visits per each type of therapy per year.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization recommended.
	Hospice services	20% coinsurance	40% coinsurance	Limited to a lifetime maximum of 6 months. Bereavement counseling is covered. Preauthorization required for inpatient. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to 1 exam per calendar year. Dollar maximums do not apply to children under age 19.
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery (for the treatment of morbid obesity only) • Chiropractic care	• Dental care (Adult & Child) • Glasses (Adult & Child) • Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult & Child) • Weight loss programs (for the treatment of morbid obesity only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov, or New Mexico Institute of Mining & Technology at (575) 835-5643. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

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Primary care physician coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$610
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,995

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,382
Copayments	$1,520
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$3,303

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) copayment	$200
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

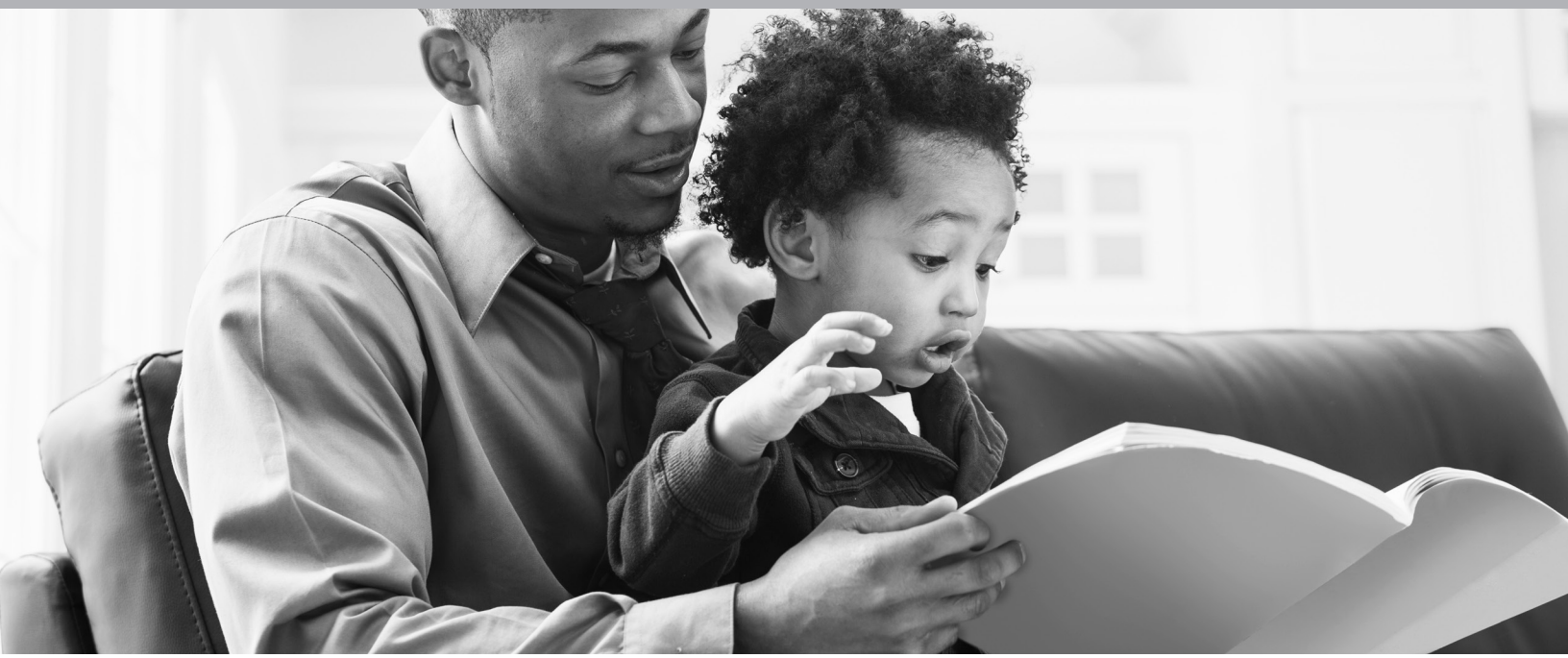
Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$256
Copayments	$750
Coinsurance	$64
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,070

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

What's Inside?



In this packet, you'll learn more about the following

Preventive care

- Annual exams and check-ups
- Well-child care
- Immunizations and screenings

Healthcare benefits when you're sick

- Inpatient and outpatient care
- Home healthcare
- Rehabilitation services
- Doctor visits and prescription drugs with reasonable copays
- Mail order and online prescription options
- A large and convenient provider network
- Dental care
- Vision care

Support when you need it

- **www.meritain.com**—access easy-to-use decision support tools that help you weigh your care options, and provide cost and quality information.

No Surprises, Just Information

In this section

- Health benefits for your family
- Enrolling at a later date
- Special enrollment situations
- If your spouse already has coverage

How healthcare reform affects your plan

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as healthcare reform, includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing. Be sure to review the important information about the ACA that is included throughout this kit.

Questions regarding how healthcare reform affects your plan can be directed to Meritain Health at **1.800.925.2272**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1.866.444.3272** or online at **www.dol.gov/ebsa/healthreform**.

Important things to know about eligibility

Health plans are put together carefully to provide the best benefits possible for participants. Meritain Health knows how important it is for healthcare consumers like you to really understand how your plan works. In this way, you can make the changes you want in your health and in your life. The next section of this packet describes some of the most important provisions of your benefits. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed, with no surprises.

Healthy balance for your family, too

Your family members can reap the rewards of the plan, too. Healthcare benefits are available for every eligible dependent. It's a great way to help your family members find the right balance between life's "roller-coaster ride" and their best health. Be sure your family knows about the opportunities open to them—share this packet and other materials you receive from the plan!

Your eligible dependents

This benefit plan is open to you and your eligible dependents. An eligible dependent is:

- Your spouse (as defined in your plan documents).
- Your children, natural or adopted.
- Stepchildren.
- Children who have been placed with you for adoption.
- Children for whom you are the legal guardian.

ACA note: Dependent coverage is available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee's biological, step, foster or adopted child (including a child placed for adoption) until such child reaches age 26.

Please refer to your summary plan description for specific requirements.

Family members covered by a different plan

If you have a family member covered by a different plan:

- You can enroll yourself and your eligible dependents in this plan.
- You can enroll yourself in this plan, but decline benefits for some or all dependent(s).
- You can decline benefits for your whole family.

When your dependents are not eligible for benefits under your plan

Tell your employer if:

- You become divorced or are legally separated from a spouse who was covered under this plan.
- A dependent child ceases to meet the terms of the plan.

To enroll the dependent for COBRA—a special limited-time plan for continuing benefits at your own expense—you must notify your employer within 60 days of that person's change in dependent status.

When you have benefits from two group plans

If you or one of your dependents have benefits under both this plan and another plan, the two plans will coordinate your benefits. One plan will be considered the primary plan (or first payer) and the other will be the secondary plan (pays only after the first plan has paid).

Generally, Meritain Health uses a birthday rule to decide which of the two plans would be the primary plan.

The birthday rule

If both parents provide benefits for a child, then the primary plan is the one from the parent whose birthday comes first in the year.

So, if one parent's birthday is January 12 and the other parent's is April 1, the primary payer will be the plan from the parent whose birthday comes first—January 12. In the unusual case that both parents have the same birthday, the plan of the parent who has provided benefits longest for the child will be primary.

If you say "no" to this plan now

You can refuse the benefits of this plan, but be sure you've looked at the pluses and minuses of that decision. Important: If you don't enroll now, you'll have to wait for your employer to offer an open enrollment period.

If you lose other group benefits that you or your dependents might have, and it's not your fault (for example, the covered person is laid off or let go from a job) you'll be able to sign up for this plan. Likewise, if you have an event such as your own marriage, divorce, or the birth or adoption of a child, you will have another brief period to sign up for this plan without waiting for your employer's open enrollment period. These are considered *qualifying events*.

Open enrollment period

If you waive or decline benefits at first but change your mind later, you can sign up during the time period designated by your employer. Refer to your summary plan description to determine if your plan offers open enrollment.

Special enrollment situations

In these situations, you may be able to add, delete or change your benefit choices.

- Involuntary loss of other benefits
- Marriage
- Birth
- Adoption
- Placement of a child in your home for adoption

If you're adding a dependent to your benefits through a special enrollment situation, let your employer know within 30 days of the marriage, birth, adoption, etc.; however, this can vary by group.

Balancing Your Life Means Protecting Your Health

Understanding your medical benefits

Chances are, you try every day to restore a healthy balance to your life, but time gets away from you, or other details come first. Meritain Health is here to help you focus, to support you every step of the way. Read about your benefits in the next sections, and learn all you can about using your plan to make healthy changes. Think of the benefits and programs as an important resource in the protection of your body, mind and spirit!

In this section

- Preventive care
- Online tools with your member portal
- Using your benefits
- Medical management and precertification
- Dental care
- Vision care
- Prescription benefits

Preventive care for you and your family—protecting your healthy balance

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.

Take an easy step towards good health

Your number one way to help yourself and your family stay healthy is with preventive care. When combined with healthy eating and exercise, vaccines and early detection are your key to a long and healthy life. That's why your employer offers many preventive treatments at no cost to you when you visit a doctor in your network.

Medical benefits at-a-glance

	Plan Two (1,000)		Plan Three (1,500)	
	In-network	Out-of-network	In-network	Out-of-network
Physician's office visits	**$30 copay***	40% coinsurance	**$30 copay***	40% coinsurance
	Deductible		**Deductible**	
Per individual	**$1,000**	**$2,000**	**$1,500**	**$3,000**
Per family	**$2,000**	**$4,000**	**$3,000**	**$6,000**
	Out-of-pocket maximum		**Out-of-pocket maximum**	
Per individual	**$3,000**	**$6,000**	**$3,500**	**$7,000**
Per family	**$6,000**	**$12,000**	**$7,000**	**$14,000**

About your deductible

The deductible does not apply to everything your plan covers. Be sure to spend some time reviewing the Summary of Benefits in the appendix of this packet for more details.

Out-of-Pocket Maximum does not include Rx copays, plan exclusions or costs over the Usual and Customary charge.
*Copay applies to all services billed by the physician for the same date of service/visit.

Changes to preventive care benefits

Your preventive care benefits have been enhanced to provide you and your family with an even greater opportunity to take command of your health and well-being. These benefits include women's preventive services, such as preventive prenatal care, contraceptives*, lactation counseling and breast pumps. You won't have to pay anything for these services when:

- The doctor or other healthcare provider is in your network and the main purpose of your visit is to get preventive care.
- You choose generic contraceptives (unless brand name drugs are otherwise allowed under your plan).
- You buy a breast pump according to the guidelines of your benefits plan.

In addition, your benefits plan covers the member share when your provider bills for the following services separately from other services:

- Administration of certain contraceptives, such as the insertion of IUDs or injections
- Women's sterilization procedures

For detailed plan information on your enhanced preventive care benefits, consult your plan document or call the number on your member ID Card. For prescription questions, please contact your Pharmacy Benefit Manager using the number on your ID Card.

**Certain religious employers and organizations may choose not to cover contraceptive services. If these requirements apply to your plan, consult your plan documents for more information.*

Healthcare for you and your family

When sickness or injury throw you off balance

Knowing that you're in good hands when you're sick is one of the most comforting feelings there is. You can be assured that your health plan has everything you'll need to get the right care when something goes wrong.

Remember this: Meritain Health is only a phone call away. If you have questions about your provider network, benefits, deductibles or claims, just give us a call.

Customer support

You can call **1.800.925.2272** to talk to our customer service representatives. We're dedicated to helping you get the most from your plan.

Balancing healthcare costs—what you pay and what the plan pays

The **Summary of Benefits** in the appendix of this packet shows how much you pay for care, and how much the plan pays. It's a listing of what is and isn't included in your benefits plan. For more detailed information, see your summary plan description.

After you pay your annual deductible and any up-front copays, the plan begins to pay a percentage of your provider's charges, for example 80 percent. The remaining percentage, for example 20 percent, is your responsibility—your out-of-pocket costs. You're protected from financial hardship by a maximum out-of-pocket amount each year—the most you'll have to pay before the plan covers costs at 100 percent.

24-hour access to online tools with your member portal

Your Meritain Health member website at **www.meritain.com** is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information you can use to manage your health and wellness.

We're committed to providing you with all the basics you expect, along with added features to support a healthy lifestyle, assist you with medical decisions, and give insight into the maximization of your healthcare dollars.

Your online tools and resources

With **www.meritain.com**, you can:

- Look up health and wellness topics.
- Find the status of a claim.
- Find in-network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Order ID Cards.

Your secure member site

First, visit **www.meritain.com**. Return users, just sign in using your username and password. The first time you access the site, you will be prompted to re-register with a new username and password for enhanced security. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

New users can create an account by following the easy instructions. You'll need your health plan ID Card the first time. Remember, each member of your family can have an account, too.

If you need help registering for your member portal, you can contact Meritain Health Customer Service at 1.800.925.2272.

Privacy regulations

Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations.

Members over 18 having difficulty creating an account with their SSN, please contact Meritain Health Customer Service at **1.800.925.2272**.

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or healthcare operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their healthcare or payment thereof (e.g., family members, close friends).

Managed Metrics biometric screenings

A biometric is a measure of your body's performance and health. Because everyone needs a starting point to measure success, Managed Metrics comes to you, at your work place, to help you get a picture of your current health. The program is voluntary.

Here's how it works

Professionals from Interactive Health Solutions (IHS), a Meritain Health partner, will conduct a health risk assessment–a confidential survey about your personal health and history–right at your work place. In a private setting, they'll draw a blood sample for a blood chemistry profile. This will be used to measure more than 34 factors that determine your health today. If you are unable to attend the scheduled screening date, you can receive a voucher to have this done at a participating lab outside of your workplace.

Once you've completed the blood draw, you'll be able to view a personalized, confidential report showing your results. The report will include any "heads-up" messages about areas you might need to discuss with your doctor.

For more information, please see the following page.

24x7 Nurse Line: Call anytime, day or night

What do you do when you're not sure WHAT to do?:

- When you don't know where to go for care (is it really an emergency?).
- When it's 4 a.m. and your child can't stop coughing?
- When you've taken a tumble and your ankle is swelling?

Now you can call the 24x7 Nurse Line to talk to a registered nurse who will listen and give you professional, seasoned advice, making sure you get care in the right place at the right time. When you call, you can also tap into our health information library, a collection of more than over 1,600 health topics, many available in Spanish or English. One more great support feature for plan participants: Our nurse counselors can connect you to community resources, like support groups, classes and seminars.

Like having your own private duty nurse?
Call the 24x7 Nurse Line, day or night, when you need advice, information, or answers to your healthcare questions: **1.844.348.4533.**

What is a Health Evaluation?

A convenient, comprehensive and confidential state of the art blood screening that includes (but is not limited to) testing for the following:

- Cardiovascular disease risks (high cholesterol; high blood pressure)
- Diabetes
- Liver and kidney disease
- Anemia
- Blood, bone, and muscle disease (including certain types of cancer)

Now that the evaluations are complete, you have access to …

- www.myinteractivehealth.com (members' only medical website)
- Monthly health newsletters & interactive webinars
- A medical drug database with information on symptoms, diseases, treatments, online health consultations and more
- A Personal Health Report explaining your results mailed to your home
- *HealthFocus* lifestyle coaching courses: one-on-one, telephonic, confidential health coaching with Masters Degreed Health Professionals. Courses options include:
    1. Tobacco-Free for Life
    2. Diabetes Prevention and Control
    3. Lifestyles for Successful Weight Loss
    4. Managing Cholesterol Levels
    5. Managing and Preventing High Blood Pressure
    6. Better Nutrition
    7. Personalized Fitness
    8. Achieving Balance

Quick Check

The purpose of the Quick Check program is to help you stay compliant with your Personal Health Goal

- Offered to all participants who screened in the prior year's health evaluations
- Participants will receive a post card from Interactive Health 6 months after screening
- Members are invited to call Interactive Health Member Services (1-800-840-6100) and request a Quick Check packet
- Quick Check testing is available through *Test at a Lab* facilities
- Each participant will receive a lab report which looks at the following metrics:
    - Fasting Glucose
    - Total Cholesterol
    - Triglycerides
    - HDL Cholesterol
    - LDL Cholesterol
- Interactive Health will not calculate a new Personal Health Score. The intent is to compare your lab values against previous lab results to determine if you are on track to meet your Personal Health Goal.

What is a Personal Health Score?

Your Personal Health Score is based on the Interactive Health Index (IHI) that was designed by physicians and other health care professionals with targets based on national medical guidelines. Your personal health score is comprised of several key health risk factors (blood pressure, LDL cholesterol, glucose, triglycerides and tobacco use) for heart disease, diabetes and stroke. These risk factors are modifiable by lifestyle changes such as diet, exercise and medications when necessary.

Each year you participate in a Health Evaluation you will be provided a Personal Health Score and Goal based on your results. We recommend that you work closely with your physician and follow his/her guidance to help you meet your Personal Health Goal for the next Health Evaluation.

How is my Personal Health Score calculated?

- **Blood Pressure:** 1 point is added per BP unit above 139/89 (Systolic/Diastolic). A credit of 5 points can be earned if both systolic and diastolic blood pressure values are below 140/90.
- **LDL Cholesterol:** 1 IHI point is added per LDL unit above your personal LDL target **level of 99 mg/dl, 129 mg/dl or 159 mg/dl**. A credit of 5 points can be earned if you are at or below your LDL target. **Your LDL target is calculated based on your personal risk factors and can change from year to year, the more risk factors you have the lower your target will be.** Risk factors include but are not limited to: tobacco use, diabetes, high blood pressure, age (men ≥ 45 years; women ≥ 55 years), Body Mass Index (BMI) and physical activity patterns.
- **Glucose:** 1 point is added per Glucose unit above 99 mg/dl. A credit of 5 points can be earned if Glucose is at or below 99 mg/dl.
- **Triglycerides:** 1 point is added per 10 Triglyceride units above 149 mg/dl. A credit of 5 points can be earned if Triglycerides are at or below 149 mg/dl.
- **Smoking:** 40 points are added for using any tobacco product.

How is my Personal Health Goal set?

1. If your current score is –20 to zero, your goal is to remain in this range
2. If your current score is 1 to 25, your goal will be –20 to zero
3. If your current score is above 25, your goal will be to improve by 60%

How does my goal affect me?

Your company may have an incentive program based on you meeting your goal.

What happens if I am unable to meet my health goals?

Incentives under this wellness program are available to all eligible employees. If you are unable to meet your health goals that are required for you to earn an incentive under this wellness program, you may qualify for an opportunity to earn the same incentive through an alternative course of action. This alternative course of action must be completed by January 25, 2018. Please contact Interactive Health at least two weeks prior to this date at 1-800-840-6100 and ask to speak to our health management team about a reasonable alternative standard to qualify for the incentive.

Your Personal Health Score is based on testing performed by Interactive Health or designees. We cannot accept lab results from any third party. All tests are final and cannot be repeated. Your score is a measure of coronary risk factors; however, it does not confirm or negate the presence of underlying heart disease or other medical conditions. LDL cholesterol and triglyceride standards are from the National Cholesterol Education Program (NCEP). Blood Pressure guidelines are from the National High Blood Pressure Education Program and National Heart Lung Blood Institute (NHLBI). Glucose standards are from the American Diabetes Association (ADA).

Your Personal Health Score and Goal

John Sample January 1, 2018

Blood Pressure Systolic

120	140	160	
LOW	MODERATE	HIGH	-5

Your BP Systolic is 110

Both your systolic and diastolic blood pressures are equal to or lower than their repective targets! You have earned a 5-point credit toward your score!

Blood Pressure Diastolic

80	90	100	
LOW	MODERATE	HIGH	0

Your BP Diastolic is 70

LDL Cholesterol

100	130	160	
LOW	MODERATE	HIGH	-5

Your LDL is 67

Your LDL value is equal to or lower than your target of 129! Congratulations! You have earned a 5-point credit toward your score!

Glucose

Normal	Pre-Diabetic	Diabetic	
LOW	MODERATE	HIGH	32

Your Glucose is 131

You are 32 units above your target of 99, which adds 32 to your score.

Triglycerides

150	200	500	
LOW	MODERATE	HIGH	-5

Your Triglycerides are 140

Your Triglyceride value is equal to or lower than your target of 149! Congratulations! You have earned a 5-point credit toward your score!

Tobacco Use ***(Includes cigarettes, cigar, pipe, chew or dip.)***

NON-USER	USER	
		40

Quitting smoking will reduce your score by 40 points.

Unfortunately, you missed your previous personal health goal of 22. Your new goal is to reduce your personal health score by 34 points by your next health evaluation.

Total 57

(Over)

What is my personal health score?

Your personal health score is based on the Interactive Health Index (IHI) that was designed by physicians and other health care professionals with targets based on national medical guidelines. Your personal health score is comprised of several key health risk factors (blood pressure, LDL cholesterol, glucose, triglycerides and tobacco use) for heart disease, diabetes and stroke. These risk factors are modifiable by lifestyle changes such as diet, exercise and medications when necessary.

Each year you participate in a Health Evaluation you will be provided a personal health score and goal based on your results. We recommend that you work closely with your physician and follow his/her guidance to help you meet your personal health goal for the next Health Evaluation. Interactive Health offers lifestyle courses and a variety of online tools at www.interactivehs.com that will provide you with support and education to help you improve your health. Please refer to the enclosed Resources Sheet to learn more about the variety of courses and tools we offer.

How is my personal health score calculated?

Blood Pressure: 1 point is added per BP unit above 139/89 (Systolic/Diastolic). A credit of 5 points can be earned if both systolic and diastolic blood pressure values are below 140/90.

LDL Cholesterol: 1 IHI point is added per LDL unit above your personal LDL target **level of 99 mg/dl, 129 mg/dl or 159 mg/dl**. A credit of 5 points can be earned if you are at or below your LDL target. **Your LDL target is calculated based on your personal risk factors and can change from year to year, the more risk factors you have the lower your target will be**. Risk factors include but are not limited to: tobacco use, diabetes, high blood pressure, age (men ≥ 45 years; women ≥ 55 years), Body Mass Index (BMI) and physical activity patterns. Enclosed is a customized **Coronary Risk Assessment** that provides you information about your personal risk factors and target.

Glucose: 1 point is added per Glucose unit above 99 mg/dl. A credit of 5 points can be earned if Glucose is at or below 99 mg/dl.

Triglycerides: 1 point is added per 10 Triglyceride units above 149 mg/dl. A credit of 5 points can be earned if Triglycerides are at or below 149 mg/dl.

Tobacco Use: 40 points are added for using any tobacco product.

How is my personal health goal set?

1. If your current score is –20 to zero, your goal will be to remain in this range
2. If your current score is 1 to 25, your goal will be –20 to zero
3. If your current score is above 25, your goal will be to improve by 60%

Additional notes about your personal health score

Your personal health score is based on testing performed by Interactive Health or designees. We cannot accept lab results from any third party. All tests are final and cannot be repeated. Your score is a measure of coronary risk factors; however, it does not confirm or negate the presence of underlying heart disease or other medical conditions. LDL Cholesterol and Triglyceride standards are from the National Cholesterol Education Program (NCEP). Blood Pressure guidelines are from the National High Blood Pressure Education Program and National Heart Lung Blood Institute (NHLBI). Glucose standards are from the American Diabetes Association (ADA).

What if I have a medical condition that might prevent me from reaching my goal?

The goal of this program is to recognize individuals for healthy lifestyles and engagement in their health. Under certain circumstances, participants may have a medical condition that makes it unreasonably difficult, or medically inadvisable, for them to pursue or achieve their goal. If you believe that this applies to you, please call Interactive Health and speak with one of our Health Management Specialists at 1-800-840-6100 to discuss your individual situation and the possible use of a medical waiver. This waiver form will need to be completed by your personal physician and returned to Interactive Health for review.

Using your medical benefits

Save when you see network providers

Your plan offers a provider network of doctors and other healthcare professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: If you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Helpful tip

You can realize savings while on the road to meeting your annual deductible when you visit doctors and facilities within your provider network.

No referrals

You don't have to choose a primary care doctor to direct all of your care or to provide referrals to specialists, but Meritain Health recommends that you build a relationship with a "home base" doctor—one who has all of your records and health history. For best benefits, see specialists that are in the network (called in-network or participating providers). Remember, if you see providers outside the network, you'll share more of the cost. To be sure the plan pays for charges from any out-of-network provider you choose, call customer service before you receive care.

When it's an emergency

If you can't see a network provider in an emergency, don't worry! Your plan will cover out-of-network emergency charges at the in-network level. For more infomation, refer to your summary plan description.

Helpful tip

It's important to know what is covered under your health plan. This can help you to plan for the cost of your healthcare expenditures. For more information, refer to your summary plan description.

When out-of-network charges may be covered at the in-network rate

If an out-of-network provider is under agreement with an in-network provider for some part of your care (for example, an out-of-network anesthesiologist or pathologist who regularly works with your doctor) the out-of-network provider's charges will be paid at the in-network rate. All plan limitations, requirements and provisions apply.

Important: If you (or your in-network provider) could choose an in-network provider for services or consultation, but decide instead to use an out-of-network provider, benefits are reduced to the out-of-network level.

Re-claiming your time

With some health plans, paperwork can put you over the edge. Time-consuming and complicated, claim forms rob you of precious time and the balance you seek. That's why Meritain Health network providers file your claims for you. Pay your copay (if applicable), and you're on your way!

Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of Meritain Health's Medical Management program. The medical management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Before you get care, call medical management

To keep your benefits at the highest level, be sure to call medical management before any of these situations:

- Admission to the hospital for elective or non-emergency care
- Within 48 hours (two working days) after an emergency or urgent hospital admission
- Before elective inpatient, outpatient or ambulatory surgery (except surgery that's performed in a doctor's office)
- Before intravenous (IV) home infusion therapy and chemotherapy, including any services performed in a doctor's office
- Before inpatient substance-abuse treatment or treatment for a mental health disorder
- Before hospice care, home healthcare or private-duty nursing
- Before entering an extended-care, rehabilitation or skilled-nursing facility

Medical management nurses

Our medical management nurses focus on:

- The recommended treatment for your health condition.
- The proposed location of your treatment.
- The proposed length of stay at that location.
- The cost-effectiveness of your treatment and setting.

Note: You and your doctor always have the right to appeal a decision made by the medical management team if you disagree with their decision. A panel of doctors will review the appeal.

Improve your overall health with dental benefits

It's amazing how important your oral health can be to your body's total balance and wholeness. Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many as six years onto your life? That's just one of the reasons why this plan includes dental care benefits for you and your enrolled dependents. Regular check-ups can keep your smiles bright and beautiful.

Dental plan deductibles and plan maximum:

Calendar year deductible (Class B, C and D combined)	
Per individual	$50
Per family	Up to two deductibles
Calendar year maximum benefit (Class B and C combined)	
Maximum per individual	$1,000
Maximum per family	$3,000
Maximum lifetime benefits	
Class D orthodontic services	$1,300

Covered dental services:

Class A services (preventive) Participant responsibility	No charge
Class B service (baic) Participant responsibility	20% after deductible
Class C service (major) Participant responsibility	50% after deductible
Class D services (orthodontic) Participant responsibility	50% after deductible

Calendar Year and lifetime dollar maximums will not apply to covered persons under eighteen (18) years of age.

Vision care—part of any balanced healthcare picture

To lead your busy life, you need to protect your vision, so your benefit plan includes eye care. Visit any vision care provider and pay for your care at the time you receive it. Then download a claim form at **www.meritain.com** and send the completed claim to Meritain Health at the address shown on your ID Card. You'll be reimbursed for the covered services shown below:

Vision benefits:

Eye Exams (one per calendar year)	100% up to $55	
Lenses and frames (per calendar year)		
Single vision	$40 single	$80 pair
Bifocal	$55 single	$110 pair
Trifocal	$70 single	$140 pair
Frames (not including lenses)	100% up to $75	
Contact lenses	$180 necessary lenses*	$130 other lenses
In lieu of all benefits available for lenses and frames		

*Benefits for necessary contact lenses are available only when visual acuity of the covered person is not correctable to 20/70 in the better eye with conventional lenses, but can be corrected to 20/70 or better by the use of contact lenses. Calendar Year dollar maximums will not apply to Covered Persons under eighteen (18) years of age.

Contact CVS/caremark
You can contact CVS/caremark customer service by calling **1.866.475.7589**.

Your prescription for a healthier budget

Your prescription drug benefit—available when you need prescriptions filled—is administered by Scrip World, powered by CVS/caremark. You can visit more than 65,000 retail pharmacies nationwide to fill your prescriptions. You also have access to clinical pharmacists for information and support.

Controlling your prescription copay

To get the most from your benefits plan, it pays to be a wise consumer. In many cases, you can control how much your share of costs will be when you fill a prescription. How? Generic drugs cost less to manufacture and they're just as effective as the name brands. You'll save money when you request them because generics have a lower copay than preferred or non-preferred drugs.

Note: To see whether a prescription drug is generic, preferred or non-preferred, check the list in the appendix of this packet.

Prescription drug copays (all plans):

Prescription drug out-of-pocket maximum (per calendar year)	
Per individual	$3,000
Per family	$6,000

Retail (30 day supply)	
Generic drugs	$10 copay
Preferred brand-name drugs	$30 copay
Non-formulary drugs	$60 copay
Preventive drugs	100%
Specialty drugs	20% up to $400 max per fill

Retail Maintenance Drugs (90-day supply)	
Generic drugs	$30 copay
Preferred brand-name drugs	$90 copay
Non-formulary drugs	$180 copay
Preventive drugs	100%

Mail Order (90-day supply)	
Generic drugs	$20 copay
Preferred brand-name drugs	$60 copay
Non-formulary drugs	$120 copay

Mandatory Generic Program

The plan requires retail pharmacies to dispense generic drugs when available. Should a covered person choose a formulary or non-formulary drug rather than the generic equivalent, the covered person will be responsible for the cost difference between the generic and formulary or non-formulary drug in addition to the copay, even if a DAW (Dispense as written) is written by the prescribing physician. The covered person's share of the prescription drug cost does not apply toward the plan's out-of-pocket maximum.

The Performance Drug List

Also called a formulary, a Performance Drug List is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs.

The preferred drug list

Also called a formulary, a preferred drug listing is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs.

How the preferred drug list works:

- Drugs are added to the list on a quarterly basis.
- Brand-name drugs can be removed at the end of the calendar year.
- Every January, the list is updated and available.
- If a generic becomes available, the brand-name drug will become a non-preferred drug, and may only be available for a higher copay.
- When a generic drug becomes available, you'll pay the lowest copay if you choose the generic.

Why generics make sense

Because companies that develop new drugs have long-term patent protection for their products, other drug companies are prevented by law from manufacturing those drugs—even if they can produce them less expensively.

When patents expire, other companies can make equivalent drugs, usually at a much lower price. Generic equivalents go through rigorous FDA testing regularly to assure that they are just as effective as the brand-name drugs.

Consider all of the compelling reasons to protect your pocketbook with the lower-price generic drugs:

- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original brand-name drug in color or shape, but only because they may have different inactive ingredients that won't change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents—but you may have to ask for them.
- Generics have the lowest copay under this plan, so you save on every prescription.

Easy on your time—two ways to get your prescription drugs

Your plan is designed with your time in mind. Use any of these two prescription options.

At your local pharmacy

When you need a prescription for 30 days or less, have it filled at a participating pharmacy. Just show the pharmacist your Meritain Health ID Card and pay your copay at the time of your purchase. If the pharmacy you choose is not in-network and your plan allows reimbursement for out-of-network pharmacies, you'll pay the entire cost at the time of purchase, then submit a claim for reimbursement. You'll receive the same amount that a participating pharmacy would receive, minus your copay.

By mail order

If you have a chronic condition and you take medication for it for long periods of time, you may fill a larger quantity prescription all at once. With CVS/caremark, you can request to receive your medication by mail or may pick it up at a local CVS/pharmacy. Ask your doctor to write two prescriptions—one for 30 days, and one for 90 days. Fill the 30-day prescription at a network pharmacy. Then complete a mail order form and send it, along with the original 90-day prescription signed by your doctor and your copay, to the address on the form.

Helpful tip

Be sure to bring your Meritain Health ID Card with you to the pharmacy when filling prescriptions. This will ensure that you receive your full benefits.

Prescriptions and your member portal

By logging in to **www.meritain.com**, you can:

- Order new prescriptions.
- Check the status of your online order.
- Find a nearby network pharmacy.
- Check on the price of a drug.
- Research drugs, supplements and vitamins.
- Learn more about your coverage.

Not every drug is covered

The plan does not include benefits for over-the-counter medications or drugs used for cosmetic purposes. There may be other exclusions. CVS/caremark customer service can help you if you have questions, or refer to your more complete summary plan description.

Certain drugs must be approved

If your prescription is for a very expensive drug, or one that can be easily abused, prior authorization may be required. Trained professionals review these prescriptions for your protection. You may need a new written prescription from your doctor for each refill. For more information, see your summary plan description or contact CVS/caremark customer service at **1.866.475.7589**.

Pharmacist support

When you have questions or concerns about your medication, it helps to consult a pharmacist. CVS/caremark pharmacists are available, in person or by phone, to provide all the information you need for a positive healthcare experience.

Find Balance Between a Good Life and Good Health

Are you ready for a health plan that can help restore balance to your life? It's simple to enroll—just follow the four steps below. If you have any questions during the enrollment process, check with your benefits administrator. Once you've completed Step 4 and you've served any waiting period, you're on your way to a fresh new approach to living your best health.

Waiting period

Participation in the plan will begin as of the first day of the month following the date he or she completes at least (1) hour of service with the employer provided all required election and enrollment forms are properly submitted to the plan administrator.

In this section

- Gathering information
- Double checking your information
- Making your decision
- Completing enrollment
- A more balanced you

Step 1—gather your information

For a complete, efficient enrollment, you may need some of the following information:

- Spouse's and children's birth dates.
- Spouse's and children's Social Security Numbers (SSN).
- Date of marriage.
- If your spouse or children are covered under another health plan, the name of the plan or insurance carrier and the effective date of benefits.
- If your benefits will include life insurance, your beneficiaries' names and SSNs.

Step 2—double-check every form

The decisions you make as you enroll in your health plan will affect your future healthcare and finances. We want to help you choose wisely. If you have not yet read the earlier sections of this packet, take time to do it now. Don't enroll without understanding your options.

Consider:

- Your personal health and the health of your family members.
- Healthcare expenses you can predict for you and your family.
- Other health benefits you or your family members may have.
- Your budget for benefits and expected healthcare services.

Step 3—make your decision

It's time to make changes in the way you think about your health and your healthcare. It's time to step up, take charge and make the best use of your plan, your money and your time. Are you ready to commit to better health, a better life—and the balance you want? Meritain Health is ready and committed to helping you.

Enrollment tips

Before you enroll, remember:

- Copays and deductibles are out-of-pocket costs you will pay for doctor visits and other medical services.
- If you or any dependent(s) are covered by another health plan, you have several options.
- If you decline benefits now, you won't be able to enroll later unless a special enrollment situation occurs, or during an open enrollment period.

Step 4—Complete your enrollment, and you're on your way!

All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Complete, sign and return your enrollment form to your employer within 30 days of your eligibility date whether you're enrolling or declining benefits.

Write clearly

If your form is unreadable, your enrollment may be delayed, or incorrect.

Don't forget the back side

Missing or incomplete information will delay your enrollment.

Sign and date your enrollment form

Remember to sign and date the form, even if you're declining benefits.

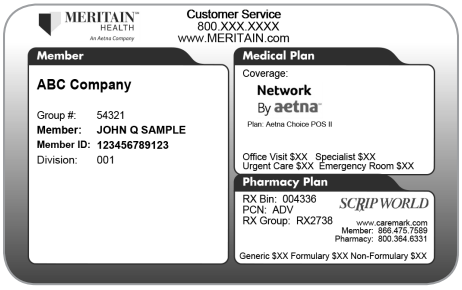
The final step toward better balance and better living

After you've completed enrollment, your employer has approved it, and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card

Card front



Card back

- Your healthcare plan includes a network of providers you can visit for healthcare services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

Need to fill a prescription before you receive your ID Card?

Not to worry—If you need to see your doctor but you don't have your ID Card yet, just tell the clinic staff that you're a member of this plan. The clinic will contact Meritain Health Customer Service to verify your benefits.

If you need a prescription before you get your new Meritain Health ID Card, just pay for your prescription and send us a completed prescription drug claim form (see the appendix for a copy). Send your receipt and the completed claim form to the address shown on the form and you'll be reimbursed up to plan limits, minus any copay.

You or your pharmacist may contact CVS/caremark Customer Service at **1.866.475.7589** with any questions.

Lost ID Card?

Contact Meritain Health at **1.800.925.2272**, or visit **www.meritain.com** to order new cards.

Appendix

In this section

- Glossary
- Summary of benefits
- 2018 medical premium rates
- Important phone numbers
- Enrollment forms
- Claim forms
- Preferred drug listing (formulary)

Glossary of terms

Ambulatory surgery

Surgery performed at an ambulatory surgical facility (a licensed public or private facility), which does not provide services or accommodations for a patient to stay overnight.

Copay

An amount of money that a participant is required to pay each time he or she visits a healthcare provider or fills a prescription.

Deductible

The annual out-of-pocket amount that a plan participant is responsible for paying before the health plan covers his or her medical costs according to the terms of the plan. Until a person meets the annual deductible, he or she pays the full cost of healthcare services received, unless the service is not subject to the annual deductible as stated in the benefit schedule.

Your member portal

Your online health information portal and your personal connection to your plan. Here you can order prescriptions, find healthcare providers, research health topics and get answers to your questions about healthcare. The personal information used to access **www.meritain.com** is confidential. You may need the information on your ID Card to log in for the first time.

Provider network

Organization that negotiates special, lower rates for healthcare services provided by physicians and other care providers who are within the network. Providers who belong to a network are called participating or in-network providers.

Usual and customary charge

Your plan reimburses charges from non-participating or out-of-network providers that are equal to, or less than, usual and customary charges. Usual and customary charges are the amounts most frequently charged for the same service:

- In the same geographic area; and
- By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, Meritain Health will process an amount equal to the usual and customary charge for the healthcare service you received, and you will be reimbursed for a portion of that amount according to your plan's out-of-network benefits.

MEDICAL SCHEDULE OF BENEFITS - PLAN 2 (1,000)

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,000	$2,000
Family	$2,000	$4,000
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Copays, medical Coinsurance and precertification penalties)		
Single	$3,000	$6,000
Family	$6,000	$12,000
TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductible, Copays, Coinsurance and precertification penalties-combined with Prescription Drug Card)		
Single	$6,000	$6,000
Family	$12,000	$12,000
NOTE: Charges that do not accrue towards the Out-of-Pocket Maximum are: Dental, Vision, amounts over Usual & Customary Charges, and Plan exclusions.		
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	26 visits	
Allergy Services (all)	80% after Deductible	60% after Deductible
Ambulance Services		
Ground Transportation	$200 Copay per trip then 100%; Deductible waived	60% after Deductible
Air Transportation	80% after Deductible	60% after Deductible
Transportation (transportation for non-medical Emergency)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	26 visits	
Diabetic Education, Supplies and Treatment		
Office Visit/Treatment	$30 Copay then 100%; Deductible waived	60% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible

Summary of Benefits

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	$30 Copay, then 100%; Deductible waived	60% after Deductible
MRI, MRA, CAT, PET Scans and Echocardiogram	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services/Emergency Room Services	$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits.
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Family Planning		
Testing and Counseling	100%; Deductible waived	60% after Deductible
Surgical Sterilization Procedures – (Women)		
Inpatient Facility	100%; Deductible waived	60% after Deductible
Outpatient Facility	100%; Deductible waived	60% after Deductible
Physician's Office	100%; Deductible waived	60% after Deductible
Contraceptive Implant Insertion	100%; Deductible waived	60% after Deductible
Contraceptive Implant Removal	100%; Deductible waived	60% after Deductible
Hearing Aids/Related Services (for Dependent children)		
Fitting and Dispensing Services	$50 Copay then 100%; Deductible waived	60% after Deductible
Hearing Aids	80% after Deductible	60% after Deductible
Hemodialysis (Outpatient)	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	6 months (an additional 6 months will be granted with Physician's verification)	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	ICU/CCU Room rate	ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		

Summary of Benefits

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Infertility		
Office visit	$50 Copay then 100%; Deductible waived	Not Covered
Treatment/Surgery	50% after Deductible	Not Covered
Artificial Insemination (e.g., in-vitro fertilization)	Not Covered	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal Care	100%; Deductible waived	60% after Deductible
All Other Postnatal Care	$30 Copay then 100%; Deductible waived	60% after Deductible
Delivery	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	$30 Copay then 100%; Deductible waived	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Therapies (e.g., physical, speech, occupational)	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	52 visits per therapy	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits		
Primary Care Physician	$30 Copay* then 100%; Deductible waived	60% after Deductible
Specialist	$50 Copay* then 100%; Deductible waived	60% after Deductible
Physician Office Surgery	80% after Deductible	60% after Deductible
*Copay applies to all services billed by the Physician for the same date of service/visit.		
Pre-Admission Testing (Outpatient) (performed within 7 days of a scheduled Inpatient admission)	80% after Deductible	60% after Deductible

Summary of Benefits

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care (includes the office visit and any other eligible item or service received at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%; Deductible waived	60%; Deductible waived
Prosthetics	80% after Deductible	60% after Deductible
Second Surgical Opinion	80% after Deductible	60% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Room and Board Allowance	Semi-Private Room Rate	
Maximum Benefit per Confinement	60 days	
Sleep Study (including overnight/non-overnight)	80% after Deductible	Not Covered
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	$2,000	
Transplants	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies to all services billed by the Physician for the same date of service/visit.		
Weight Loss Treatment	80% after Deductible	60% after Deductible
Maximum Benefit	$2,400 Calendar Year Maximum up to 3 courses of treatment per Covered Person per Lifetime	
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 2 (1,000)

BENEFIT DESCRIPTION	BENEFIT
CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Prescription Drug Copays) Single Family	 $3,000 $6,000
TOTAL OVERALL CALENDAR YEAR MAJOR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Copays and precertification penalties - combined with major medical) Single Family	 $6,000 $12,000
Retail Pharmacy: 30-day supply	
Generic Drug	$10 Copay
Formulary Drug	$30 Copay
Non-Formulary Drug	$60 Copay
Preventive Drug Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100%)
Specialty Drug	20% Copay up to $400 maximum per fill
Retail Pharmacy: 90-day supply (Maintenance Drugs)	
Generic Drug	$30 Copay
Formulary Drug	$90 Copay
Non-Formulary Drug	$180 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	$20 Copay
Formulary Drug	$60 Copay
Non-Formulary Drug	$120 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Diabetic Services
If diabetic services and supplies are purchased through *the mail order program*, you will receive a 90-day supply at no cost mailed to your home address. These diabetic supplies include: meter, pen, lancets, test strips and alcohol swabs.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program
Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

MEDICAL SCHEDULE OF BENEFITS - PLAN 3 (1,500)

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,500	$3,000
Family	$3,000	$6,000
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Copays, medical Coinsurance and precertification penalties)		
Single	$3,500	$7,000
Family	$7,000	$14,000
TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductibles, Copays, Coinsurance and precertification penalties-combined with Prescription Drug Card)		
Single	$6,500	$7,000
Family	$13,000	$14,000
NOTE: Charges that do not accrue towards the Out-of-Pocket Maximum are: Dental, Vision, amounts over Usual & Customary Charges, and Plan exclusions.		
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	26 visits	
Allergy Services (all)	80% after Deductible	60% after Deductible
Ambulance Services		
Ground Transportation	$200 Copay per trip, then 100%; Deductible waived	60% after Deductible
Air Transportation	80% after Deductible	60% after Deductible
Transportation (transportation for non-medical Emergency)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	26 visits	
Diabetic Education, Supplies and Treatment		
Office Visit/Treatment	$30 Copay then 100%; Deductible waived	60% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible

Summary of Benefits

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	$30 Copay, then 100%; Deductible waived	60% after Deductible
MRI, MRA, CAT, PET Scans and Echocardiogram	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME) (excludes DME associated with diabetes)	80% after Deductible	60% after Deductible
Emergency Services/Emergency Room Services	$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Family Planning		
Testing and Counseling	100%; Deductible waived	60% after Deductible
Surgical Sterilization Procedures – (Women)		
Inpatient Facility	100%; Deductible waived	60% after Deductible
Outpatient Facility	100%; Deductible waived	60% after Deductible
Physician's Office	100%; Deductible waived	60% after Deductible
Contraceptive Implant Insertion	100%; Deductible waived	60% after Deductible
Contraceptive Implant Removal	100%; Deductible waived	60% after Deductible
Hearing Aids/Related Services (for Dependent children)		
Fitting and Dispensing Services	$50 Copay then 100%; Deductible waived	60% after Deductible
Hearing Aids	80% after Deductible	60% after Deductible
Hemodialysis (Outpatient)	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	6 months (an additional 6 months will be granted with Physician's verification)	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	ICU/CCU Room rate	ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
*A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		

Summary of Benefits

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Pre-Admission Testing (Outpatient) (performed within 7 days of a scheduled Inpatient admission)	80% after Deductible	60% after Deductible
Preventive Services and Routine Care (includes the office visit and any other eligible item or service received at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%; Deductible waived	60%; Deductible waived
Prosthetics	80% after Deductible	60% after Deductible
Second Surgical Opinion	80% after Deductible	60% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Room and Board Allowance	Semi-Private Room Rate	
Maximum Benefit per Confinement	60 days	
Sleep Study (including overnight/non-overnight)	80% after Deductible	Not Covered
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	$2,000	
Transplants	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies to all services billed by the Physician for the same date of service/visit.		
Weight Loss Treatment	80% after Deductible	60% after Deductible
Maximum Benefit	$2,400 Calendar Year Maximum up to 3 courses of treatment per Covered Person, per Lifetime	
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

Specialty Pharmacy Program
Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

DENTAL SCHEDULE OF BENEFITS - ALL PLANS

BENEFIT DESCRIPTION	BENEFIT (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE Single Family	 $50 Up to 2 Deductibles
CLASS B AND C EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	
Calendar Year Maximum per Covered Person	$1,000
Calendar Year Maximum per Family	$3,000
CLASS D ORTHODONTIC LIFETIME MAXIMUM BENEFIT	$1,300 per Covered Person
DENTAL BENEFITS	
Class A-Preventive Services	100%; Deductible waived
Class B-Basic Services	80% after Deductible
Class C-Major Services	50% after Deductible
Class D-Orthodontic Services	50% after Deductible

NOTE: Calendar Year and Lifetime dollar maximums will not apply to Covered Persons under 19 years of age.

VISION SCHEDULE OF BENEFITS - ALL PLANS

BENEFIT DESCRIPTION	BENEFIT	
Eye Exam, One Exam per Calendar Year	100% up to $55	
Lenses and Frames, per Calendar Year	**Single**	**Pair**
Single vision	$40	$80
Bifocal	$55	$110
Trifocal	$70	$140
Contact lenses, one pair per Calendar Year (including charges for contact lens fitting) In lieu of all benefits available for lenses and frames: Necessary Lenses* Other Lenses.	100% up to: $180 $130	
Frames (not including lenses), per Calendar Year	100% up to $75	

NOTE: Calendar Year dollar maximums will not apply to Covered Persons under 19 years of age.

***Necessary Contact Lenses**
Benefits for necessary contact lenses are available only when visual acuity of the Covered Person is not correctable to 20/70 in the better eye with conventional lenses, but can be corrected to 20/70 or better by the use of contact lenses.

MEDICAL RATES FOR ACTIVE EMPLOYEES

Premiums for 2018

Annual Salary	NM Tech %	Employee %
$15,000-$19,999	80	20
$20,000-$24,999	70	30
$25,000 and above	60	40

Plan 2 (1,000) Individual

Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	100.98	403.92	504.91
$20,000-$24,999	151.47	353.43	504.91
$25,000 and above	201.96	302.94	504.91

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	77.68	310.71	388.39
$20,000-$24,999	116.52	271.87	388.39
$25,000 and above	155.36	233.03	388.39

Plan 2 (1,000) Employee +1

Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	209.44	837.76	1047.20
$20,000-$24,999	314.16	733.04	1047.20
$25,000 and above	418.88	628.32	1047.20

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	161.11	644.43	805.53
$20,000-$24,999	241.66	563.87	805.53
$25,000 and above	322.21	483.32	805.53

Plan 2 (1,000) Family

Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	252.86	1011.43	1264.29
$20,000-$24,999	379.29	885.00	1264.29
$25,000 and above	505.72	758.57	1264.29

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	194.51	778.02	972.53
$20,000-$24,999	291.76	680.77	972.53
$25,000 and above	389.01	583.52	972.53

MEDICAL RATES FOR ACTIVE EMPLOYEES
Premiums for 2018

Annual Salary	NM Tech %	Employee %
$15,000-$19,999	80	20
$20,000-$24,999	70	30
$25,000 and above	60	40

Plan 3 (1,500) Individual
Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	98.75	394.98	493.73
$20,000-$24,999	148.12	345.61	493.73
$25,000 and above	197.49	296.24	493.73

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	75.96	303.83	379.79
$20,000-$24,999	113.94	265.85	379.79
$25,000 and above	151.92	227.87	379.79

Plan 3 (1,500) Employee + 1
Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	187.99	751.95	939.94
$20,000-$24,999	281.98	657.96	939.94
$25,000 and above	375.98	563.96	939.94

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	144.61	578.42	723.03
$20,000-$24,999	216.91	506.12	723.03
$25,000 and above	289.21	433.82	723.03

Plan 3 (1,500) Family
Bi-Weekly

20 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	239.96	959.85	1199.81
$20,000-$24,999	359.94	839.87	1199.81
$25,000 and above	479.92	719.88	1199.81

26 Pay Periods	Employee	Employer	Total Premium
$15,000-$19,999	184.59	738.34	922.93
$20,000-$24,999	276.88	646.05	922.93
$25,000 and above	369.17	553.76	922.93

Retiree Premiums for 2018
Effective 01/01/2018-12/31/2018

New Mexico Institute of Mining & Technology
Monthly Schedule

	Plan 2 (1,000)	Plan 3 (1,500)
Retiree		
Retiree Eligible for Medicare	$352.08	$293.21
Retiree Ineligible for Medicare	$465.00	$358.90
Retiree + 1		
Retiree & Individual Medicare Eligible	$683.89	$609.69
Retiree & One Individual Eligible for Medicare	$824.43	$746.23
Retiree & Individual Medicare Ineligible	$893.16	$809.06
Retiree and Family		
Retire and Family	$1355.17	$1123.33

Important Contact Information

Important plan contacts

What do you need help with?	Who to contact	
My medical/dental/vision benefits	Meritain Health Customer Service	1.800.925.2272 www.meritain.com
My prescription drug benefits	CVS/caremark Customer Service	1.866.475.7589 www.meritain.com
The Aetna Choice® POS II provider network	Aetna provider line	1.800.343.3140 www.aetna.com/docfind/custom/mymeritain
Precertification	Meritain Health Medical Management	1.800.242.1199
Healthy and Wellness	24/7 Nurse Line	1.877.348.4533
• Enrollment or benefit elections • Enrolling in COBRA benefits	New Mexico Institute of Mining & Technology human resources representative	1.575.835.5643

COMPANY NAME: New Mexico Institute of Mining & Technology ***GROUP #:*** 13935

BENEFIT ENROLLMENT FORM

MERITAIN™ HEALTH
An Aetna Company

THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS

CITY	STATE	ZIP

HOME PHONE NUMBER	WORK PHONE NUMBER

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? ☐YES ☐NO (i.e. Medicare, Tricare, spouse's plan)
IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____
TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____
IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____
ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. # / CLOCK #

ANNUAL SALARY: $

☐ HOURLY ☐ SALARY

☐ NEW ENROLLMENT
- ☐ Active ☐ Retiree
- ☐ Full Time ☐ Part Time
- ☐ COBRA

☐ ENROLLMENT CHANGE
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Reinstatement ☐ Loss of Coverage
- ☐ Other: _____

Employer Representative Signature: _____

Date: _____

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	COVERAGE LEVEL
☐ MEDICAL/RX/DENTAL/VISION	☐ PLAN 2 (1,000) ☐ PLAN 3 (1,500)	☐ EMPLOYEE ☐ EMPLOYEE + ONE ☐ FAMILY ☐ DECLINE

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:
a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or
b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE	DISABLED DEPENDENT*
					☐MEDICAL/RX/DENTAL/VISION	☐YES ☐NO
					☐MEDICAL/RX/DENTAL/VISION	☐YES ☐NO
					☐MEDICAL/RX/DENTAL/VISION	☐YES ☐NO
					☐MEDICAL/RX/DENTAL/VISION	☐YES ☐NO
					☐MEDICAL/RX/DENTAL/VISION	☐YES ☐NO

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

COMPANY NAME: **New Mexico Institute of Mining & Technology**

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF **YES**, ☐FULL TIME ☐PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL					
☐PRESCRIPTION					
☐DENTAL					
☐VISION					

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐YES ☐NO
EMPLOYER PROVIDING COVERAGE:
IF **YES**, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL						
☐PRESCRIPTION						
☐DENTAL						
☐VISION						

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID,TRICARE, MICHILD, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐YES ☐NO IF **YES**, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IS MEDICARE COVERAGE DUE TO:
					☐AGE ☐DISABILITY ☐ESRD
					☐AGE ☐DISABILITY ☐ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE

Health Claim Form

MERITAIN HEALTH℠
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

Section 1. EMPLOYEE INFORMATION

Name (last, first, initial)			Sex	Employer Name		
Home Address			Identification Number		Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )		Home Telephone ( )	

Section 2. PATIENT INFORMATION

The patient is: ☐ **The employee** (Go to section 3) ☐ **Employee's Spouse** (Complete spouse information) ☐ **Employee's Child** (Complete spouse and child information)

Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer					
Spouse's Employer's Address					

Section 3. OTHER COVERAGE

☐ **Yes** (then complete) ☐ **No** (go to section 4) **Name of Policy Holder:**

Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage ☐ **Group** ☐ **Individual**	Group Number	Contract or Policy Number	
Spouse's Employer				
Spouse's Employer's Address				

Section 4. ABOUT THIS CLAIM

☐ **Injury** ☐ **Illness**
Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was this injury the result of an accident? ☐ **Yes** ☐ **No**

If auto insurance was involved, please provide:	**Policy #**	**Name of insurance company**	**Address (city, state, zip)**

Was this a work-related injury? ☐ **Yes** ☐ **No**

If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature: **Date:**

ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits to the doctor or supplier of services listed here.

Provider to be paid	Employee's Signature
Provider's tax ID number or Social Security Number	Date

MERITAIN HEALTH
An Aetna Company

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

A	**Patient Name (last, first, initial)**	**Birthdate**
B	**Address**	
C	**Is this condition the result of an injury arising from patient's employment? ☐ Yes ☐ No** ***If yes, please contact the Worker's Compensation Carrier/Administrator for proper instruction regarding this claim.***	
D	**Pregnancy? ☐ Yes ☐ No**	**If yes, expected date of delivery**
E	**If illness, date of first treatment**	**If treating injury, date of injury**
F	**Name of referring physician**	**Referring physician's address**
G	**Name and facility where services were rendered (if other than home or office)**	
H	**Was laboratory work performed outside your office? ☐ Yes ☐ No**	
I	**For service related to hospitalization, give dates:** **☐ Admitted** **☐ Discharged**	
J	**Diagnosis and current conditions (if diagnosis other than ICD-10* used, give name):** **1.** **2.** **3.** **4.**	

K

Dates of Service From	To	Places of Services**	Procedure Code (If other than CPT*** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges

*ICD-10 * International Classification of Disease
*** CPT Current Procedural Terminology (current edition)

**Abbreviations: 11-Physician's Office 12-Inpatient Hospital 23- Emergency Room 12-Patient's Home 22-Outpatient Hospital 81-Independent Laboratory

Date	Physician's Name (print)	Degree	Provider's Tax ID Number or Social Security Number:
			Must be furnished under authority of law

Physician's Signature	Telephone
	( )

Street Address	City	State	Zip Code

STATUS AND BENEFIT INFORMATION:
1.800.925.2272

Send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

ADA American Dental Association® Dental Claim Form

Please submit this form to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

fold

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

fold

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

fold

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Vision Claim Form

MERITAIN HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 27810
Minneapolis, MN 55427
Fax: 1.763.852.5057

For ALL claims, this area must be filled in completely.

Employee Information			
Employee's Name (last, first, middle initial)			Employee ID Number
Address			Employee's Date of Birth
City	State	Zip Code	☐ Single ☐ Married ☐ Widowed ☐ Divorced

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

Patient Information		
Patient's Name (if other than employee)	Patient's ID Number	
Patient's Date of Birth (Month, Day, Year)	Relationship to Employee ☐ Spouse ☐ Child	If child, is (s)he married? ☐ Yes ☐ No
Is patient covered by another Employer Group Plan or Retirement Group Plan? ☐ Yes ☐ No (If yes, please complete the two items below)		
Name of Employer	Group Number	Name and address of Insurance Company or Organization

Release
Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.
I hereby authorize payment of these benefits be send directly to: ☐ Provider of Service ☐ Employee **(attach itemized bill or receipt)**
Patient's Signature (parent or guardian if claim is on a minor) — Date

The below sections are to be completed by the Provider.

Exam			
Indicate the nature of disease, injury or vision disorder	Date of examination		Name of provider performing services
Refraction? Yes☐ ☐ No Contact Lenses? Yes☐ ☐ No Tonometry? Yes☐ ☐ No Cataract Surgery? Yes☐ ☐ No			Address
Examination Charge: $			City
Amount paid by employee: $			State / Zip Code
Signature of provider	Degree/Title	Date	Provider's Social Security or Tax ID Number (required by law):

Lenses						**Frames**		
Date ordered:		Date dispensed:		☐ Pair ☐1/2 Pair		Date ordered	Date dispensed	Parts ☐ Complete ☐ Partial
	Sphere	Cylinder	Axis	Prism	Add	**Frame Charge**	**$**	
OD						Name of provider performing services (please print)		
OS								
Type Lens:				**Charge**		Address	City, State, Zip	
☐ Single vision ☐Bifocal ☐Trifocal ☐Lenticular								
☐ Contact Lenses						Provider's Social Security Number or Tax ID Number		
☐ Oversized Lenses								
☐ Sunglasses						Signature of provider	Degree/Title	Date
☐ Tint #								
☐ Photosensitive – i.e. Brown, Gray, etc.						**Total Charge:**	**$**	**Amount paid by employee:** **$**
☐ Other								
Lens Manufacturer:								
Lens Charge				**$**				

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.

Performance Drug List

The **CVS Caremark® Performance Drug List** is a guide within select therapeutic categories for clients, plan members and health care providers. **Generics should be considered the first line of prescribing**. If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost-effective. Generics listed in therapeutic categories are for representational purposes only. This is not an all-inclusive list. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics,* and generic products in lowercase *italics*.

PLAN MEMBER

Your benefit plan provides you with a prescription benefit program administered by CVS Caremark. Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from this list. Take this list along when you or a covered family member sees a doctor.

Please note:

- Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the U.S. Food and Drug Administration (FDA) may not be covered upon release to the market.
- Your prescription benefit plan design may alter coverage of certain products or vary copay [1] amounts based on the condition being treated.
- You may be responsible for the full cost of non-formulary products that are removed from coverage.
- For specific information regarding your prescription benefit coverage and copay [1] information, please visit **www.caremark.com** or contact a CVS Caremark Customer Care representative.
- CVS Caremark may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.
- In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market.

HEALTH CARE PROVIDER

Your patient is covered under a prescription benefit plan administered by CVS Caremark. As a way to help manage health care costs, authorize generic substitution whenever possible. If you believe a brand-name product is necessary, consider prescribing a brand name on this list.

Please note:

- Generics should be considered the first line of prescribing.
- The member's prescription benefit plan design may alter coverage of certain products or vary copay [1] amounts based on the condition being treated.
- This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. The member's specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the FDA may not be covered upon release to the market.
- The member's prescription benefit plan may have a different copay [1] for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to **www.caremark.com** to check coverage and copay [1] information for a specific medicine.

ANALGESICS

§ NSAIDs

diclofenac sodium
meloxicam
naproxen

§ NSAIDs, COMBINATIONS

diclofenac sodium-misoprostol

§ NSAIDs, TOPICAL

diclofenac sodium solution
VOLTAREN GEL

§ COX-2 INHIBITORS

celecoxib

§ GOUT

allopurinol
colchicine tablet
probenecid
COLCRYS
ULORIC

§ OPIOID ANALGESICS

codeine-acetaminophen
fentanyl transdermal
fentanyl transmucosal lozenge
hydrocodone-acetaminophen
hydromorphone
hydromorphone ext-rel
methadone
morphine
morphine ext-rel
morphine suppository
oxycodone
oxycodone-acetaminophen
tramadol
tramadol ext-rel
BUTRANS
FENTORA
HYSINGLA ER
NUCYNTA
NUCYNTA ER
OPANA ER
OXYCONTIN
SUBSYS

VISCOSUPPLEMENTS

GEL-ONE
HYALGAN
SUPARTZ FX

ANTI-INFECTIVES

ANTIBACTERIALS

§ CEPHALOSPORINS

cefdinir
cefprozil
cefuroxime axetil
cephalexin
SUPRAX

§ ERYTHROMYCINS / MACROLIDES

azithromycin
clarithromycin
clarithromycin ext-rel
erythromycins
DIFICID

§ FLUOROQUINOLONES

ciprofloxacin
ciprofloxacin ext-rel
levofloxacin
moxifloxacin

§ PENICILLINS

amoxicillin
amoxicillin-clavulanate
dicloxacillin
penicillin VK

§ TETRACYCLINES

doxycycline hyclate
minocycline
tetracycline

§ ANTIFUNGALS

fluconazole
itraconazole
terbinafine tablet

ANTIRETROVIRAL AGENTS

§ ANTIRETROVIRAL COMBINATIONS

ATRIPLA
COMPLERA
EPZICOM
EVOTAZ
PREZCOBIX
STRIBILD
TRIUMEQ
TRUVADA

INTEGRASE INHIBITORS
ISENTRESS
TIVICAY

§ NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
abacavir
lamivudine

PROTEASE INHIBITORS
NORVIR
PREZISTA
REYATAZ

ANTIVIRALS

§ CYTOMEGALOVIRUS AGENTS
valganciclovir

§ HEPATITIS C AGENTS
ribavirin
EPCLUSA (genotypes 2, 3)
HARVONI (genotypes 1, 4, 5, 6)

§ HERPES AGENTS
acyclovir
valacyclovir

INFLUENZA AGENTS
RELENZA
TAMIFLU

§ MISCELLANEOUS
clindamycin
ivermectin
metronidazole
nitrofurantoin
sulfamethoxazole-trimethoprim
ALBENZA
SIVEXTRO
XIFAXAN 550 MG

ANTINEOPLASTIC AGENTS

HORMONAL ANTINEOPLASTIC AGENTS

§ ANTIANDROGENS
bicalutamide
ZYTIGA

§ KINASE INHIBITORS
imatinib mesylate
BOSULIF
SPRYCEL

§ MISCELLANEOUS
VISTOGARD

CARDIOVASCULAR

§ ACE INHIBITORS
fosinopril
lisinopril
quinapril
ramipril

§ ACE INHIBITOR / DIURETIC COMBINATIONS
fosinopril-hydrochlorothiazide
lisinopril-hydrochlorothiazide
quinapril-hydrochlorothiazide

§ ANGIOTENSIN II RECEPTOR ANTAGONISTS / DIURETIC COMBINATIONS
candesartan / candesartan-hydrochlorothiazide
eprosartan
irbesartan / irbesartan-hydrochlorothiazide
losartan / losartan-hydrochlorothiazide
telmisartan / telmisartan-hydrochlorothiazide
valsartan / valsartan-hydrochlorothiazide
BENICAR / BENICAR HCT

§ ANGIOTENSIN II RECEPTOR ANTAGONIST / CALCIUM CHANNEL BLOCKER COMBINATIONS
amlodipine-telmisartan
amlodipine-valsartan
AZOR

§ ANGIOTENSIN II RECEPTOR ANTAGONIST / CALCIUM CHANNEL BLOCKER / DIURETIC COMBINATIONS
amlodipine-valsartan-hydrochlorothiazide
TRIBENZOR

ANTILIPEMICS

§ BILE ACID RESINS
cholestyramine
WELCHOL

CHOLESTEROL ABSORPTION INHIBITORS
ZETIA

§ FIBRATES
fenofibrate
fenofibric acid

§ HMG-CoA REDUCTASE INHIBITORS / COMBINATIONS
atorvastatin
fluvastatin
lovastatin
pravastatin
rosuvastatin
simvastatin
VYTORIN

§ NIACINS
niacin ext-rel

§ OMEGA-3 FATTY ACIDS
omega-3 acid ethyl esters
VASCEPA

PCSK9 INHIBITORS
REPATHA

§ BETA-BLOCKERS
atenolol
carvedilol
metoprolol succinate ext-rel
metoprolol tartrate
nadolol
propranolol
propranolol ext-rel
BYSTOLIC
COREG CR

§ CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem ext-rel [2]
nifedipine ext-rel
verapamil ext-rel

§ CALCIUM CHANNEL BLOCKER / ANTILIPEMIC COMBINATIONS
amlodipine-atorvastatin

§ DIGITALIS GLYCOSIDES
digoxin

DIRECT RENIN INHIBITORS / DIURETIC COMBINATIONS
TEKTURNA / TEKTURNA HCT

§ DIURETICS
furosemide
hydrochlorothiazide
metolazone
spironolactone-hydrochlorothiazide
torsemide
triamterene-hydrochlorothiazide

NEPRILYSIN INHIBITOR / ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS
ENTRESTO

§ NITRATES
nitroglycerin lingual spray
NITROLINGUAL
NITROSTAT

NITRATE / VASODILATOR COMBINATIONS
BIDIL

PULMONARY ARTERIAL HYPERTENSION

ENDOTHELIN RECEPTOR ANTAGONISTS
LETAIRIS
TRACLEER

§ PHOSPHODIESTERASE INHIBITORS
sildenafil

PROSTAGLANDIN VASODILATORS
ORENITRAM

SOLUBLE GUANYLATE CYCLASE STIMULATORS
ADEMPAS

§ MISCELLANEOUS
RANEXA

CENTRAL NERVOUS SYSTEM

§ ANTICONVULSANTS
carbamazepine
carbamazepine ext-rel
diazepam rectal gel
divalproex sodium
divalproex sodium ext-rel
ethosuximide
gabapentin
lamotrigine
lamotrigine ext-rel
levetiracetam
levetiracetam ext-rel
oxcarbazepine
phenobarbital
phenytoin
phenytoin sodium extended
primidone
tiagabine
topiramate
valproic acid
zonisamide
FYCOMPA
OXTELLAR XR
QUDEXY XR
TROKENDI XR
VIMPAT

§ ANTIDEMENTIA
donepezil
galantamine
galantamine ext-rel
memantine
rivastigmine
rivastigmine transdermal
NAMENDA XR

ANTIDEPRESSANTS

§ SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)
citalopram
escitalopram
fluoxetine
paroxetine
paroxetine ext-rel
sertraline
FLUOXETINE 60 MG
TRINTELLIX
VIIBRYD

§ SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)
duloxetine
venlafaxine
venlafaxine ext-rel capsule
PRISTIQ

§ MISCELLANEOUS AGENTS
bupropion
bupropion ext-rel
mirtazapine
trazodone

§ ANTIPARKINSONIAN AGENTS
amantadine
carbidopa-levodopa
carbidopa-levodopa ext-rel
carbidopa-levodopa-entacapone
entacapone
pramipexole
ropinirole
ropinirole ext-rel
selegiline
AZILECT
MIRAPEX ER
NEUPRO

ANTIPSYCHOTICS

§ ATYPICALS
aripiprazole
clozapine
olanzapine
quetiapine
risperidone
ziprasidone
ARISTADA
LATUDA
SEROQUEL XR

§ ATTENTION DEFICIT HYPERACTIVITY DISORDER
amphetamine-dextroamphetamine mixed salts
amphetamine-dextroamphetamine mixed salts ext-rel
guanfacine ext-rel
methylphenidate
methylphenidate ext-rel
APTENSIO XR
QUILLIVANT XR
STRATTERA
VYVANSE

FIBROMYALGIA
LYRICA
SAVELLA

§ HUNTINGTON'S DISEASE AGENTS
tetrabenazine

HYPNOTICS

§ NONBENZODIAZEPINES
eszopiclone
zolpidem
zolpidem ext-rel

TRICYCLICS
SILENOR

MIGRAINE
§ SELECTIVE SEROTONIN AGONISTS
naratriptan
rizatriptan
sumatriptan
zolmitriptan
RELPAX
ZOMIG NASAL SPRAY

SELECTIVE SEROTONIN AGONIST / NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) COMBINATIONS
TREXIMET

§ MULTIPLE SCLEROSIS AGENTS
glatiramer
AUBAGIO
BETASERON
COPAXONE 40 MG
GILENYA
REBIF
TECFIDERA

§ MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine

NARCOLEPSY
NUVIGIL

POSTHERPETIC NEURALGIA
GRALISE

PSYCHOTHERAPEUTIC - MISCELLANEOUS
§ OPIOID ANTAGONISTS
naloxone injection
NARCAN NASAL SPRAY

§ PARTIAL OPIOID AGONIST / OPIOID ANTAGONIST COMBINATIONS
buprenorphine-naloxone sublingual tablet
SUBOXONE FILM

VASOMOTOR SYMPTOM AGENTS
BRISDELLE

ENDOCRINE AND METABOLIC

§ ANDROGENS
ANDRODERM
AXIRON

ANTIDIABETICS
AMYLIN ANALOGS
SYMLINPEN

§ BIGUANIDES
metformin
metformin ext-rel

§ BIGUANIDE / SULFONYLUREA COMBINATIONS
glipizide-metformin

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS
JANUVIA
TRADJENTA

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR / BIGUANIDE COMBINATIONS
JANUMET
JANUMET XR
JENTADUETO
JENTADUETO XR

INCRETIN MIMETIC AGENTS
TRULICITY
VICTOZA

INSULINS
BASAGLAR †
HUMULIN R U-500
LEVEMIR
NOVOLIN 70/30
NOVOLIN N
NOVOLIN R
NOVOLOG
NOVOLOG MIX 70/30
TRESIBA

§ INSULIN SENSITIZERS
pioglitazone

§ INSULIN SENSITIZER / BIGUANIDE COMBINATIONS
pioglitazone-metformin

§ INSULIN SENSITIZER / SULFONYLUREA COMBINATIONS
pioglitazone-glimepiride

§ MEGLITINIDES
nateglinide
repaglinide

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS
FARXIGA
JARDIANCE

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITOR / BIGUANIDE COMBINATIONS
XIGDUO XR

§ SULFONYLUREAS
glimepiride
glipizide
glipizide ext-rel

SUPPLIES
BD ULTRAFINE INSULIN SYRINGES AND NEEDLES
DEXCOM CONTINUOUS GLUCOSE MONITORING SYSTEM
ONETOUCH ULTRA STRIPS AND KITS [3]
ONETOUCH VERIO STRIPS AND KITS [3]

ANTIOBESITY
INJECTABLE
SAXENDA

ORAL
BELVIQ
CONTRAVE

CALCIUM REGULATORS
§ BISPHOSPHONATES
alendronate
ibandronate
risedronate
ATELVIA

§ CALCITONINS
calcitonin-salmon

PARATHYROID HORMONES
FORTEO

§ CARNITINE DEFICIENCY AGENTS
levocarnitine

CONTRACEPTIVES
§ MONOPHASIC
ethinyl estradiol-drospirenone
ethinyl estradiol-norethindrone acetate
BEYAZ
LO LOESTRIN FE
MINASTRIN 24 FE
SAFYRAL

§ TRIPHASIC
ethinyl estradiol-norgestimate
ORTHO TRI-CYCLEN LO

FOUR PHASE
NATAZIA

§ EXTENDED CYCLE
ethinyl estradiol-levonorgestrel

§ TRANSDERMAL
ethinyl estradiol-norelgestromin

VAGINAL
NUVARING

ESTROGENS
§ ORAL
estradiol
estropipate
PREMARIN

§ TRANSDERMAL
estradiol
DIVIGEL
EVAMIST
MINIVELLE

VAGINAL
ESTRACE CREAM
PREMARIN CREAM
VAGIFEM

ESTROGEN / PROGESTINS
§ ORAL
estradiol-norethindrone
PREMPHASE
PREMPRO

TRANSDERMAL
COMBIPATCH

ESTROGEN / SELECTIVE ESTROGEN RECEPTOR MODULATOR COMBINATIONS
DUAVEE

FERTILITY REGULATORS
GNRH / LHRH ANTAGONISTS
CETROTIDE

§ OVULATION STIMULANTS, GONADOTROPINS
FOLLISTIM AQ
OVIDREL

§ GLUCOCORTICOIDS
dexamethasone
methylprednisolone
prednisone

GLUCOSE ELEVATING AGENTS
GLUCAGEN HYPOKIT
GLUCAGON EMERGENCY KIT

HUMAN GROWTH HORMONES
HUMATROPE
NORDITROPIN

§ PHOSPHATE BINDER AGENTS
calcium acetate
PHOSLYRA
RENVELA
VELPHORO

PROGESTINS
§ ORAL
medroxyprogesterone
progesterone, micronized
MEGACE ES

VAGINAL
CRINONE
ENDOMETRIN

§ SELECTIVE ESTROGEN RECEPTOR MODULATORS
raloxifene
OSPHENA

§ THYROID SUPPLEMENTS
levothyroxine
SYNTHROID

GASTROINTESTINAL

§ ANTIEMETICS
dronabinol
granisetron
meclizine
metoclopramide
ondansetron
prochlorperazine
promethazine
trimethobenzamide
DICLEGIS
SANCUSO
VARUBI

§ H_2 RECEPTOR ANTAGONISTS
ranitidine

INFLAMMATORY BOWEL DISEASE
§ ORAL AGENTS
balsalazide
budesonide capsule
sulfasalazine
sulfasalazine delayed-rel
APRISO
LIALDA
PENTASA
UCERIS

§ RECTAL AGENTS
hydrocortisone enema
mesalamine rectal suspension
CANASA
CORTIFOAM

§ IRRITABLE BOWEL SYNDROME
AMITIZA
LINZESS
LOTRONEX
VIBERZI

§ LAXATIVES
lactulose
peg 3350-electrolytes
MOVIPREP
SUPREP

OPIOID-INDUCED CONSTIPATION
MOVANTIK

PANCREATIC ENZYMES
CREON
VIOKACE
ZENPEP

§ PROTON PUMP INHIBITORS

esomeprazole
lansoprazole
omeprazole
pantoprazole
DEXILANT

§ STEROIDS, RECTAL

PROCTOFOAM-HC

§ ULCER THERAPY COMBINATIONS

PYLERA

GENITOURINARY

§ BENIGN PROSTATIC HYPERPLASIA

alfuzosin ext-rel
doxazosin
dutasteride
finasteride
tamsulosin
terazosin
CARDURA XL
RAPAFLO

ERECTILE DYSFUNCTION

ALPROSTADIL AGENTS

MUSE

PHOSPHODIESTERASE INHIBITORS

CIALIS

§ URINARY ANTISPASMODICS

oxybutynin
oxybutynin ext-rel
tolterodine
tolterodine ext-rel
trospium
trospium ext-rel
MYRBETRIQ
TOVIAZ
VESICARE

HEMATOLOGIC

§ ANTICOAGULANTS

warfarin
ELIQUIS
XARELTO

HEMATOPOIETIC GROWTH FACTORS

ARANESP
PROCRIT
ZARXIO

HEMOPHILIA AGENTS

KOGENATE FS
KOVALTRY
NOVOEIGHT
NUWIQ

§ PLATELET AGGREGATION INHIBITORS

clopidogrel
dipyridamole ext-rel-aspirin
BRILINTA
EFFIENT

IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS

GRASTEK
ORALAIR
RAGWITEK

BIOLOGIC DISEASE-MODIFYING AGENTS [6]

ENBREL
HUMIRA

§ DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)

RASUVO

NUTRITIONAL / SUPPLEMENTS

§ ELECTROLYTES

potassium chloride liquid

VITAMINS AND MINERALS

§ PRENATAL VITAMINS

prenatal vitamins
CITRANATAL

RESPIRATORY

ANAPHYLAXIS TREATMENT AGENTS

EPIPEN
EPIPEN JR

§ ANTICHOLINERGICS

SPIRIVA

ANTICHOLINERGIC / BETA AGONIST COMBINATIONS

§ SHORT ACTING

ipratropium-albuterol inhalation solution
COMBIVENT RESPIMAT

LONG ACTING

ANORO ELLIPTA
BEVESPI AEROSPHERE

BETA AGONISTS, INHALANTS

§ SHORT ACTING

albuterol inhalation solution
PROAIR HFA
PROAIR RESPICLICK

LONG ACTING

Hand-held Active Inhalation

ARCAPTA
SEREVENT

Nebulized Passive Inhalation

PERFOROMIST

§ CYSTIC FIBROSIS

tobramycin inhalation solution
BETHKIS

§ LEUKOTRIENE RECEPTOR ANTAGONISTS

montelukast
zafirlukast

§ NASAL ANTIHISTAMINES

azelastine
olopatadine

§ NASAL STEROIDS / COMBINATIONS

flunisolide
fluticasone
mometasone
triamcinolone
DYMISTA

PHOSPHODIESTERASE-4 INHIBITORS

DALIRESP

PULMONARY FIBROSIS AGENTS

ESBRIET
OFEV

STEROID / BETA AGONIST COMBINATIONS

ADVAIR
BREO ELLIPTA
DULERA

§ STEROID INHALANTS

budesonide inhalation suspension
ASMANEX
FLOVENT DISKUS
FLOVENT HFA
PULMICORT FLEXHALER
QVAR

TOPICAL

DERMATOLOGY

§ ACNE

adapalene
benzoyl peroxide
clindamycin solution
clindamycin-benzoyl peroxide
erythromycin solution
erythromycin-benzoyl peroxide
tretinoin
ACANYA
ATRALIN
BENZACLIN
DIFFERIN
EPIDUO
RETIN-A MICRO
TAZORAC

§ ACTINIC KERATOSIS

fluorouracil cream 5%
fluorouracil solution
imiquimod
PICATO
ZYCLARA

§ ANTIFUNGALS

ciclopirox
clotrimazole
econazole
ketoconazole
nystatin
JUBLIA
LUZU
NAFTIN

§ ANTIPSORIATICS

acitretin
calcipotriene
methoxsalen

CORTICOSTEROIDS

§ Low Potency

desonide
hydrocortisone

§ Medium Potency

hydrocortisone butyrate
mometasone
triamcinolone
CLODERM
LOCOID LOTION

§ High Potency

desoximetasone
fluocinonide

§ Very High Potency

clobetasol cream, foam, gel, lotion, ointment, shampoo

§ IMMUNOMODULATORS

tacrolimus
ELIDEL

§ ROSACEA

metronidazole
FINACEA
ORACEA
SOOLANTRA

MOUTH / THROAT / DENTAL AGENTS

PROTECTANTS

EPISIL
MUGARD

OPHTHALMIC

§ ANTIALLERGICS

azelastine
cromolyn sodium
olopatadine
PATADAY
PAZEO

§ ANTI-INFECTIVES

ciprofloxacin
erythromycin
gentamicin
levofloxacin
ofloxacin
sulfacetamide
tobramycin
BESIVANCE
MOXEZA
VIGAMOX

§ ANTI-INFECTIVE / ANTI-INFLAMMATORY COMBINATIONS

neomycin-polymyxin B-bacitracin-hydrocortisone
neomycin-polymyxin B-dexamethasone
tobramycin-dexamethasone
TOBRADEX OINTMENT
TOBRADEX ST
ZYLET

ANTI-INFLAMMATORIES

§ Nonsteroidal

bromfenac
diclofenac
ketorolac
PROLENSA

§ Steroidal

dexamethasone
ALREX
DUREZOL
LOTEMAX

BETA-BLOCKERS

§ Nonselective

timolol maleate solution
BETIMOL

Selective

BETOPTIC S

§ CARBONIC ANHYDRASE INHIBITORS

dorzolamide
AZOPT

§ CARBONIC ANHYDRASE INHIBITOR / BETA-BLOCKER COMBINATIONS

dorzolamide-timolol
COSOPT PF

CARBONIC ANHYDRASE INHIBITOR / SYMPATHOMIMETIC COMBINATIONS

SIMBRINZA

DRY EYE DISEASE

RESTASIS
XIIDRA

§ PROSTAGLANDINS

latanoprost
travoprost
TRAVATAN Z
ZIOPTAN

§ SYMPATHOMIMETICS

brimonidine
ALPHAGAN P

SYMPATHOMIMETIC / BETA-BLOCKER COMBINATIONS

COMBIGAN

OTIC

§ ANTI-INFECTIVE / ANTI-INFLAMMATORY COMBINATIONS

CIPRODEX

QUICK REFERENCE DRUG LIST

A

abacavir
ACANYA
acitretin
acyclovir
adapalene
ADEMPAS
ADVAIR
ALBENZA
albuterol inhalation solution
alendronate
alfuzosin ext-rel
allopurinol
ALPHAGAN P
ALREX
amantadine
AMITIZA
amlodipine
amlodipine-atorvastatin
amlodipine-telmisartan
amlodipine-valsartan
amlodipine-valsartan-hydrochlorothiazide
amoxicillin
amoxicillin-clavulanate
amphetamine-dextroamphetamine mixed salts
amphetamine-dextroamphetamine mixed salts ext-rel
ANDRODERM
ANORO ELLIPTA
APRISO
APTENSIO XR
ARANESP
ARCAPTA
aripiprazole
ARISTADA
ASMANEX
ATELVIA
atenolol
atorvastatin
ATRALIN
ATRIPLA
AUBAGIO
AXIRON
azelastine
AZILECT
azithromycin
AZOPT
AZOR

B

balsalazide
BASAGLAR †
BD ULTRAFINE INSULIN SYRINGES AND NEEDLES
BELVIQ
BENICAR
BENICAR HCT
BENZACLIN
benzoyl peroxide
BESIVANCE
BETASERON
BETHKIS
BETIMOL
BETOPTIC S
BEVESPI AEROSPHERE
BEYAZ
bicalutamide
BIDIL
BOSULIF
BREO ELLIPTA
BRILINTA
brimonidine
BRISDELLE
bromfenac
budesonide capsule
budesonide inhalation suspension
buprenorphine-naloxone sublingual tablet
bupropion
bupropion ext-rel
BUTRANS
BYSTOLIC

C

calcipotriene
calcitonin-salmon
calcium acetate
CANASA
candesartan
candesartan-hydrochlorothiazide
carbamazepine
carbamazepine ext-rel
carbidopa-levodopa
carbidopa-levodopa ext-rel
carbidopa-levodopa-entacapone
CARDURA XL
carvedilol
cefdinir
cefprozil
cefuroxime axetil
celecoxib
cephalexin
CETROTIDE
cholestyramine
CIALIS
ciclopirox
CIPRODEX
ciprofloxacin
ciprofloxacin ext-rel
citalopram
CITRANATAL
clarithromycin
clarithromycin ext-rel
clindamycin
clindamycin solution
clindamycin-benzoyl peroxide
clobetasol cream, foam, gel, lotion, ointment, shampoo
CLODERM
clopidogrel
clotrimazole
clozapine
codeine-acetaminophen
colchicine tablet
COLCRYS
COMBIGAN
COMBIPATCH
COMBIVENT RESPIMAT
COMPLERA
CONTRAVE
COPAXONE 40 MG
COREG CR
CORTIFOAM
COSOPT PF
CREON
CRINONE
cromolyn sodium
cyclobenzaprine

D

DALIRESP
desonide
desoximetasone
dexamethasone
DEXCOM CONTINUOUS GLUCOSE MONITORING SYSTEM
DEXILANT
diazepam rectal gel
DICLEGIS
diclofenac
diclofenac sodium
diclofenac sodium solution
diclofenac sodium-misoprostol
dicloxacillin
DIFFERIN
DIFICID
digoxin
diltiazem ext-rel [2]
dipyridamole ext-rel-aspirin
divalproex sodium
divalproex sodium ext-rel
DIVIGEL
donepezil
dorzolamide
dorzolamide-timolol
doxazosin
doxycycline hyclate
dronabinol
DUAVEE
DULERA
duloxetine
DUREZOL
dutasteride
DYMISTA

E

econazole
EFFIENT
ELIDEL
ELIQUIS
ENBREL
ENDOMETRIN
entacapone
ENTRESTO
EPCLUSA
EPIDUO
EPIPEN
EPIPEN JR
EPISIL
eprosartan
EPZICOM
erythromycin
erythromycin solution
erythromycin-benzoyl peroxide
erythromycins
ESBRIET
escitalopram
esomeprazole
ESTRACE CREAM
estradiol
estradiol-norethindrone
estropipate
eszopiclone
ethinyl estradiol-drospirenone
ethinyl estradiol-levonorgestrel
ethinyl estradiol-norelgestromin
ethinyl estradiol-norethindrone acetate
ethinyl estradiol-norgestimate
ethosuximide
EVAMIST
EVOTAZ

F

FARXIGA
fenofibrate
fenofibric acid
fentanyl transdermal
fentanyl transmucosal lozenge
FENTORA
FINACEA
finasteride
FLOVENT DISKUS
FLOVENT HFA
fluconazole
flunisolide
fluocinonide
fluorouracil cream 5%
fluorouracil solution
fluoxetine
FLUOXETINE 60 MG
fluticasone
fluvastatin
FOLLISTIM AQ
FORTEO
fosinopril
fosinopril-hydrochlorothiazide
furosemide
FYCOMPA

G

gabapentin
galantamine
galantamine ext-rel
GEL-ONE
gentamicin
GILENYA
glatiramer
glimepiride
glipizide
glipizide ext-rel
glipizide-metformin
GLUCAGEN HYPOKIT
GLUCAGON EMERGENCY KIT
GRALISE

granisetron
GRASTEK
guanfacine ext-rel

H

HARVONI
HUMATROPE
HUMIRA
HUMULIN R U-500
HYALGAN
hydrochlorothiazide
hydrocodone-acetaminophen
hydrocortisone
hydrocortisone butyrate
hydrocortisone enema
hydromorphone
hydromorphone ext-rel
HYSINGLA ER

I

ibandronate
imatinib mesylate
imiquimod
ipratropium-albuterol inhalation solution
irbesartan
irbesartan-hydrochlorothiazide
ISENTRESS
itraconazole
ivermectin

J

JANUMET
JANUMET XR
JANUVIA
JARDIANCE
JENTADUETO
JENTADUETO XR
JUBLIA

K

ketoconazole
ketorolac
KOGENATE FS
KOVALTRY

L

lactulose
lamivudine
lamotrigine
lamotrigine ext-rel
lansoprazole
latanoprost
LATUDA
LETAIRIS
LEVEMIR
levetiracetam
levetiracetam ext-rel
levocarnitine
levofloxacin
levothyroxine
LIALDA
LINZESS
lisinopril
lisinopril-hydrochlorothiazide
LO LOESTRIN FE
LOCOID LOTION
losartan
losartan-hydrochlorothiazide
LOTEMAX
LOTRONEX
lovastatin
LUZU
LYRICA

M

meclizine
medroxyprogesterone
MEGACE ES
meloxicam
memantine
mesalamine rectal suspension
metformin
metformin ext-rel
methadone
methoxsalen
methylphenidate
methylphenidate ext-rel
methylprednisolone
metoclopramide
metolazone
metoprolol succinate ext-rel
metoprolol tartrate
metronidazole
MINASTRIN 24 FE
MINIVELLE
minocycline
MIRAPEX ER
mirtazapine
mometasone
montelukast
morphine
morphine ext-rel
morphine suppository
MOVANTIK
MOVIPREP
MOXEZA
moxifloxacin
MUGARD
MUSE
MYRBETRIQ

N

nadolol
NAFTIN
naloxone injection
NAMENDA XR
naproxen
naratriptan
NARCAN NASAL SPRAY
NATAZIA
nateglinide
neomycin-polymyxin B-bacitracin-hydrocortisone
neomycin-polymyxin B-dexamethasone
NEUPRO
niacin ext-rel
nifedipine ext-rel
nitrofurantoin
nitroglycerin lingual spray
NITROLINGUAL
NITROSTAT
NORDITROPIN
NORVIR
NOVOEIGHT
NOVOLIN 70/30
NOVOLIN N
NOVOLIN R
NOVOLOG
NOVOLOG MIX 70/30
NUCYNTA
NUCYNTA ER
NUVARING
NUVIGIL
NUWIQ
nystatin

O

OFEV
ofloxacin
olanzapine
olopatadine
omega-3 acid ethyl esters
omeprazole
ondansetron
ONETOUCH ULTRA STRIPS AND KITS [3]
ONETOUCH VERIO STRIPS AND KITS [3]
OPANA ER
ORACEA
ORALAIR
ORENITRAM
ORTHO TRI-CYCLEN LO
OSPHENA
OVIDREL
oxcarbazepine
OXTELLAR XR
oxybutynin
oxybutynin ext-rel
oxycodone
oxycodone-acetaminophen
OXYCONTIN

P

pantoprazole
paroxetine
paroxetine ext-rel
PATADAY
PAZEO
peg 3350-electrolytes
penicillin VK
PENTASA
PERFOROMIST
phenobarbital
phenytoin
phenytoin sodium extended
PHOSLYRA
PICATO
pioglitazone
pioglitazone-glimepiride
pioglitazone-metformin
potassium chloride liquid
pramipexole
pravastatin
prednisone
PREMARIN
PREMARIN CREAM
PREMPHASE
PREMPRO
prenatal vitamins
PREZCOBIX
PREZISTA
primidone
PRISTIQ
PROAIR HFA
PROAIR RESPICLICK
probenecid
prochlorperazine
PROCRIT
PROCTOFOAM-HC
progesterone, micronized
PROLENSA
promethazine
propranolol
propranolol ext-rel
PULMICORT FLEXHALER
PYLERA

Q

QUDEXY XR
quetiapine
QUILLIVANT XR
quinapril
quinapril-hydrochlorothiazide
QVAR

R

RAGWITEK
raloxifene
ramipril
RANEXA
ranitidine
RAPAFLO
RASUVO
REBIF
RELENZA
RELPAX
RENVELA
repaglinide
REPATHA
RESTASIS
RETIN-A MICRO
REYATAZ
ribavirin
risedronate
risperidone
rivastigmine
rivastigmine transdermal
rizatriptan
ropinirole
ropinirole ext-rel
rosuvastatin

S

SAFYRAL
SANCUSO
SAVELLA
SAXENDA
selegiline
SEREVENT
SEROQUEL XR
sertraline
sildenafil
SILENOR
SIMBRINZA
simvastatin
SIVEXTRO
SOOLANTRA
SPIRIVA
spironolactone-hydrochlorothiazide
SPRYCEL
STRATTERA
STRIBILD
SUBOXONE FILM
SUBSYS
sulfacetamide
sulfamethoxazole-trimethoprim
sulfasalazine
sulfasalazine delayed-rel
sumatriptan
SUPARTZ FX
SUPRAX
SUPREP
SYMLINPEN
SYNTHROID

T

tacrolimus
TAMIFLU
tamsulosin
TAZORAC
TECFIDERA
TEKTURNA
TEKTURNA HCT
telmisartan
telmisartan-hydrochlorothiazide
terazosin
terbinafine tablet
tetrabenazine
tetracycline
tiagabine
timolol maleate solution
TIVICAY
TOBRADEX OINTMENT
TOBRADEX ST
tobramycin
tobramycin inhalation solution
tobramycin-dexamethasone
tolterodine
tolterodine ext-rel
topiramate
torsemide
TOVIAZ
TRACLEER
TRADJENTA
tramadol
tramadol ext-rel
TRAVATAN Z
travoprost
trazodone
TRESIBA
tretinoin
TREXIMET
triamcinolone
triamterene-hydrochlorothiazide
TRIBENZOR
trimethobenzamide
TRINTELLIX
TRIUMEQ
TROKENDI XR
trospium

trospium ext-rel
TRULICITY
TRUVADA

U

UCERIS
ULORIC

V

VAGIFEM
valacyclovir
valganciclovir
valproic acid
valsartan
valsartan-hydrochlorothiazide
VARUBI
VASCEPA
VELPHORO
venlafaxine
venlafaxine ext-rel capsule
verapamil ext-rel
VESICARE
VIBERZI
VICTOZA
VIGAMOX
VIIBRYD
VIMPAT
VIOKACE
VISTOGARD
VOLTAREN GEL
VYTORIN
VYVANSE

W

warfarin
WELCHOL

X

XARELTO
XIFAXAN 550 MG
XIGDUO XR
XIIDRA

Z

zafirlukast
ZARXIO
ZENPEP
ZETIA
ZIOPTAN
ziprasidone
zolmitriptan
zolpidem
zolpidem ext-rel
ZOMIG NASAL SPRAY
zonisamide
ZYCLARA
ZYLET
ZYTIGA

PREFERRED OPTIONS LIST

DRUG NAME(S)	PREFERRED OPTION(S)*
ABILIFY	*aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone,* LATUDA, SEROQUEL XR
ABSTRAL	*fentanyl transmucosal lozenge,* FENTORA, SUBSYS
ACCU-CHEK STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
ACTOS	*pioglitazone*
ADDERALL XR	*amphetamine-dextroamphetamine mixed salts, amphetamine-dextroamphetamine mixed salts ext-rel, guanfacine ext-rel, methylphenidate, methylphenidate ext-rel,* APTENSIO XR, QUILLIVANT XR, STRATTERA, VYVANSE
ADRENACLICK	EPIPEN, EPIPEN JR
ADVICOR	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin*, VYTORIN
AEROSPAN	ASMANEX, FLOVENT DISKUS, FLOVENT HFA, PULMICORT FLEXHALER, QVAR
ALCORTIN A	*hydrocortisone*
ALLISON MEDICAL INSULIN SYRINGES [5]	BD ULTRAFINE INSULIN SYRINGES
ALOQUIN	*hydrocortisone*
ALORA	*estradiol*, DIVIGEL, EVAMIST, MINIVELLE
ALTOPREV	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin*, VYTORIN
ALVESCO	ASMANEX, FLOVENT DISKUS, FLOVENT HFA, PULMICORT FLEXHALER, QVAR
AMRIX	*cyclobenzaprine*
ANDROGEL	ANDRODERM, AXIRON
ANGELIQ	*estradiol-norethindrone*, PREMPHASE, PREMPRO
ANTARA	*fenofibrate, fenofibric acid*
APEXICON E	*desoximetasone, fluocinonide*
APIDRA	NOVOLOG
ARMOUR THYROID	*levothyroxine*, SYNTHROID
ARTHROTEC	*celecoxib*; *diclofenac sodium, meloxicam* or *naproxen* **WITH** *esomeprazole, lansoprazole, omeprazole, pantoprazole* or DEXILANT
ASACOL HD	*balsalazide, sulfasalazine, sulfasalazine delayed-rel,* APRISO, LIALDA, PENTASA, UCERIS
ASCENSIA STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
ATACAND, ATACAND HCT	*candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide, valsartan, valsartan-hydrochlorothiazide,* BENICAR, BENICAR HCT
ATROVENT HFA	SPIRIVA
AVONEX	*glatiramer,* AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA
AXERT	*naratriptan, rizatriptan, sumatriptan nasal spray, sumatriptan tablet, zolmitriptan*, RELPAX, ZOMIG NASAL SPRAY
AZELEX	*adapalene, benzoyl peroxide, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin,* ACANYA, ATRALIN, BENZACLIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC
BECONASE AQ	*flunisolide, fluticasone, mometasone, triamcinolone,* DYMISTA
BENZAC AC, BENZAC W	*adapalene, benzoyl peroxide, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin,* ACANYA, ATRALIN, BENZACLIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC
BENZIQ	*adapalene, benzoyl peroxide, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin,* ACANYA, ATRALIN, BENZACLIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC
BREEZE 2 STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
butalbital-acetaminophen-caffeine capsule	*naratriptan, rizatriptan, sumatriptan, zolmitriptan,* RELPAX, ZOMIG NASAL SPRAY
BYDUREON	TRULICITY, VICTOZA
BYETTA	TRULICITY, VICTOZA
CARAC	*fluorouracil cream 5%, fluorouracil solution, imiquimod,* PICATO, ZYCLARA
CARDIZEM	*diltiazem ext-rel* (except generic CARDIZEM LA)
CARDIZEM CD	*diltiazem ext-rel* (except generic CARDIZEM LA)

DRUG NAME(S)	PREFERRED OPTION(S)*
CARDIZEM LA (and its generics)	*diltiazem ext-rel* (except generic CARDIZEM LA)
CARNITOR	*levocarnitine*
CARNITOR SF	*levocarnitine*
CLIMARA PRO	COMBIPATCH
CLINDAGEL	*erythromycin solution*
clobetasol spray	*clobetasol foam*
CLOBEX SPRAY	*clobetasol foam*
CONTOUR NEXT STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
CONTOUR STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
CRESTOR	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin*, VYTORIN
CYMBALTA	*duloxetine, venlafaxine, venlafaxine ext-rel capsule,* PRISTIQ
DAKLINZA	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)
DELZICOL	*balsalazide, sulfasalazine, sulfasalazine delayed-rel,* APRISO, LIALDA, PENTASA, UCERIS
DETROL LA	*oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel,* MYRBETRIQ, TOVIAZ, VESICARE
DEXPAK	*dexamethasone, methylprednisolone, prednisone*
DIOVAN, DIOVAN HCT	*candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide, valsartan, valsartan-hydrochlorothiazide,* BENICAR, BENICAR HCT
DORAL	*eszopiclone, zolpidem, zolpidem ext-rel,* SILENOR
DUTOPROL	*metoprolol succinate ext-rel* **WITH** *hydrochlorothiazide*
EDARBI, EDARBYCLOR	*candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide, valsartan, valsartan-hydrochlorothiazide,* BENICAR, BENICAR HCT
EDLUAR	*eszopiclone, zolpidem, zolpidem ext-rel,* SILENOR
ENABLEX	*oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel,* MYRBETRIQ, TOVIAZ, VESICARE
ENJUVIA	*estradiol, estropipate,* PREMARIN
ESTRING	ESTRACE CREAM, PREMARIN CREAM, VAGIFEM
EUFLEXXA	GEL-ONE, HYALGAN, SUPARTZ FX
EVZIO	*naloxone injection*, NARCAN NASAL SPRAY
EXFORGE	*amlodipine-telmisartan, amlodipine-valsartan,* AZOR
EXFORGE HCT	*amlodipine-valsartan-hydrochlorothiazide,* TRIBENZOR
EXTAVIA	*glatiramer,* AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA
FEMRING	ESTRACE CREAM, PREMARIN CREAM, VAGIFEM
FETZIMA	*duloxetine, venlafaxine, venlafaxine ext-rel capsule,* PRISTIQ
FIORICET CAPSULE	*naratriptan, rizatriptan, sumatriptan, zolmitriptan*, RELPAX, ZOMIG NASAL SPRAY
FIRST TESTOSTERONE	ANDRODERM, AXIRON
fluorouracil cream 0.5%	*fluorouracil cream 5%, fluorouracil solution, imiquimod,* PICATO, ZYCLARA
FORTAMET	*metformin, metformin ext-rel*
FORTESTA	ANDRODERM, AXIRON
FOSAMAX PLUS D	*alendronate, ibandronate, risedronate,* ATELVIA
FOSRENOL	*calcium acetate,* PHOSLYRA, RENVELA, VELPHORO
FREESTYLE STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
FROVA	*naratriptan, rizatriptan, sumatriptan nasal spray, sumatriptan tablet, zolmitriptan*, RELPAX, ZOMIG NASAL SPRAY
GELNIQUE	*oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel,* MYRBETRIQ, TOVIAZ, VESICARE
GENOTROPIN	HUMATROPE, NORDITROPIN
GLEEVEC	*imatinib mesylate,* BOSULIF, SPRYCEL
GLUMETZA	*metformin, metformin ext-rel*
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
HUMALOG	NOVOLOG
HUMALOG MIX 50/50	NOVOLOG MIX 70/30
HUMALOG MIX 75/25	NOVOLOG MIX 70/30
HUMULIN	NOVOLIN
INCRUSE ELLIPTA	SPIRIVA
INNOPRAN XL	*atenolol, carvedilol, metoprolol succinate ext-rel, metoprolol tartrate, nadolol, propranolol, propranolol ext-rel*, BYSTOLIC, COREG CR
INTERMEZZO	*eszopiclone, zolpidem, zolpidem ext-rel,* SILENOR
INTUNIV	*amphetamine-dextroamphetamine mixed salts, amphetamine-dextroamphetamine mixed salts ext-rel, guanfacine ext-rel, methylphenidate, methylphenidate ext-rel,* APTENSIO XR, QUILLIVANT XR, STRATTERA, VYVANSE
INVOKAMET	XIGDUO XR
INVOKANA	FARXIGA, JARDIANCE
ISTALOL	*timolol maleate solution*, BETIMOL
JALYN	*dutasteride* or *finasteride* **WITH** *alfuzosin ext-rel, doxazosin, tamsulosin, terazosin* or RAPAFLO
KAZANO	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
KLOR-CON/25	*potassium chloride liquid*

DRUG NAME(S)	PREFERRED OPTION(S)*
KOMBIGLYZE XR	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
LANTUS	BASAGLAR †, LEVEMIR, TRESIBA
LASTACAFT	*azelastine, cromolyn sodium, olopatadine,* PATADAY, PAZEO
LESCOL XL	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin,* VYTORIN
LEVITRA	CIALIS
LIPITOR	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin,* VYTORIN
LIPTRUZET	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin,* VYTORIN
LIVALO	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin,* VYTORIN
LUMIGAN	*latanoprost, travoprost,* TRAVATAN Z, ZIOPTAN
LUNESTA	*eszopiclone, zolpidem, zolpidem ext-rel,* SILENOR
Matzim LA	*diltiazem ext-rel* (except generic CARDIZEM LA)
MENEST	*estradiol*, *estropipate*, PREMARIN
MENOSTAR	*estradiol*
MICARDIS, MICARDIS HCT	*candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide, valsartan, valsartan-hydrochlorothiazide,* BENICAR, BENICAR HCT
MILLIPRED	*dexamethasone, methylprednisolone, prednisone*
MONOVISC	GEL-ONE, HYALGAN, SUPARTZ FX
NAPRELAN	*celecoxib, diclofenac sodium, meloxicam, naproxen*
NATESTO	ANDRODERM, AXIRON
NESINA	JANUVIA, TRADJENTA
NEUPOGEN	ZARXIO
NEXIUM	*esomeprazole, lansoprazole, omeprazole, pantoprazole,* DEXILANT
NILANDRON	*bicalutamide*, ZYTIGA
NITROMIST	*nitroglycerin lingual spray,* NITROLINGUAL, NITROSTAT
NORITATE	*metronidazole*, FINACEA, SOOLANTRA
NORVASC	*amlodipine*
NOVACORT	*hydrocortisone*
NOVO NORDISK NEEDLES [5]	BD ULTRAFINE NEEDLES
NUTROPIN AQ	HUMATROPE, NORDITROPIN
OLEPTRO	*trazodone*
OLUX-E	*clobetasol foam*
OLYSIO	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)
OMNARIS	*flunisolide, fluticasone, mometasone, triamcinolone*, DYMISTA
OMNITROPE	HUMATROPE, NORDITROPIN
ONGLYZA	JANUVIA, TRADJENTA
OPSUMIT	LETAIRIS, TRACLEER
ORTHOVISC	GEL-ONE, HYALGAN, SUPARTZ FX
OSENI	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
OWEN MUMFORD NEEDLES [5]	BD ULTRAFINE NEEDLES
OXYTROL	*oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel,* MYRBETRIQ, TOVIAZ, VESICARE
PANCREAZE	CREON, VIOKACE, ZENPEP
PENNSAID	*diclofenac sodium, diclofenac sodium solution, meloxicam, naproxen,* VOLTAREN GEL
PERRIGO NEEDLES [5]	BD ULTRAFINE NEEDLES
PERTZYE	CREON, VIOKACE, ZENPEP
PEXEVA	*citalopram*, *escitalopram, fluoxetine*, *paroxetine*, *paroxetine ext-rel*, *sertraline*, FLUOXETINE 60 MG, TRINTELLIX, VIIBRYD
PLAVIX	*clopidogrel,* BRILINTA, EFFIENT
PLEGRIDY	*glatiramer,* AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA
PRADAXA	*warfarin,* ELIQUIS, XARELTO
PRALUENT	REPATHA
PRECISION XTRA STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
PRED MILD	*dexamethasone*, DUREZOL, LOTEMAX
PREFERAOB	*generic prenatal vitamins*, CITRANATAL
PREFEST	*estradiol-norethindrone*, PREMPHASE, PREMPRO
PRENATAL PLUS	*generic prenatal vitamins*, CITRANATAL
PREVACID	*esomeprazole, lansoprazole, omeprazole, pantoprazole,* DEXILANT
PROTONIX	*esomeprazole, lansoprazole, omeprazole, pantoprazole,* DEXILANT
PROTOPIC	*tacrolimus,* ELIDEL
PROVENTIL HFA	PROAIR HFA, PROAIR RESPICLICK
QNASL	*flunisolide, fluticasone, mometasone, triamcinolone,* DYMISTA
QSYMIA	BELVIQ, CONTRAVE, SAXENDA
RAYOS	*dexamethasone, methylprednisolone, prednisone*
RELION INSULIN	NOVOLIN INSULIN
RELISTOR	MOVANTIK
RHINOCORT AQUA	*flunisolide, fluticasone, mometasone, triamcinolone*, DYMISTA
RIOMET	*metformin, metformin ext-rel*
ROZEREM	*eszopiclone, zolpidem, zolpidem ext-rel,* SILENOR
SAIZEN	HUMATROPE, NORDITROPIN
STRIANT	ANDRODERM, AXIRON
SURE-TEST STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]

DRUG NAME(S)	PREFERRED OPTION(S)*
SYMBICORT	ADVAIR, BREO ELLIPTA, DULERA
SYNVISC, SYNVISC-ONE	GEL-ONE, HYALGAN, SUPARTZ FX
TANZEUM	TRULICITY, VICTOZA
TASIGNA	*imatinib mesylate,* BOSULIF, SPRYCEL
TECHNIVIE	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)
TESTIM	ANDRODERM, AXIRON
testosterone gel 1% [7]	ANDRODERM, AXIRON
TEVETEN, TEVETEN HCT	*candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide, valsartan, valsartan-hydrochlorothiazide,* BENICAR, BENICAR HCT
TOBI	*tobramycin inhalation solution,* BETHKIS
TOBI PODHALER	*tobramycin inhalation solution,* BETHKIS
TOUJEO	BASAGLAR †, LEVEMIR, TRESIBA
TRICOR	*fenofibrate, fenofibric acid*
TRIGLIDE	*fenofibrate, fenofibric acid*
TRILIPIX	*fenofibrate, fenofibric acid*
TRIVIDIA INSULIN SYRINGES [5]	BD ULTRAFINE INSULIN SYRINGES
TRUETEST STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
TRUETRACK STRIPS AND KITS [4]	ONETOUCH ULTRA STRIPS AND KITS [3], ONETOUCH VERIO STRIPS AND KITS [3]
TUDORZA	SPIRIVA
ULTIMED INSULIN SYRINGES [5]	BD ULTRAFINE INSULIN SYRINGES
ULTIMED NEEDLES [5]	BD ULTRAFINE NEEDLES

DRUG NAME(S)	PREFERRED OPTION(S)*
VALCYTE	*valganciclovir*
VALTREX	*acyclovir, valacyclovir*
venlafaxine ext-rel tablet (except 225 mg)	*duloxetine, venlafaxine, venlafaxine ext-rel capsule*, PRISTIQ
VENLAFAXINE EXT-REL TABLET (except 225 mg)	*duloxetine, venlafaxine, venlafaxine ext-rel capsule*, PRISTIQ
VENTOLIN HFA	PROAIR HFA, PROAIR RESPICLICK
VERAMYST	*flunisolide, fluticasone, mometasone, triamcinolone*, DYMISTA
VIAGRA	CIALIS
VIEKIRA PAK	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)
VITAFOL-ONE	*generic prenatal vitamins*, CITRANATAL
VOGELXO	ANDRODERM, AXIRON
XENAZINE	*tetrabenazine*
XOPENEX HFA	PROAIR HFA, PROAIR RESPICLICK
XTANDI	*bicalutamide*, ZYTIGA
ZEGERID	*esomeprazole, lansoprazole, omeprazole, pantoprazole,* DEXILANT
ZEPATIER	EPCLUSA (genotypes 2, 3), HARVONI (genotypes 1, 4, 5, 6)
ZETONNA	*flunisolide, fluticasone, mometasone, triamcinolone,* DYMISTA
ZUBSOLV	*buprenorphine-naloxone sublingual tablet,* SUBOXONE FILM
ZYFLO, ZYFLO CR	*montelukast, zafirlukast*

You may be responsible for the full cost of certain non-formulary products that are removed from coverage. Please check with your plan sponsor for more information.

FOR YOUR INFORMATION: Generics should be considered the first line of prescribing. This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. New-to-market products and new variations of products already in the marketplace will not be added to the formulary until the product has been evaluated, determined to be clinically appropriate and cost-effective, and approved by the CVS Caremark Pharmacy and Therapeutics Committee (or other appropriate reviewing body). In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market. Specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. The member's prescription benefit plan may have a different copay [1] for specific products on the list. Unless specifically indicated, drug list products will include all dosage forms. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. Generics listed in therapeutic categories are for representational purposes only. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to **www.caremark.com** to check coverage and copay [1] information for a specific medicine.

An exception process may exist for specific clinical or regulatory circumstances that may require coverage of an excluded medication.

***** The preferred options in this list are a broad representation within therapeutic categories of available treatment options and do not necessarily represent clinical equivalency.

§ Generics are available in this class and should be considered the first line of prescribing.

[†] Expected Availability 12/15/16

[1] Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

[2] Listing does not include generic CARDIZEM LA.

[3] A ONETOUCH blood glucose meter may be provided at no charge by the manufacturer to those individuals currently using a meter other than ONETOUCH. For more information on how to obtain a blood glucose meter, call: 1-800-588-4456.

[4] ONETOUCH brand test strips are the only preferred options.

[5] BD ULTRAFINE syringes and needles are the only preferred options.

[6] Coverage may be altered or copay [1] amounts may vary based on the condition being treated (e.g. psoriasis).

[7] Listing reflects the authorized generics for TESTIM and VOGELXO.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.
CVS Caremark may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber. The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

 15045-1-010117 **www.caremark.com**

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. For specific information, visit **www.caremark.com** or contact a CVS Caremark Customer Care representative.

CVS caremark™

Intentionally left blank

Enjoy **easy refills** and the extra **convenience** of **automatic refills.**

You can refill your mail order prescription in three simple ways:

OPTION 1

Online at **www.caremark.com**

OPTION 2

Call us at the number on the back of your prescription ID card

OPTION 3

Mail in a completed order form (there's one included in your prescription delivery)

Save time when you sign up for **ReadyFill at Mail®**. This automatic prescription refill and renewal program is a no-cost service provided by CVS Caremark Mail Service Pharmacy. We do all of the refill ordering work for you. No need to fill out forms, make calls or go online to order refills. If a copay* is required, you will ONLY be charged when your prescription ships.

Ready when you are.

When you enroll qualified prescriptions in ReadyFill at Mail, we will automatically refill your prescriptions at the appropriate time, unless you cancel. We will also contact your doctor to renew a prescription once the last refill is up or the prescription is about to expire.

ReadyFill at Mail stays in contact.

You can select which prescription(s) to include and your preferred method of communication (automated phone call, email or text message) to receive notices about them. If you select automated phone calls or text messages, you may also receive notice by email or U.S. mail.

Enroll in ReadyFill at Mail

1. **Register or sign in to Caremark.com, then go to the Manage Rx page. Select the eligible prescriptions you want to enroll and follow the steps.**

OR

2. **Call the toll-free Customer Care number on your prescription ID card.**

So many **benefits, no extra cost.**

Your prescription benefit plan offers a way for you to save both time and money on long-term prescriptions. For medicines you or your family members take regularly, the CVS Caremark Mail Service Pharmacy will deliver them to you – at no extra cost. Mail service is available for prescriptions used to treat conditions such as high cholesterol, asthma, arthritis, diabetes, heart disease and high blood pressure.

CVS Caremark Mail Service Pharmacy offers many benefits, including:

- **Greater convenience:** Order 90-day supplies of your medicine through mail service, and enjoy no-cost, dependable and regular delivery of prescriptions to your home or location of choice. This saves you a trip to the retail pharmacy every 30 days.

- **Lower prescription costs:** Most 90-day prescriptions ordered through mail service cost less compared to getting three 30-day supplies at a retail pharmacy. Visit the Savings Center at www.caremark.com to see how much you can save.
- **Personal service:** Speak with a registered pharmacist by calling the 24-hour, toll-free number on your prescription card when you have questions about your prescriptions.
- **Secure delivery:** Your medicines are sent in plain packaging to protect your privacy. The package is tamper-proof and, if necessary, temperature-controlled to protect certain medications and for your safety. You can even track delivery on your own through **Caremark.com**, or call us at the number on your prescription ID card and we can do it for you.

It's easy to start using mail service. Choose ONE of the following three ways:

1. **Call the FastStart® toll-free number** on your prescription ID card

   A representative will let you know which of your prescriptions can be filled through CVS Caremark Mail Service Pharmacy. We will then contact your doctor for a 90-day prescription and will mail your medication to you.

When you call, be sure to have:

- The ID number from your prescription card
- Your doctor's first and last name and phone number
- Your payment information and mailing address

2 Log onto www.caremark.com/faststart

Going online is a quick and easy way to start using mail service. Once you provide the requested information, we'll contact your doctor for a 90-day prescription. If you haven't registered yet on **Caremark.com**, be sure to have your prescription card with your ID number handy when you register for the first time.

3 Fill out and send a mail service order form

If you already have a 90-day prescription, you can send it to us with a completed mail service order form. Please have the following information with you when you complete the form:

- The ID number from your prescription ID card
- Your complete mailing address, including zip code
- Your doctor's first and last name and phone number
- A list of your allergies and other health conditions
- Your credit or debit card number if you prefer that method of payment

- You can also pay by check, electronic check, Bill Me Later® or money order (Cash is NOT accepted)
- Your original prescription from your doctor for up to a 90-day supply

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medicine:

- One for a short-term supply (30 days or less) that can be filled at a retail pharmacy participating in the CVS Caremark Retail Pharmacy Network

AND

- One for the maximum days supply allowed by your plan (usually 90 days), with up to three refills. Enclose this prescription along with the mail service order form you send in.

Members give us high marks for service.

Each year, close to five million people choose the convenience and cost savings of CVS Caremark Mail Service Pharmacy to fill their long-term prescriptions. A recent survey**of members using mail service revealed that:

- 98 percent are very satisfied overall
- 97 percent think mail service is convenient
- 96 percent would recommend mail service to their family and friends
- 95 percent think mail service is easy to use

If you have questions or need help with your mail-service order, simply call the toll-free number on your prescription ID card.

Convenience. Cost-savings. Delivered to you.

CVS Caremark Mail Service Pharmacy

ReadyFill at Mail is available for most common maintenance medications for chronic conditions or long-term therapy. Not all mail service prescriptions are eligible. Medications such as controlled substances, specialty drugs and prescriptions covered by certain government payers, including Medicare Part B, are not part of this program. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

*Copay, copayment or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, or a fixed amount or other charge, with the balance, if any, paid by the Plan.

**CVS Caremark Mail Service Pharmacy 2009 Member Satisfaction Survey.

49-28346a 082613

TDD: 1-800-863-5488

CVS CAREMARK

CVS CAREMARK Mail Service Order Form

Mail this form to:

CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

Enter ID # below if not shown or if different from above

Prescription Plan Sponsor or Company Name

Please fold here

Please use **blue or black ink, capital letters,** and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit ID Card.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Name | Apt./Suite #

○ **Use this address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

We may package all of these prescriptions together unless you tell us not to.

C **Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: ◯ Easy open caps ◯ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ◯ M ◯ F Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health Information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid Reflux ◯ Glaucoma ◯ Heart Problem ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Issues ◯ Thyroid ◯ Other: _____

2nd person with a refill or new prescription. This person needs: ◯ Easy open caps ◯ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ◯ M ◯ F Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health Information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid Reflux ◯ Glaucoma ◯ Heart Problem ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Issues ◯ Thyroid ◯ Other: _____

Please fold here

Please fold here

D **Special Instructions:** _____

E **How would you like to pay for this order?** Fill in the oval to choose a payment.

◯ **Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.

◯ **Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.

◯ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

◯ Fill in this oval to use your card on file.

◯ Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER _____ Exp. Date MMYY

_____
Credit Card Holder Signature/Date

◯ **Check or Money Order.** Amount: $ ____ . __

- Make check or money order out to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

◯ Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Regular delivery is free and will take 7 to 10 days from the day you send this form.
If you want faster delivery, choose:

◯ **2nd Business Day ($17)**
◯ **Next Business Day ($23)**

Business days are only Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.

MTP-MOF-2010

Mail Service Means One Less Thing for You to Do

Your prescription benefit offers you the convenient option to get 90-day* supplies of your long-term** medications delivered to you by mail. When you use the CVS Caremark Mail Service Pharmacy to fill your prescriptions, you'll enjoy the many benefits it provides:

- **Added value** – 24/7 access to pharmacists, alert messages by e-mail, text or phone
- **Cost savings** – one 90-day supply may cost less than three 30-day supplies at a retail pharmacy
- **Greater convenience** – at-home delivery at no extra cost, easy refills online or by phone
- **Quality and safety** – dedicated pharmacists checking each and every order

Let us handle the legwork of filling your long-term prescriptions so you don't have to. See the back side to learn how to get started.

To learn more, visit www.caremark.com or call the number on your Prescription Card.

*Actual quantity may vary depending on your plan.

**A long-term medication is taken regularly for chronic conditions, such as high blood pressure, high cholesterol or diabetes, or long-term therapy.

Mail Service

Your medicine will be delivered within 10 days from the time your order is placed.

CVS CAREMARK

Get Started with CVS Caremark Mail Service

It's quick and easy!

If you have a prescription, choose one of two ways to submit it:

- **Mail your prescription** and a completed order form to CVS Caremark
- **Ask your doctor** to call in your prescription toll-free at 1-800-378-5697

If you need a prescription, choose from two FastStart® options to get started:

- **Phone** – Call FastStart toll-free at **1-800-875-0867*** from 7 a.m. to 7 p.m. (CT) Monday-Friday
- **Online** – Log on to **www.caremark.com/faststart** and sign in or register, if necessary

Have your Prescription Card number, the names of your medicines, your doctor's information and your payment information ready. We'll handle the rest.

*For TDD assistance, please dial toll-free 1-800-231-4403.

Mail Service

FastStart is quick, convenient and saves you a trip to the doctor's office for a new prescription.

CVS CAREMARK

www.caremark.com

CVS CAREMARK Specialty Pharmacy

Specialty Guideline Management (SGM) Frequently Asked Questions

Specialty medications, whether they are injectable, infused or oral formulations, are expensive, have significant side effect profiles, and are often used to treat chronic diseases. Because of this, patients who take specialty medications require greater clinical oversight and attention. Many of our clients request that we implement specific criteria to ensure clinically appropriate use of specialty medications. Here are some frequently asked questions on how CVS Caremark Specialty Pharmacy helps ensure proper oversight, patient safety and clinical appropriateness on behalf of our clients.

Q1: How does CVS Caremark Specialty Pharmacy ensure appropriate use of specialty medications?

A1: Specialty drugs—typically high-cost biologic medications—often have complex dosing regimens and the risk of serious adverse reactions. CVS Caremark Specialty Pharmacy has a comprehensive prior authorization program, Specialty Guideline Management (SGM), to promote patient safety and ensure appropriate use of specialty medications. SGM helps to prevent adverse events and waste associated with specialty medications that are not appropriate, safe and/or effective for the member.

Evidence-based criteria include U.S. Federal Drug Administration (FDA) approved indications and other use of drugs that are sufficiently supported by accepted compendia, national practice guidelines and medical evidence.

Q2: How does SGM work?

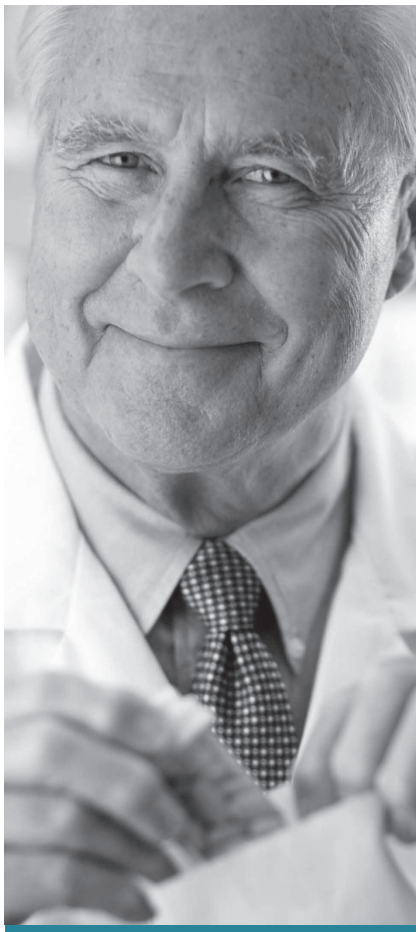
A2: Our Case Review Unit consists of clinician-led teams of nurses and pharmacists. They conduct both prospective and concurrent clinical reviews to help ensure that the prescribed specialty medication is appropriate, safe and effective for the member.

Q3: How are SGM guidelines developed?

A3: SGM criteria are developed by pharmacists on our clinical development team, reviewed by one or more of our medical directors and external physician specialists, and approved by the CVS Caremark National Pharmacy & Therapeutics (P&T) Committee. Independent external review helps ensure the program is clinically appropriate and consistent with generally-accepted standards of care.

Q4: How often are SGM guidelines updated?

A4: Clinical guidelines are continuously updated as new safety or medical evidence becomes available. We ensure our SGM criteria incorporate the latest evidence-based guidelines.



SGM can help save up to 7 percent of specialty spend.

To learn more about the program, please contact your CVS Caremark account team.

cvscaremarkspecialtyrx.com

CVS CAREMARK | Specialty Pharmacy

Q5: Why is pharmacogenomics testing and lab data required for certain drugs?

A5: Pharmacogenomics testing evaluates genetic factors influencing drug response. This testing along with other lab data is required for certain drugs to help ensure safety and effectiveness in certain disease states based on evidence-based guidelines.

Q6: How long does the typical SGM case review take?

A6: SGM review can be completed real-time if the physician calls in and provides all the necessary clinical information required for a specific condition—including diagnosis, pertinent lab values (i.e., viral load, liver function), failed medication treatments and pharmacogenomic testing. For faxed reviews, once all necessary information is received, a response is generally rendered within 24 hours. We send the member a letter, and the physician a fax, with the outcome of the review.

Q7: How will physicians know if an SGM review is required prior to starting therapy?

A7: If an SGM review is required, the physician's office will be notified by phone and/or fax.

Q8: What are common reasons for an SGM denial?

A8: Reasons include the following:

- Diagnosis does not meet criteria for coverage
- First line treatment not attempted/shown to be unsuccessful
- Medicines are inappropriate due to a disease or medical condition
- Medicine duplication or excessive use

Q9: How are denials handled?

A9: If there is an SGM denial, the member and physician office is notified. Our Case Review Unit will provide the physician office with the reason for the denial and information on the appeal process.

Q10: Can clients receive notification when a claim is denied?

A10: Clients can be granted access to our Web-based portal that has claim denial information.

Q11: How many members do not meet guidelines?

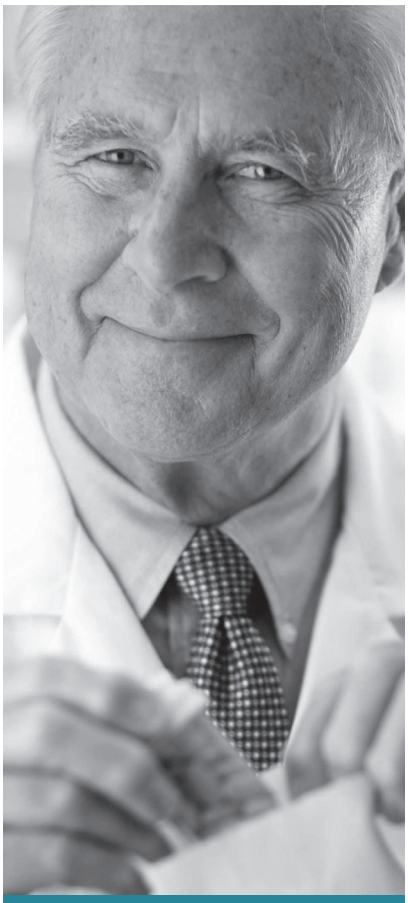
A11: The portion of members who do not meet guidelines varies by therapy, and can range from 4 percent to 40 percent.

Q12: What are the cost savings for this program?

A12: This program can help clients save up to 7 percent of specialty spend.

Q13: How much does a standard SGM review cost?

A13: The standard fee is $30 per review.



How many members do not meet guidelines?

The portion of members who do not meet guidelines varies by therapy, and can range from 4 percent to 40 percent.

To learn more about the SGM program, please contact your CVS Caremark account team.

cvscaremarkspecialtyrx.com

1. Internal CVS Caremark data, 2011. CVS Caremark Enterprise Analytics, September 2012.
2. Internal CVS Caremark data, 2010. CVS Caremark Enterprise Analytics, September 2011.

Plan member privacy is important to CVS Caremark. Our employees are trained regarding the appropriate way to handle members' private health information.

CVS CAREMARK

14423-1010
STANDARD

Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number *(refer to your prescription card)*

Group No./Group Name

Name *(Last Name)*

(First Name)

(MI)

Address

Address 2

City

State

Zip

Country

Patient Information–Use a separate claim form for each patient.

Name *(Last Name)*

(First Name)

(MI)

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other _____

Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? ❍ Yes ❍ No

Is the medicine covered under any other group insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company_____ ID #_____

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

Signature of Member **Date**

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this "Days Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

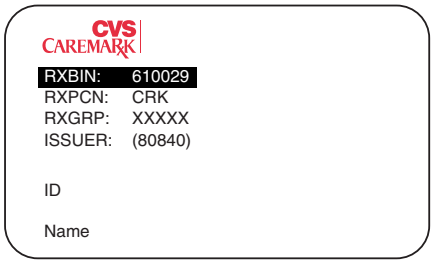
If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

If this claim is from a foreign country, please fill in below:

Country: _____ **Currency:** _____ **Amount:** _____

Additional Comments

STEP 3 Mailing Instructions:



The RXBIN # is located on front of your CVS Caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.

RXBIN # 610415 mail to:

CVS Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

RXBIN # 004336 , 012114 mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

RXBIN # 610029 mail to:

CVS Caremark
P.O. Box 52196
Phoenix, Arizona 85072-2196

RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

CVS Caremark
P.O. Box 52010
Phoenix, Arizona 85072-2010

RXBIN # 610473 , 610475 mail to:

CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

IMPORTANT REMINDER

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Important Notices

Notice of Special Enrollment Rights
New Mexico Institute of Mining & Technology

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependents become ineligible for Medicaid or a state child health insurance program (CHIP) and coverage is terminated, you and your dependents may enroll in this plan if eligible. You must request enrollment within 60 days after Medicaid or CHIP coverage is terminated.

If you or your dependents become eligible for a state premium assistance subsidy under Medicaid or a state child health insurance program (CHIP), you and your dependents may enroll in this plan if eligible. You must request enrollment within 60 days after eligibility for the subsidy is determined.

In addition, if you have a new dependent a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents. However, you must request enrollment within 30 days after the date of marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact:

Angie Gonzales at (575) 835-5643

Women's Health and Cancer Rights Act (WHCR)
Annual Notice

To:	All Participants in the New Mexico Institute of Mining & Technology Health Benefit Plan
Re:	Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Message:

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including the following?

- all stages of reconstruction;
- surgery to achieve symmetry between the breasts;
- prostheses; and
- complications resulting from a mastectomy, including lymphedema.

As required by the Women's Health and Cancer Rights Act of 1998, your medical program provides benefits for mastectomy related services (including the services listed above).

Coverage may be subject to applicable annual deductibles and copayment provisions. If you would like more information about the benefits available for mastectomy-related services, please refer to your SPD or call **Meritain Health, Inc.** at the following telephone number.

Toll-Free: (800) 925-2272

Important Notice from
New Mexico Institute of Mining & Technology
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with New Mexico Institute of Mining & Technology and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **New Mexico Institute of Mining & Technology has determined that the prescription drug coverage offered by the New Mexico Institute of Mining & Technology is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current New Mexico Institute of Mining & Technology coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drugs benefits.

If you do decide to join a Medicare drug plan and drop your current New Mexico Institute of Mining & Technology coverage, be aware that you and your dependents will be able to apply for coverage during an open enrollment period for the New Mexico Institute of Mining and Technology benefit plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with New Mexico Institute of Mining & Technology and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through New Mexico Institute of Mining & Technology changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 26, 2017
Name of Entity/Sender:	New Mexico Institute of Mining & Technology
Contact--Position/Office:	Human Resources
Address:	801 Leroy Place, Brown Hall; Socorro, NM 87801
Phone Number:	(575) 835-5643

INTERACTIVE HEALTH INFORMATION PRIVACY STATEMENT for Wellness Vendors and Employer-Sponsored Wellness Programs

Latest Revised Date: November 22, 2016

THIS PRIVACY STATEMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Interactive Health Solutions, Inc. d/b/a/ Interactive Health (and its subsidiaries Health Solutions, Inc., Health Solutions Services, Inc. individually and collectively referred to as "Interactive Health") and your Employer-Sponsored Wellness Program respects that you have entrusted us with your health information, and we are committed to safeguarding all the information you supply—including personal information, results of biometric screening tests, and information in your health risk assessment. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for various biometric measurements, including BMI, Blood Pressure, Glucose, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

This wellness program is voluntary and available to all eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act. This Statement sets forth Interactive Health's obligations and your rights in accordance with the Health Insurance Portability & Accountability Act and its amendments ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act and its amendments ("HITECH"), and the regulations issued under these Acts, but does not imply that Interactive Health is necessarily acting as a Covered Entity as defined by HIPAA. In most instances, Interactive Health receives and shares your "Protected Health Information" ("PHI") as a Business Associate and in accordance with a Business Associate Agreement. If you participate in a wellness program or disease management program ("Program") as a member of a "Health Plan", the Health Plan may have a separate Notice of Privacy Practices that might also be applicable to your PHI. When you receive health care services from a third-party, such as laboratory testing services, the laboratory's Notice of Privacy Practices may apply to your PHI. All capitalized terms not otherwise defined in this Privacy Statement will have the meanings assigned to them under HIPAA. References to "us", "we" and "our" refer to Interactive Health.

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

Interactive Health has policies and procedures in place to protect the privacy and security of your personal information including your PHI. Interactive Health uses a combination of physical, electronic, and procedural safeguards in accordance with applicable Federal and State laws. To use the Interactive Health website or mobile device accessible applications you will create your own password protected account. Data transfer, storage, and integrity are secured and transmitted via secure encryption technology, regular data backups, and key code authentication. Interactive Health also limits access to your PHI only to those employees, contractors and agents who need the data to do their jobs or provide their services.

We reserve the right to change the terms of our Information Privacy Statement and to make the new provisions effective for all PHI that we maintain. If and when this statement is changed, we will post this information on our website and provide you with a copy of the revised Information Privacy Statement upon your request or as otherwise required by law. It is your responsibility to check our website periodically for updates or changes to our privacy statement.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

1. USES AND DISCLOSURES FOR PARTICIPANT SERVICES, PAYMENT, AND HEALTH CARE OPERATIONS

Interactive Health is permitted to use and disclose PHI for participant services, payment, and health care operations and, when applicable, in accordance with a Business Associate Agreement as required by HIPAA. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. The following examples are illustrative and do not list every type of use or disclosure that may fall within that category.

Participant Services: Interactive Health may use and disclose your PHI in connection with your participation in a Program to help you understand your health and potential risks to your health. Your Program may involve, at your option, completing a health risk assessment form, obtaining laboratory biometric screenings for various health risks, discussing your health with health care coaches or others associated with your Program. Interactive Health may provide you with online viewing of forms, explanations of lab test results and other health care information that may be relevant to you. Interactive Health may disclose PHI to third-parties designated by the sponsoring health plan for use in your participation in the Program.

Payment: HIPAA permits the use and disclosure of PHI so that we can bill and collect payment for our services, however Interactive Health's policy is not to share biometric screening results in connection with billing and payment processes.

Health Care Operations: Interactive Health is permitted to use and disclose your PHI in performing business operations. These include conducting quality improvement activities, training and auditing functions, and cost management analysis and customer service. We may use and disclose your PHI to provide training to new employees who work with PHI within the scope of their employment. All of our employees receive training on the importance of maintaining the privacy of your PHI. Interactive Health may also provide data aggregation services to your sponsoring health plan as part of the plan's health care operations whereby Interactive Health would aggregate de-identified information for purposes of data analyses relating to the plan's operations. De-Identified Information is PHI that has been de-identified by removing all references to individually identifiable information.

Health Related Services: Interactive Health may contact you to provide appointment reminders or to provide you with information about changes to your Program or other participant services that may be of interest to you as we view such information as part of the services you receive under your Program. And, as directed by you or your sponsoring health plan, our contracted third-party vendors

may contact you directly with such Program information.

2. OTHER USES AND DISCLOSURES

Disclosures Required By Law: We will disclose your PHI when required to do so by law. For example, we may disclose your PHI when required by national security laws, or when required by the U.S. Department of Health & Human Services.

Business Associates: In accordance with the Participant Services, Health Care Operations, and/or Payment permitted uses and disclosures, we may provide your PHI to other companies (such as third-party wellness providers, disease management providers, Health plans, and/or other health management providers) or other individuals (i) to assist us in providing you with health and wellness services in conjunction with your Program, or (ii) that perform various activities on our behalf. These other entities are referred to under HIPAA as Business Associates. Interactive Health is required by HIPAA to have written Business Associate Agreements with these entities whenever we will share your PHI with the Business Associate. Likewise, we may receive your PHI by virtue of providing Business Associate services to your sponsoring health plan or Covered Entity. Business Associates are required by HIPAA to maintain privacy and security of PHI and to only use/disclose your PHI in accordance with HIPAA.

Incentive Program: Interactive Health may provide certain elements of your information to your sponsoring health plan or incentive administrator for purposes of administering the Health Plan or the implementation of incentives related to your participation in the Program. Your employer may receive a confirmation only that you have qualified for an incentive. However, Interactive Health will not provide your employer with information you supplied on your Health Risk Assessment, your biometric screening results, or how you qualified for an incentive. Employees who choose to participate in the wellness program will be eligible for incentives, as detailed in your Employer-Sponsored Wellness Program. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable alternative standard or a reasonable accommodation.

Uses and Disclosures Requiring Authorization: Other uses and disclosures of PHI about you will be made only with your written authorization. Each authorization will contain an expiration date, your signature and date. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization. You may make such revocation by providing written notice to the address provided below. Information disclosed pursuant to your authorization may be subject to re-disclosure by the recipient and no longer be protected under HIPAA.

Website and Security Procedures: Interactive Health may use personally identifiable information collected through our website to tailor your use and experience on the website and to authenticate your access to our website.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Right to Request Restrictions: You have the right to request additional restrictions on certain uses and disclosures of PHI, including those related to family members or to certain individuals involved in your care or benefit coverage that otherwise are permitted by HIPAA. Interactive Health is not required to agree to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases. To request restrictions, you must make your request in writing to the Covered Entity (for example, your sponsoring health plan), or in accordance with any Business Associate responsibilities assumed by us, to our Privacy Officer.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that Interactive Health contact you at home, rather than at work. You must make your request in writing to the Covered Entity (for example, your sponsoring health plan), or in accordance with any Business Associate responsibilities assumed by us, to our Privacy Officer in writing. \

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you from the Covered Entity, and perhaps in certain records that Interactive Health maintains as a Business Associate. We may deny your request only in limited circumstances. To inspect and copy PHI, contact our Privacy Officer. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used to meet your request.

Right to Amend: You have the right to request that the Covered Entity, and perhaps in certain instances that we, amend PHI about you as long as such information is kept by or for our office. To make this type of request of us, you must submit your request in writing to our Privacy Officer. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request or if we are not the proper entity under HIPAA to perform such amendments.

Right to Receive an Accounting of Disclosures: You have the right to receive a list of certain disclosures of your PHI in the past six years other than disclosures made for participant services, payment or health care operations, disclosures made to you or made pursuant to an authorization, and certain limited exceptions under HIPAA. You may exercise this right by contacting the Covered Entity and Interactive Health will work closely with the Covered Entity to provide any accounting of disclosures in accordance with HIPAA.

Right to Breach Notification: Under HIPAA, a Covered Entity must provide notification to you upon any Breach of your Unsecured PHI. Interactive Health will work with the Covered Entity to provide any information necessary as required of a Business Associate.

Right to a Paper Copy of this Statement: You have a right to receive a paper copy of this statement even if you have previously agreed to receive this statement electronically. To obtain a paper copy or a prior version of this statement, contact the Privacy Officer.

Questions/Complaints: If you want further information about matters covered in this Privacy Statement, or believe that your privacy rights have been violated, or disagree with a decision made about access to your personal and health information, you can contact our Privacy Officer. You may also submit a complaint to the Office of Civil Rights of the U.S. Department of Health and Human Services. We want to hear your concerns and you will not be retaliated against if you file a complaint. **For more information regarding this notice, protections against discrimination and retaliation from your Employer, or a reasonable alternative standard Contact your Sponsored Wellness Program.**

For more information about this Notice from your Wellness Provider:	**For more information about HIPAA or to file a complaint:**
Interactive Health, Attention: Privacy Officer 1700 East Golf Road, Suite 900, Schaumburg, Illinois 60173 (800) 840-6100	The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 / Toll Free: 1-877-696-6775

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

New Mexico Institute of Mining & Technology Health Benefit Plan
Notice of Privacy Practices

Effective Date: September 23, 2013

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Dental
- Vision

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit

management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of New Mexico Institute of Mining & Technology. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions

are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities**.** The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested

and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information

is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at New Mexico Institute of Mining & Technology, 801 Leroy Place, Brown Hall; Socorro, New Mexico 87801 or by calling (575) 835-5643. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and

- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at Mexico Institute of Mining & Technology, 801 Leroy Place, Brown Hall; Socorro, New Mexico 87801 or by calling (575) 835-5643.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at Mexico Institute of Mining & Technology, 801 Leroy Place, Brown Hall; Socorro, New Mexico 87801 or by calling (575) 835-5643.

MERITAIN HEALTH

An Aetna Company