

Prescription Benefits

State of Indiana

CVS Caremark manages your prescription drug benefit
under a contract with the State of Indiana Personnel Department.

This Prescriptions Benefit document describes how to get prescription medications, what medications are covered and not covered, and what portion of the prescription costs you will be required to pay.

CVS Caremark, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit under contract with the State of Indiana. CVS Caremark maintains the Preferred Drug list (also known as a Formulary), manages a network of retail pharmacies and operates Mail Service and Specialty Drug pharmacies. CVS Caremark, in consultation with the Plan, also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions and other safety measures.

Employees and dependents covered by the State of Indiana prescription drug benefit can use either retail or the CVS Caremark Mail Service Pharmacy. Your benefit covers most prescription drugs, plus insulin and some over-the-counter (OTC) diabetes supplies and certain other OTC items considered preventative under the Health Care Reform Act. Certain medications are subject to limitations and may require prior authorization for continued use.

Retail Pharmacies

Retail pharmacy service is most convenient for short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the CVS Caremark network.

All major chain pharmacies participate in the network. If you are using an independent drugstore, you should confirm whether it participates, too. To find out, visit www.caremark.com, use the CVS Caremark mobile app, or call CVS Caremark Customer Care at 1-866-234-6869.

CVS Caremark Mail Service

Members that need medication on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma.

- Medications are shipped standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after we receive your order.
- Refills usually arrive in less time – refills ordered online or via the CVS Caremark Mobile App are usually delivered within 3-5 days and refill orders mailed in are usually delivered within 6-9 days.
- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines and other important details.
- You can track your prescriptions and order refills at www.caremark.com, via the CVS Caremark mobile app, or by calling 1-866-234-6869.
- Registered pharmacists are available around the clock for consultation.

SCHEDULE OF BENEFITS

State of Indiana Prescription benefit plan design TRADITIONAL PLAN			
	Retail, network pharmacy (Up to 30-day supply)	CVS Caremark Mail Service (Up to a 90-day supply)	Retail, network pharmacy (Up to 90-day supply)
Generics	\$10	\$20	\$30
Brands: preferred / formulary	20% of prescription cost Min \$30 Max \$50	20% of prescription cost Min \$60 Max \$100	20% of prescription cost Min \$90 Max \$150
Brands: non-preferred / non-formulary	40% of prescription cost Min \$50 Max \$70	40% of prescription cost Min \$100 Max \$140	40% of prescription cost Min \$150 Max \$210
Contraceptive/Preventative Meds (Generic and single-source as mandated by the Affordable Care Act)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)
Retail and CVS Specialty) (up to a 30-day supply)			
Specialty drugs	40% of prescription cost Minimum \$75 Maximum \$150		
<p>Deductible (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$1,000 single / \$2,000 family* Prescription drug copayments/coinsurance are subject to the deductible. <p>Out-of-pocket/OOP limit (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$2,500 single / \$5,000 family* Prescription drug copayments/coinsurance are subject to the OOP limit; once the member and/or family OOP limit is satisfied, no additional copayments/coinsurance are required for the remainder of the calendar year. <p>Retail out-of-network claims (direct) are reimbursed based on copays above and member also pays any difference between the pharmacy charge and the allowable costs</p>			

State of Indiana Prescription benefit plan design CONSUMER DRIVEN HEALTH PLAN 1			
	Retail, network pharmacy (Up to 30-day supply)	CVS Caremark Mail Service (Up to a 90-day supply)	Retail, network pharmacy (Up to 90-day supply)
Generics	\$10	\$20	\$30
Brands: preferred / formulary	20% of prescription cost Min \$30 Max \$50	20% of prescription cost Min \$60 Max \$100	20% of prescription cost Min \$90 Max \$150
Brands: non-preferred / non-formulary	40% of prescription cost Min \$50 Max \$70	40% of prescription cost Min \$100 Max \$140	40% of prescription cost Min \$150 Max \$210
Contraceptive/Preventative Meds (Generic and single-source as mandated by the Affordable Care Act)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)
Retail and CVS Specialty (up to a 30- day supply)			
Specialty drugs	40% of prescription cost Minimum \$75 Maximum \$150		
<p>Deductible (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$3,000 single / \$6,000 family* Prescription drug copayments/coinsurance are subject to the deductible. <p>Out-of-pocket/OOP limit (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$4,500 single / \$9,000 family* Prescription drug copays/coinsurance are subject to the OOP limit; once the member and/or family OOP limit is satisfied, no additional copayments/coinsurance are required for the remainder of the calendar year. <p>Retail out-of-network claims (direct) are reimbursed based on copays above and member also pays any difference between the pharmacy charge and the allowable costs</p>			

State of Indiana Prescription benefit plan design CONSUMER DRIVEN HEALTH PLAN 2			
	Retail, network pharmacy (Up to 30-day supply)	CVS Caremark Mail Service (Up to a 90-day supply)	Retail, network pharmacy (Up to 90-day supply)
Generics	\$10	\$20	\$30
Brands: preferred / formulary	20% of prescription cost Min \$30 Max \$50	20% of prescription cost Min \$60 Max \$100	20% of prescription cost Min \$90 Max \$150
Brands: non-preferred / non-formulary	40% of prescription cost Min \$50 Max \$70	40% of prescription cost Min \$100 Max \$140	40% of prescription cost Min \$150 Max \$210
Contraceptive/Preventative Meds (Generic and single-source as mandated by the Affordable Care Act)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)	\$0 (not subject to the deductible)
Retail and CVS Specialty (up to a 30-day supply)			
Specialty drugs	40% of prescription cost Minimum \$75 Maximum \$150		
<p>Deductible (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$2,000 single / \$4,000 family* Prescription drug copayments/coinsurance are subject to the deductible. <p>Out-of-pocket/OOP limit (combined Rx + medical accumulator):</p> <ul style="list-style-type: none">* \$4,000 single / \$8,000 family* Prescription drug copayments/coinsurance are subject to the OOP limit; once the member and/or family OOP limit is satisfied, no additional copayments/coinsurance are required for the remainder of the calendar year <p>Retail out-of-network claims (direct) are reimbursed based on copays above and member also pays any difference between the pharmacy charge and the allowable costs</p>			

Prior Authorization

Prior Authorization may be required for certain prescription drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. CVS Caremark uses criteria developed by their Pharmacy and Therapeutics Committee which have been reviewed and adopted by the Plan. CVS Caremark may contact your provider if additional information is required to determine whether Prior Authorization should be granted. CVS Caremark communicates the results of the decision to both you and your provider.

If Prior Authorization is denied, written notification is sent to both you and your providers. You have the right to appeal through the appeals process. The written notification of denial you receive provides instructions for filing an appeal.

To ask if a drug requires Prior Authorization, please contact CVS Caremark Customer Care at 1-866-234-6869.

You, your provider, or pharmacist, may check with CVS Caremark Customer Care to verify covered prescription drugs, any quantity and/or age limits, prior authorization, or other requirements of the Plan.

Formulary or preferred drug list

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage while maintaining the high quality of care.

CVS Caremark shall not remove a prescription drug from the Plan's formulary, change the cost sharing requirements that apply to a prescription drug, or change the utilization review requirements that apply to a prescription drug unless:

- At least sixty (60) days before the removal or change is effective, send written notice of the removal or change to each Plan member for whom the prescription drug has been prescribed during the preceding twelve (12) month period or
- At the time a Plan member for whom the prescription drug has been prescribed during the preceding twelve (12) month period requests a refill of the prescription drug, provide to the Plan member: (1) written notice of the removal or change; and (2) a sixty (60) day supply of the prescription drug under the terms that applied before the removal or change.

You may request a copy of the preferred drug list or formulary by calling CVS Caremark Customer Care at 1-866-234-6869 or view the list online at www.caremark.com.

Step Therapy

To the extent the Plan participates in programs to encourage the prescribing of generics and lower cost alternative preferred brand drugs. These programs may produce savings to you.

If a prescription is subject to a step therapy protocol, you may request a protocol exception. To request an exception, call CVS Caremark at the Customer Service telephone number on the back

of your ID card or complete the form available online at www.caremark.com. CVS Caremark may request a copy of relevant documentation from the Plan member's medical record in order to process the request. CVS Caremark will make a determination concerning the request, or an appeal or denial of a protocol exception request, not more than:

- In an urgent care situation, one (1) business day after receiving the request or appeal; or
- In a non-urgent care situation, three (3) business days after receiving the request or appeal.

A protocol exception will be granted if any of the following apply:

- A preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the covered individual.
- A preceding prescription drug is expected to be ineffective, based on both of the following: (1) the known clinical characteristics of the Plan member; (2) known characteristics of the preceding prescription drug, as found in sound clinical evidence.
- The Plan member has previously received: (1) a preceding prescription drug or (2) another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug; and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the Plan member because the Plan member's use of the preceding prescription drug is expected to: (1) cause a significant barrier to the Plan member's adherence to or compliance with the Plan member's plan of care; (2) worsen a comorbid condition of the Plan member; or (3) decrease the Plan member's ability to achieve or maintain reasonable functional ability in performing daily activities.

When a Protocol exception has been requested CVS Caremark shall notify the Plan member and the Plan member's health care provider of the authorization or denial of coverage for the prescription drug. If the exception is denied the notice will include a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

Specialty Pharmacy Network

"Specialty Drugs" are prescription legend drugs which:

- Are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Often have limited availability, special dispensing and delivery requirements, and/or require additional patient support.

Retail specialty pharmacies and CVS Specialty Pharmacy, the mail order specialty pharmacy, may fill specialty drug prescription orders, subject to a 30-day supply, and subject to the applicable coinsurance or copayment shown in the Schedule of Benefits.

CVS Specialty Pharmacy provides personalized counseling, expedited delivery, complimentary supplies (such as needles and syringes), and safety checks. If you or a dependent use specialty

medications you can order through CVS Specialty. The advantages for you include:

- Free expedited scheduled delivery to the location you choose (your home, doctor's office, outpatient clinic), and free supplies to administer your medication (e.g., needles, syringes)
- The ability to have your Specialty medication sent to a local CVS/Pharmacy location of your choice for pick-up
- Individualized support from trained nurses and patient care representatives
- 24/7 access to registered pharmacists for questions
- To order specialty medications from CVS Specialty, please call 1-800-237-2767 toll-free or have your doctor call 1-800-237-2767 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.
- You can also drop your specialty prescription off at a local CVS/Pharmacy location of your choice. The pharmacist at your local CVS/Pharmacy location will then transmit the specialty prescription to CVS Specialty who will contact you

You may call CVS Caremark to learn more about CVS Specialty. Or locate a retail specialty pharmacy and determine if a specialty drug is covered, by calling the Customer Service telephone number on the back of your ID card.

Website

Plan members have access to internet features offered through www.caremark.com.

On the CVS Caremark web site, you can refill mail order prescriptions, manage your mail order account, locate a pharmacy, print forms, look up preferred medications and identify cost saving opportunities.

Mobile App

Download the CVS Caremark app for on-the-go access to helpful tools and resources from the iTunes Store or the Google Play Store. Features include Easy Refills, Simple Sign-In, Fill New Prescriptions, Pharmacy Locator, and Manage Your Profile.

Covered Prescription Drug Benefits

Prescription drugs, unless otherwise stated below, must be medically necessary and not experimental or investigative, in order to be Covered Services. For certain prescription drugs, the prescribing physician may be asked to provide additional information before CVS Caremark can determine medical necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific prescription drugs. Covered Services will be limited based on medical necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

- Prescription legend drugs
- Certain OTC medications as indicated under the Affordable Health Care Act*
- Injectable insulin and needles and syringes used for administration of insulin.
- Non-insulin needles and syringes
- Select Contraceptive drugs: oral, transdermal, intravaginal, and injectable. Contact CVS Caremark to determine approved covered contraceptives.
- Contraceptive devices
- Prescription vitamins including prescription fluoride supplements as well as those covered under the Affordable Care Act*
- Influenza immunizations and those immunizations covered under the Affordable Health

Care Act*

- Certain supplies and equipment are covered such as diabetic test strips, lancets, swabs, glucose monitors, and inhaler spacers. Contact CVS Caremark to determine approved covered supplies. If certain supplies, equipment, or appliances are not available through the prescription benefit, they may be available through the medical benefit.
- Injectables unless otherwise noted as benefit exclusions.
- Prescription medical foods such as nutritional supplements, infant formulas, supplements to treat inherited metabolic diseases (including PKU)
- Prescription and some OTC smoking cessation drugs with limits of 168 days of therapy per year for nicotine, bupropion/ Zyban and for Chantix*

Non-Covered Prescription Drug Benefits

- Over the counter drugs except insulin and those covered under the Affordable Health Care Act*
- Over the counter vitamins except those covered under the Affordable Health Care Act*
- Estriol compounds
- Compounds for hormone therapy, topical use, anti-aging or cosmetic use, or compound kits, or compounds that contain a bulk powder or dietary supplements, hyaluronic acid, lipoic acid, methylcobalamin, resveratrol, valine, vanadium
- Medications used for cosmetic purposes only such as hair growth stimulants
- Allergy sera
- Blood and blood plasma products except for hemophilia factors
- Experimental/ Investigative Drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause
- Drug treatment related to infertility
- Over the counter homeopathic or herbal medicines
- Insulin Pump and Pump Supplies
- Periodontal Products
- Peak Flow Meters
- Nebulizers
- Select Medical Devices with a 510K certification, including Scar Treatment products, Dermatological products, Wound Care products, Oral Wound Care products, and Artificial Saliva products
- Dietary Management products
- Combination vitamins that require a prescription (not including vitamins classified as Prenatals, Pediatrics, and Multivitamins that require a prescription), unless otherwise specified by the Plan
- Anti-Obesity GLP1 Drugs

*Certain prescription and OTC medications are considered preventive by the Affordable Care Act and are covered by the benefit. A prescription is required to obtain these preventive medications through your prescription benefit. For more information, contact CVS Caremark Customer Care at 1-866-234-6869.

If your medication is in a category not covered by the prescription drug benefit, please check with your medical carrier as it may be covered by that benefit. Example: allergy sera.

Deductible/Coinsurance/Copayment

Each prescription order may be subject to a deductible and coinsurance/copayment. If the prescription order includes more than one covered drug, a separate coinsurance/ copayment will apply to each covered drug. The amount you pay for your prescription drugs will be the lowest of the minimum copay, the discounted drug price, or a retail pharmacy's usual and customary price and it will be no more than the lesser of your scheduled copayment/coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable deductible and coinsurance/copayment. If you receive Covered Services from a non-network pharmacy, a deductible and coinsurance/copayment amount may also apply.

Days' Supply

The number of days' supply of a drug that you may receive is limited. The days' supply limit applicable to prescription drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for a retail prescription under this Plan, you should ask your retail pharmacist. If your prescription is through CVS Caremark Mail Service or CVS Specialty, call CVS Caremark and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your ID card.

Days' supply may be less than the amount shown in the Schedule of Benefits due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Tiers

Your copayment/coinsurance amount may vary based on whether the prescription drug, including covered Specialty Drugs, has been classified by the Plan as a first, or second, or third, or fourth "tier" drug. The determination of tiers is made by the Plan, on behalf of the Employer, based upon clinical information, and, where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and certain clinical economic factors.

- Tier 1 generally includes generic prescription drugs.
- Tier 2 generally includes preferred brand name or generic drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes non-preferred brand name or certain generic drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other drugs in lower tiers.
- Tier 4 generally includes injectable, specialty drugs. To see if a drug is in the 4th tier, call CVS Caremark Customer Care

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a retail pharmacy, a specialty pharmacy, a non-network retail pharmacy, or the CVS Caremark Mail Service program. It is also based upon the Tier classified by the Plan for the prescription drug or specialty drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days' supply.

The Plan, on behalf of the Employer, retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable deductible and/or copayment/coinsurance for which you are responsible.

Automatic rebates help save you money. The State of Indiana participates in a program that benefits from manufacturer rebates on many brand-name medications. When a rebate is available, we apply the savings to your deductible or coinsurance—so you pay less out of pocket for your prescription at pick-up. This is one of the many ways we work together to help control your costs.

For Covered Services provided by a non-network retail pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a network or a non-network pharmacy.

Network Retail Pharmacy –

- The retail pharmacy network includes the following chains: CVS (including Target stores which contain a CVS/Pharmacy inside), Kroger, Meijer, Walgreens, Wal-Mart, almost all independent pharmacies, and more.
- For the names of participating pharmacies, call 1-866-234-6869 or visit www.caremark.com
- Present your written prescription from your physician and your ID card to the pharmacist at a network retail pharmacy. Alternatively, some physicians send prescriptions to pharmacies electronically. The Pharmacy will submit your claim for you. You will be charged at the point of purchase for applicable deductible and/or copayment/coinsurance amounts. If you do not present your ID card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to CVS Caremark using a direct claim reimbursement form, which you can request from CVS Caremark customer service or by visiting https://www.caremark.com/portal/asset/paperclaim_std_eng.pdf.

Specialty Drugs –

- Specialty medications are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, and other conditions.
- By ordering your specialty medications through our dedicated specialty pharmacy, CVS Specialty, you can receive toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week. CVS Specialty offers therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs. For more

information or to order your specialty medications, please call Member Services at 1-800-237-2767.

Non-Network Retail Pharmacy –

- If you visit a non-network retail pharmacy, you are responsible for payment of the entire amount charged by the non-network pharmacy and will then need to submit a prescription drug claim to CVS Caremark for reimbursement consideration
- These forms are available from CVS Caremark by calling the customer service number on the back of your identification card or by visiting https://www.caremark.com/portal/asset/paperclaim_std_eng.pdf
- You must complete the form, attach an itemized receipt to the claim form, and submit to CVS Caremark. The itemized receipt must show:
 - name and address of the non-network retail pharmacy;
 - patient's name;
 - prescription number;
 - date the prescription was filled;
 - NDC number (drug number)
 - name of the drug and strength
 - cost of the prescription;
 - quantity and days' supply of each covered drug or refill dispensed.
 - Doctor name or ID number
 - DAW (dispense as written) code
- You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by CVS Caremark' normal or average contracted rate with network pharmacies on or near the date of service.

CVS Caremark Mail Service –

- Through Mail Service, you may receive up to a 90-day supply of many maintenance medications.
- Complete the order form and the Health, Allergy, & Medication Questionnaire the first time you order through this service. You may mail written prescriptions from your physician or have your physician fax or send the prescription electronically to the CVS Caremark Mail Service Pharmacy.
- You will need to submit the applicable deductible, coinsurance and/or copayment amounts to the CVS Caremark Mail Service Pharmacy when you request a prescription or refill.
- Medications are shipped standard delivery at no additional cost. You can track your prescriptions and order refills at www.caremark.com or by calling 1-866-234-6869.
- Registered pharmacists are available around the clock for consultation.

DEFINITIONS

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell

the new drug for a certain number of years.

Generic Drugs – Prescription drugs that have been determined by the FDA to be equivalent to brand name drugs but are not made or sold under a registered trade name or trademark. Generic drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the brand name drug.

Mail Service – Offers you a convenient means of obtaining maintenance medications by mail if you take prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Mail Service Pharmacy that has entered into a reimbursement agreement with the Plan and sent directly to your home.

Maintenance medications – Maintenance drugs are those generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol. Examples of maintenance medications are Zocor and generic simvastatin, and Lipitor to lower cholesterol/lipids. What is the difference between long-term and short-term drugs? Long-term drugs are those taken on an ongoing basis, such as those used to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time.

Network Specialty Pharmacy – A Pharmacy that has entered into a contractual agreement or is otherwise engaged by the plan to render Specialty Drug Services, or with another organization that has an agreement with the plan, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Specialty Pharmacy – Any pharmacy that has not entered into a contractual agreement nor is otherwise engaged by to render Specialty Drug Services, or with another organization that has an agreement with the Plan, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Pharmacy - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order. A pharmacy may be a network provider or a non-network provider.

Pharmacy and Therapeutics (P&T) Committee – The P&T Committee consists of healthcare professionals whose primary purpose is to recommend policies in the evaluation, selection, and therapeutic use of drugs.

Preceding Prescription Drug - A prescription drug that, according to step therapy protocol, must be (1) first used to treat a covered individual's condition; and (2) as a result, determined to be inappropriate to treat the Plan member's condition.

Prescription Order – A legal request, written by a provider, for a prescription drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug & Cosmetic Act,

such substances must bear a message on its original packing label that states, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under the Plan.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription drugs and their criteria for coverage are defined by the P&T Committee.

Step Therapy Protocol exception - A determination by the prescription drug plan administrator that, based on a review of a request for the determination and any supporting documentation: (1) a step therapy protocol is not medically appropriate for treatment of a particular Plan member’s condition; and (2) the prescription drug plan will:

- Not require the Plan member’s use of a preceding prescription drug under the step therapy protocol; and
- Provide immediate coverage for another prescription drug that is prescribed for the covered Plan member.

Step Therapy - A protocol that specifies that, as a condition of coverage, the order in which certain prescription drugs must be used to treat a Plan member’s condition.

Urgent Care Situation - A Plan member’s injury or condition about which the following apply: (1) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, the injury or condition could seriously jeopardize the Plan member’s life, health or ability to regain maximum function; (2) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, the injury or condition could subject the Plan member to severe pain that cannot be adequately managed, based on the Plan member’s treating health care provider’s judgment.

HOW TO REACH CVS CAREMARK:

On the Internet

- To reach CVS Caremark online, go to www.caremark.com
- Visit the CVS Caremark website anytime to refill your mail-order prescriptions, check the status of your Mail Service order, request more claim forms and order forms, view the formulary or find a participating retail pharmacy near you.
- You can download the CVS Caremark mobile app for your Smartphone

By telephone

- Call 1-866-234-6869 to get answers to your questions about your prescription drug program.

Paper Claims

- Please send prescriptions to:
CVS/Health Attn: Commercial Claims
PO box 52136
Phoenix, AZ 85072-2136

Special Services

- You may call a registered pharmacist at any time for emergency consultations at 1-866-234-6869
- Our hearing-impaired members may use our TDD number at 1-800-231-4403, 24 hours a day, 7 days a week.
- Visually impaired members may request that their mail-order prescriptions include labels in large print or BRAILLE by calling 1-866-234-6869.
- For information on specialty medications through CVS Specialty, call toll-free at 1-800-237-2767

GRIEVANCE & APPEAL PROCEDURES:

To formally lodge a complaint with CVS Caremark, please call 1-866-234-6869. Your initial response will be addressed by a Customer Service Representative.

Your concerns will be logged into CVS Caremark' Customer Service Contact System. Unresolved complaints will be escalated to a customer service resolution expert or to a supervisor. You can also request that your issue be escalated.

If your issue is still not resolved to your satisfaction, you have the right to file a formal appeal either verbally by phone, or by mail. To file an appeal, you can submit a request by faxing to CVS Caremark at 1.866.689.3092, or in writing to:

CVS Caremark, Inc.
Attention: Appeals Department
MC 109
PO Box 52084
Phoenix, AZ 85072-2084

You will receive a follow up phone call and/or letter regarding resolution of your issue.

CVS Caremark's Internal Review Appeal Process

There are two types of internal appeals that may be submitted through a first or second level appeal request:

Administrative – These are benefit coverage decisions that are strictly based on the Plan's benefit design. These appeals do not require additional information to be obtained from the prescribing doctor but may require additional information from you.

Clinical – These are benefit coverage decisions that are based on the plan's prior authorization requirement and require additional information to be obtained from the prescribing doctor, such as clinical records or medical history information.

Once you are notified that a claim is denied in whole or in part, you have the right to appeal. Requests appeals need to be received within 180 days of the initial denial. Appeals must be submitted in writing. Acceptable submission methods include fax or mail directly to CVS Caremark. All administrative and clinical appeals are reviewed according to the plan design provisions and a decision will be mailed within 15 business days of receipt of a written request by CVS Caremark for pre-service claims and within 30 days for post-service claims. Urgent pre-service claims will be processed within 72 hours from the receipt of the inquiry by CVSCaremark.

Independent (External) Review Appeal Process

You have the right to an Independent (External) Review Appeal of an “Adverse Benefit Determination”. An “Adverse Benefit Determination” is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a plan benefit and may apply to both clinical and non-clinical determinations. To request an Independent (External) Review Appeal, you must have exhausted CVS Caremark’s Internal Review Appeal process described above.

CVS Caremark contracts with Independent Review Organizations (IRO) that has a network of medical experts that review your coverage denial. The request may be made by you or your authorized representative by submitting supporting documentation, such as clinical records or medical history information. You must submit your request within four months after receiving the notice stating the results of your first and/or second level appeal request. The IRO will provide you and CVS Caremark (on behalf of the plan) with written notice of its final external review decision within 45 days after the IRO receives the request. You may also request an expedited Independent (External) Review and it will be conducted as quickly as possible.

A benefit determination made pursuant to the Independent (External) Review Appeal is binding on both the plan and you, except to the extent that other remedies may be available to you under either State or Federal law. For instance, if your claim is again denied following the Independent (External) Review Appeal, you may still be able to bring a claim in court to contest that decision.

How to File an Appeal Request

You can submit all appeal requests by faxing to CVS Caremark at 1.866.689.3092, or in writing to:

CVS Caremark, Inc.
Attention: Appeals Department
MC 109
PO Box 52084
Phoenix, AZ 85072-2084

Appeals of Adverse Benefit Determinations or Adverse Coverage Determinations:

If an Adverse Coverage Determination is rendered on the member’s Claim, the member may file an appeal of that determination. The member’s appeal of the Adverse Coverage Determination must be made in writing and submitted to CVS Caremark within the time frame specified by applicable federal or state requirements after the member receives notice of the Adverse Benefit Determination or Adverse Coverage Determination.

If the Adverse Coverage Determination is rendered with respect to an Urgent Care Claim, the member and/or the member’s authorized representative may submit an appeal by calling, faxing,

or mailing the request to CVS Caremark.

The member's appeal should include the following information:

- A clear statement that the communication is intended to appeal an Adverse Coverage Determination;
- Name of the person for whom the appeal is being filed. The member or prescriber may file an appeal. The member may also have a relative, friend, advocate, or anyone else (including an attorney) act on their behalf as their authorized representative;
- CVS Caremark identification number;
- Date of birth;
- A statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information, or other information relating to the Claim

CVS Caremark's Review:

Review of Adverse Coverage Determinations - CVS Caremark provides a single-level appeal for Adverse Coverage Determinations. Upon receipt of an appeal of an Adverse Coverage Determination, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor in the PDD.

During its review of an appeal of an Adverse Coverage Determination, CVS Caremark shall:

- Provide for a full and fair review, allowing the member to review the Claim file and to present evidence and testimony. This includes providing the member (free of charge) with new or additional evidence or rationale relied upon in advance of a final internal Adverse Benefit Determination, and giving the member a reasonable opportunity to respond;
- Take into account all comments, documents, records, and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination of the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members;
- Provide a review that is designed to ensure the independence and impartiality of the person making the decision;
- Provide a review that does not give consideration to the initial Adverse Coverage Determination and is conducted by someone other than the individual who made the initial Adverse Coverage Determination (or a subordinate of such individual); and
- Provide for an expedited review process for Urgent Care Claims.

For a claim requiring a Medical Necessity Review, CVS Caremark, in addition to the above, shall also:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Upon request, identify the health care professional, if any, whose advice was obtained in connection with the Adverse Coverage Determination.