IMPORTANT INFORMATION REGARDING THE

ZF NORTH AMERICA, INC.
WELFARE BENEFIT PLAN

PRESCRIPTION DRUG BENEFIT PROGRAM

Revised and Restated as of
January 1, 2015

Prescription drug coverage is provided only to employees and eligible dependents who are enrolled in one of the ZF medical plan options. Express Scripts, Inc. ("ESI") administers the prescription drug card program for ZF North America, Inc. The prescription drug program is a part of the ZF North America, Inc. Welfare Benefits Plan.

There is a separate prescription drug ID card for this coverage.

PHARMACY NETWORK

When filling a prescription, please use an ESI network pharmacy. With ESI, you have access to a wide network of pharmacies. You can locate an ESI pharmacy by calling (800) 987-5248 or by visiting their website at www.express-scripts.com.

How To Fill A Prescription: You may fill your prescriptions at any ESI network pharmacy and receive a 30-day supply. You can also receive up to a 90-day supply through the mail order program. If you want to utilize the mail order program administered by ESI, it's best to ask your doctor for two prescriptions – one to fill at a retail pharmacy to meet your immediate needs and one to send in to the mail order pharmacy. Detailed information on the mail order program can be obtained from Human Resources or ESI.

PRESCRIPTION DRUG COSTS

Our plan features a two-tier drug structure – generic and brand. Covered medications are listed on the drug formulary. The amount you pay for each prescription depends on whether the drug is a brand or generic medication. Your costs are summarized in *Appendix A,* and are subject to change.

The pharmacy benefit uses a drug classification list, sometimes referred to as a formulary. A formulary is a list of prescription medications selected for coverage under the plan. Drugs may be included on the formulary based upon their effectiveness, safety and cost. When new medications become available, they are evaluated by ESI and are either placed onto the formulary or rejected for coverage under the program. The ZF plans utilize the *Preferred Formulary.*

A generic drug contains the same active ingredients and comes in the same strengths as the original brand-name drug. The medications used are approved by the U.S. Food and Drug Administration (FDA), yet cost much less than their brand-name counterparts. You save the most when you choose generic drugs.

LIMITATIONS, RESTRICTIONS & EXCLUSIONS

Not all prescription drugs will be covered under the plan. Some of the medications covered under the program have limits and restrictions. Some medications are excluded from coverage. These plan details are summarized in *Appendix B.*

In addition, some drugs require prior authorization and/or step therapy, or certain clinical criteria must be met before coverage is provided. You may not have coverage for a specific drug unless your physician and ESI agree that the alternatives are not effective and/or harmful to your health.

Mandatory Generic Enforcement: In the ZF PPO plan, if your doctor writes you a prescription for a Brand Name Drug or you have your pharmacy fill a prescription with a Brand Name Drug when a Generic Drug is available, you are responsible for the appropriate Brand copay plus the difference in cost between the Generic Drug and the Brand Name drug.

MEDICAL PLAN INCLUSION

The provisions of the medical coverage are incorporated by reference in the prescription drug coverage except where inconsistent with the provisions of the prescription drug benefit. To be covered under the prescription drug program, you must be covered under one of the ZF medical plans.

CLAIMS PROCEDURES

ESI is responsible for evaluating the benefit claims under the Plan. ESI will make a decision on your claim in accordance with reasonable claims procedures, as required by ERISA. ESI has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to make a decision on your claim.

HOW TO FILE A CLAIM: If a participating pharmacy fills your prescription, present your identification card and pay the applicable co-payment amount.

You may submit a claim for benefits if the pharmacist will not file it on your behalf, or if the prescription is not run through your coverage for some reason (i.e. you do not have your prescription card with you, and pay out-of-pocket for the medication).

Submit your claims on a completed claim form to the below address. Claim forms can be obtained from Human Resources or by contacting ESI.

Express Scripts ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

INITIAL BENEFIT NOTIFICATION

Post-Service Determinations: A post-service care claim is one that may be filed and approved **after** the service is rendered.

In the case of a post-service claim, ESI shall notify you of the determination within thirty (30) days after receipt of the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if ESI determines that such an extension is necessary due to matters beyond the control of the Plan.

If you fail to provide ESI with sufficient information to make a determination, ESI shall notify you of the specific information necessary to complete the claim. You shall be permitted forty-five (45) days to provide the specified information.

Concurrent Care Determinations: A concurrent care decision is one where ESI has approved your ongoing course of treatment, and then the Plan reduces or terminates coverage for your course of treatment (other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim.

In the case of a reduction or termination of an ongoing course of treatment that ESI had previously approved, or in the case of your request to extend the course of treatment previously approved by ESI, ESI shall notify you of the benefit determination within a

reasonable period of time. In the case of urgent care, in no event shall the period of time exceed twenty-four (24) hours after receipt of the claim.

HOW TO APPEAL YOUR ADVERSE BENEFIT DETERMINATION

If you wish to appeal an adverse benefit determination you shall: 1) Receive full and fair review of the claim and the appeal of the adverse benefit determination; 2) The request for an appeal of an adverse benefit determination must be in writing, and filed with ESI.

An *administrative appeal* is based on the plan's benefit design or conditions of coverage without additional information required from the prescriber. A *clinical* appeal is based on conditions of coverage and may require additional information from the prescriber.

Address your appeal request to:

Administrative Appeals
Express Scripts
PO Box 66587
St. Louis, MO 63166-6587
Attn: Administrative Appeals Department

Phone: (800) 946-3979

Clinical Appeals
Express Scripts
PO Box 66588
St. Louis, MO 63166-6588
Attn: Clinical Appeals Department

Phone: (800) 753-2851

You shall have one hundred-eighty (180) days to file an appeal following receipt of an adverse benefit determination. See Appendix C for more details on the appeal process.

YOUR RIGHT TO BRING CIVIL SUIT

You have the right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review. Other voluntary alternative dispute resolutions may be available. You should contact the local office of the Department of Labor. Copies of the documents, records and other information relevant to the denied claim shall be made available to you at no charge, upon written request.

Appendix A – Copayments as of January 1, 2015

ZF PPO

PRESCRIPTION DRUG COPAYMENTS (RETAIL)

30-day supply

	In-Network	Out-of-Network
Generic	$15 copay	$15 copay
Brand	40% copay (minimum of $15 and maximum of $75)	40% copay (minimum of $15 and maximum of $75)

PRESCRIPTION DRUG COPAYMENTS (MAIL ORDER)

Up to a 90-day supply

	In-Network	Out-of-Network
Generic	$38 copay	Not covered
Brand	40% copay (minimum of $38 and maximum of $188)	Not covered

ZF HDHP

PRESCRIPTION DRUG COPAYMENTS (RETAIL)

30-day supply

	In-Network	Out-of-Network
Generic	20% copay after deductible	40% copay after deductible
Brand	20% copay after deductible	40% copay after deductible

PRESCRIPTION DRUG COPAYMENTS (MAIL ORDER)

Up to a 90-day supply

	In-Network	Out-of-Network
Generic	20% copay after deductible	Not covered
Brand	20% copay after deductible	Not covered

ADDITIONAL INFORMATION

- Under Health Care Reform legislation, certain preventive drugs in the ZF PPO and ZF HDHP are covered at $0 copay. See ESI for a list of these medications.
- In the ZF PPO and ZF HDHP, out-of-pocket prescription drug costs accumulate toward the medical out-of-pocket maximum.

- In the ZF HDHP, for medications on the *preventive drug list,* you will pay the coinsurance for the drug without having to first satisfy your deductible. The amount will count toward your out-of-pocket maximum.
- If you use a non-participating pharmacy, you must pay the difference above the amount ESI would pay a participating pharmacy.
- Even though your physician has written a prescription for a drug, the drug may not be covered if there is an equivalent over-the-counter drug available, or if it is on the excluded list. Your pharmacist should tell you when this is the case. You can also contact ESI to check if a medication is covered, and if not, if there are alternative options covered under the plan.
- Insulin, needles, and syringes purchased on the same day in the same quantity will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.

Appendix B – Exclusions and Limitations

Some drugs require prior authorization and/or step therapy and certain clinical criteria must be met before coverage is provided. You may not have coverage for a specific drug unless your physician and ESI agree that the alternatives are not effective and/or harmful to your health. If you have questions or concerns, you should contact ESI.

Certain classes of drugs, or certain medications, are excluded from coverage. ***You should contact ESI to inquire about a specific medication or drug class.*** In most cases, if you fill a prescription for a drug on the excluded list, you will pay the full retail price.

Additionally, prescriptions are generally not covered under the program if they are:

- Over-the-counter
- Investigational
- Insulin non-drugs
- Glucowatch products
- Abortifacients Mifeprex
- Nutritional Supplements and Combo Nutritional Products
- Ostomy Supplies
- 3-Month Prepackaged Injectables (Non-Specialty)
- S 100402 - Alcohol Swabs
- Cosmetic Drugs – including all Hypopigmentation, Renova, Vaniqa
- Biologicals, Immunizations/Vaccines, Allergy Sera, Blood prd

Appendix C – Appeals

PURPOSE
To outline the ESI Reviews and Appeals Procedures for Commercial clients.

COVERAGE REVIEW DESCRIPTION
A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. ESI reviews both clinical and administrative coverage review requests:

- **Clinical coverage review request**: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- **Administrative coverage review request**: A request for coverage of a medication that is based on the Plan's benefit design.

HOW TO REQUEST AN INITIAL COVERAGE REVIEW
The preferred method to request an initial clinical coverage review is for the prescriber or dispensing Pharmacist to call the ESI Coverage Review Department at (800) 753-2851. Alternatively, the prescriber may submit a completed coverage review form to Fax (877) 329-3760.

Forms may be obtained online at www.express-scripts.com/services/physicians/. Requests may also be mailed to Express Scripts Attn: Prior Authorization Dept., PO Box 66571, St. Louis, MO 63166-6571. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing to Express Scripts Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at (800) 753-2851.

HOW A COVERAGE REVIEW IS PROCESSED
In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to ESI for review. For an administrative coverage review request, the member must submit information to ESI to support their request.

The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe *Decisions are completed as soon as possible from receipt of request but no later than:*	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

HOW TO REQUEST A LEVEL 1 APPEAL OR URGENT APPEAL AFTER AN INITIAL COVERAGE REVIEW HAS BEEN DENIED

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient Member ID Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests:

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax (877) 852-4070

Administrative appeal requests: Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax (877) 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: Phone (800) 935-6103 / Fax (877) 852-4070

Administrative appeal requests: Phone (800) 946-3979 / Fax (877) 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

HOW A LEVEL 1 APPEAL OR URGENT APPEAL IS PROCESSED
ESI completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by an ESI Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company. Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** *Decisions are completed as soon as possible from receipt of request but no later than:*	**Notification of Decision**	
		Approval	**Denial**
Standard Pre-Service	15 days	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

HOW TO REQUEST A LEVEL 2 APPEAL AFTER A LEVEL 1 APPEAL HAS BEEN DENIED
When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient Member ID Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests:	Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588 Fax (877) 852-4070
Administrative appeal requests:	Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587 Fax (877) 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests:	Phone (800) 935-6103 Fax (877) 852-4070
Administrative appeal requests:	Phone (800) 946-3979 Fax (877) 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

HOW A LEVEL 2 APPEAL IS PROCESSED
ESI completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an ESI Pharmacist, Physician, panel of clinicians or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** *Decisions are completed as soon as possible from receipt of request but no later than:*	**Notification of Decision**	
		Approval	**Denial**
Standard Pre-Service	15 days	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful)