GIC's Pharmacy Benefit

GIC's prescription drug benefits are administered through CVS Caremark.

For questions about any of the information in this section, please contact CVS Caremark at 1-877-876-7214 (option 2)

CVS Caremark is the pharmacy benefit manager for your prescription drug benefit plan. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Member Services toll free at 1-877-876-7214 (option 2).

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, except for the over-the-counter versions of preventive drugs, medications are covered only if a prescription is needed for their dispensing. Diabetes supplies and insulin are also covered by the plan.

Copayments and Deductible

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (mostly generic drugs), Tier 2 (preferred drugs), Tier 3 (non-preferred drugs), or drugs which require no copayments. The following shows your deductible and copayment based on the type of prescription you fill and where you get it filled.

Deductible for Prescription Drugs

Deductible (fiscal year July 1, 2024, through June 30, 2025)

- For individual coverage: **$100 for one person**
- For family coverage: **$200 for the entire family**
- No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Copayments for Prescription Drugs

Participating Retail pharmacy up to a 30-day supply and mail order or CVS Pharmacy up to a 90-day supply:

Tier 1 – Generic Drugs

30-day supply:	$10
90-day supply:	$25

Tier 2 – Preferred Drugs

30-day supply:	$30
90-day supply:	$75

Tier 3 – Non-Preferred Drugs

30-day supply:	$65
90- day supply:	$165

Other:

$0 member cost (deductible does not apply)

- Orally administered anti-cancer drugs
- Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products)
- ACA Preventive drugs: Refer to the "Preventive Drugs" section below for detailed information.

Specialty Drugs: Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy. Please call CVS Specialty toll free at (800) 237-2767.

Specialty Drugs: Tier 1
$10 per 30-day supply

Specialty Drugs: Tier 2
$30 per 30-day supply

Specialty Drugs: Tier 3
$65 per 30-day supply

Orally Administered Anti-Cancer Specialty Drugs
$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply, some exceptions may apply.

Copayments for ADHD Medications

May be filled through mail order or any network pharmacy. Quantities are limited to a 60-day supply per state statute:

Tier 1: 30-day supply: $10
Tier 1: 60-day supply: $20

Tier 2: 30-day supply: $30
Tier 2: 60-day supply: $60

Tier 3: 30-day supply: $65
Tier 3: 60-day supply: $130

Out-of-Pocket Limit
This plan has an out-of-pocket limit that is combined with your medical and behavioral health out-of-pocket limit. Deductibles and copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%. *Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.*

Individual	$5,000
Family	$10,000

How to Use the Plan
After you first enroll in the plan, CVS Caremark will send you a welcome packet and CVS Caremark Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any).

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register at **caremark.com** on your effective date. As a registered user, you can check drug costs, order mail order refills, and review your prescription drug history. You can access this site 24 hours a

day. You may also check this information via the CVS Caremark mobile app.

Filling Your Prescription

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from CVS Caremark.

Prescriptions for specialty drugs must be filled as described in the CVS Specialty subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription Card, except for the limited circumstances detailed in the "Claim Forms" subsection.

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment.

Prescriptions filled at a non-participating retail pharmacy are not covered.

You can find the nearest participating retail pharmacy anytime online after registering at **caremark.com** or by calling toll free at 1-877-876-7214 (option 2).

If you do not have your Prescription Card, the pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk at (800) 365-6331. Members can also access their pharmacy ID card information via the CVS Caremark mobile app.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from CVS Caremark explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions through mail order or at a CVS Pharmacy.

PLEASE NOTE: CVS Caremark will allow two 30-day fills for long-term medications at your regular pharmacy before being asked to switch to 90-day supplies. If you want to keep filling your long-term medication prescriptions at your current pharmacy in 30-day supplies without paying the full cost, **you must opt-out once your new plan starts by calling CVS Caremark at (877) 876-7214 option 2.**

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment, or at a CVS Pharmacy.

The CVS Mail Service Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail order. Prescriptions can be filled at a CVS Pharmacy location across the country.

Convenient for You
You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Using the CVS Caremark Mail Order Pharmacy:

If you would like to receive your prescription(s) by mail order or if there are no refills left on your prescription, request a new prescription by visiting **Caremark.com/Mail Service** and we will contact your doctor for you. Or you can ask your doctor to send a new prescription to CVS Caremark Mail Service Pharmacy.

CVS Specialty

CVS Specialty is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple-sclerosis and rheumatoid arthritis.

You will have to fill your specialty medications at CVS Specialty. This means that your prescriptions can be sent to your home, doctor's office or at a CVS Retail Pharmacy.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by CVS Caremark to ensure the medications are being prescribed appropriately.

CVS Specialty offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all fifty states using one of ourpreferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all your specialty drug questions. CVS Specialty will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Specialty, call toll free at (800) 237-2767. Hours of operation: 7:30am – 9pm EST M-F; 9am – 4pm EST on Saturday; closed on Sunday.

CVS Specialty

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, or other approved location
- **Refill Reminders** – Ongoing refill reminders from CVS Caremark.
- **Language Assistance** – Language-interpreting services are provided for non-English speaking patients

Claim Forms*

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription Card, are covered as follows:

Claims Reimbursement
Type of Claim

- Claims for purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription card.

Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment.

-or-

Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

*Claim forms are available to registered users on **caremark.com** or by calling 1-877-876-7214 (option 2).

Other Plan Provisions

ACA Preventive Drugs

Coverage will be provided for the following drugs:

Aspirin
Generic OTC aspirin, 81mg to help prevent illness and death from preeclampsia in females who are between 12 and 59 years old.

Bowel preparation medications
Generic and brand products until generics become available (Rx only) for adults ages 45 to 75 years old.

Contraceptives
Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products. Brand products are covered at no cost until a generic become available. OTC requires prescription for claims processing. Per state statute, some oral contraceptives can be dispensed up to a 3-month supply for the first fill and up to a 12-month supply for subsequent fills.

Diabetes Prevention:

Generic (Rx only) metformin 850mg for preventing or delaying diabetes in adults aged 35 to 70

Folic acid supplements
Generic OTC products (0.4mg – 0.8mg strengths only) when prescribed for women 55 years of age or younger.

HIV Pre-Exposure Prophylaxis (PrEP)
Generic (Rx only)

Immunization vaccines
Generic or brand versions prescribed for children or adults.

Oral fluoride supplements
Generic and brand prescription versions, children 5 years of age or younger for the prevention of dental caries.

Breast cancer
Generic prescriptions (anastrozole, exemestane, raloxifene, tamoxifen) for the primary prevention ofbreast cancer for females who are at increased risk, age 35 years and older.

Tobacco cessation
Generic (Rx and OTC) tobacco cessation products and brand-name Rx products (Nicotrol, Nicotrol NS) until generics become available. Annual limit of two 12-week cycles (168 days)

Statins
Generic-only, single-entity, low-to-moderate dose statin agents for adults 40 to 75 years old.

Call CVS Caremark at 1-877-876-7214 (option 2) for additional coverage information on specific preventative drugs.

Brand-Name Drugs with Exact Generic Equivalents
The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name preventive drugs. Contact CVS Caremark for more information.

Prescription Drugs with Over the Counter (OTC) Equivalents
Some prescription drugs have over the counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products.

Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are similar to the prescription drugs.

Prior Authorization
Some drugs in your plan require prior authorization. Prior authorization ensures that you are receiving the right drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive

prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call CVS Caremark at 800-294-5979.

Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[2]

Topical Acne products
Aklief, ArazloTazorac® 0.05% and 0.1% cream, gel; Fabior 0.1% foam; (Retin-A®, Retin-A® Micro®; Avita®; Tretin·X™; Atralin™ gel: other generic topical tretinoin products) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®; Veltin™), Winlevi

Testosterone – Topical
Androderm, AndroGel, Axiron, Fortesta, Natesto, Striant, Testim, Vogelxo

Testosterone – Injectable
Aveed®, Depo® - Testosterone [testosterone cypionate injection, generics], Delatestryl®, Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]

Compounded - Select medications
A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Diabetes GLP-1 agonists
Adlyxin, Byetta®, Bydureon®/ BCISE, Mounjaro, Ozempic, Rybelsus, Tanzeum
Trulicity®, Victoza®,

Nutritional Supplements
Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Pain
Fentanyl Transmucosal Drugs (Abstral®, Actiq®, Fentora®, Lazanda®, Subsys®) Lidoderm®, Ztlido

Weight Management

Adipex (phentermine), Bontril (phendimetrazine), Contrave (bupropion; naltrexone), Didrex [benzphetamine), Sanorex (mazindol), Suprenza [phentermine], Tenuate (diethylpropion), Xenical (orlistat), Qsymia, Saxenda, Wegovy, Zepbound

Dry Eyes
Cequa, Restasis®, Xildra®

Current Examples of Top Drug Classes that May require Prior Authorization for Medical Necessity

Asthma/COPD Agents
Autoimmune Agents
Dermatological Agents
Diabetic Supplies
Erectile Dysfunction Oral Agents
Erythropoiesis - Stimulating Agents
Glaucoma
Growth Hormones
Hepatitis C Agents
Insulins
Nasal Steroids
Ophthalmic Agents
Opioid Analgesics
Osteoarthritis - Hyaluronic Acid Derivatives
Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on **caremark.com**, refer to the National Preferred Formulary or call CVS Caremark toll free at 1-877-876-7214 (option 2) for more information.

Quantity Dispensing Limits

To promote member safety and appropriate and cost- effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.
Quantity per dispensing limits is based on the following:

- ❑ FDA-approved product labeling
- ❑ Common usage for episodic or intermittent treatment
- ❑ Nationally accepted clinical practice guidelines
- ❑ Peer-reviewed medical literature
- ❑ As otherwise determined by the plan
- ❑ Examples of drugs with quantity limits currentlyinclude Cialis®, Imitrex®, and lidocaine ointment.

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- ❑ Adverse drug-to-drug interaction with another drug purchased through the plan
- ❑ Duplicate prescriptions
- ❑ Inappropriate dosage and quantity; or
- ❑ Too-early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions

Benefits exclude:

- Dental preparations (e.g., topical fluoride, Arestin®), except for oral fluoride

- Over-the-counter drugs, vitamins, or minerals (except for diabetic supplies and preventive drugs)
- Prescription Homeopathic and Miscellaneous Natural products
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of eighteen
- Injectable allergens
- Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others
- Special medical formulas and medical food products, except as required by state law
- Compounded medications-some exclusions apply-examples include bulk powders, bulk chemicals, and proprietary bases used in compounded medications
- Drugs administered intrathecally, or a drug which must be infused into a space other than the blood, by or under the direction of health care professionals and recommended to be administered under sedation or supervision
- Drugs not suitable for coverage under a pharmacy/outpatient prescription drug benefit, as determined by Caremark
- Select Medical Devices and Artificial Saliva products
- Prescription digital therapeutics, unless otherwise specified
- Unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act
- Therapeutic devices or appliances, including support garments, ostomy supplies, durable medical equipment, and non-medical substances
- Scar products
- Miscellaneous topical analgesics (containing ingredients in strengths typically used in OTC analgesics) and convenience kits (containing two or more products to be used separately
- Prescription Multivitamins (other than pediatric and prenatal multivitamins)

[2] This list is not all inclusive and is subject to change during the year. Call CVS Caremark toll free at 1-877-876-7214 (option 2) to check if your drugs are included in the program.

Definitions:

Acute Drugs - Drugs prescribed for a short-term illness or condition, expected to clear up in a short amount of time. They are usually not taken for more than thirty days, and additional refills are typically not included.

Biosimilars -. Biosimilars are FDA-approved biologic medications made to be highly similar to original biologics. They go through rigorous evaluation to ensure they have no clinically meaningful differences from the original biologics, and they are as safe and effective. Biosimilars provide the same treatment benefits and have the same risks. Both biologics and biosimilars are approved by the FDA and are currently available to treat conditions like Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, multiple sclerosis, certain cancers, diabetes and more. FDA-approved Biosimilars are now available for Humira (examples include Hyrimoz and adalimumab-adaz) which are highly similar and have no clinically meaningful differences than the original biologic (Humira). Additional information on Biosimilars is available within the **Patient Biosimilars Resource Center** on CVSSpecialty.com

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

Controlled Drug - Prescription medications that are designated as a Controlled Drug under the Controlled Substances Act (CSA). These include prescription drugs associated with potential for dependency or abuse.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than theapplicable copayment, the member pays only the lesser amount.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark National Preferred Formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to bejust as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol. They are often filled in 90-day supplies.

Non-Preferred Drug - A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drugavailable on the formulary.

Out-of-Pocket Limit – The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by CVS Caremark. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Over the Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a

prescription. Your plan does not provide benefits for OTC drugs, except for preventive drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the CVS Caremark Nationwide network. All major pharmacy chains and most independently owned pharmacies participate.

Preferred Drug – A preferred brand- name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists and hasbeen selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act (ACA).

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatmentof a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order, and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at 617-727-2310.

Specialty Drugs

Specialty drugs are usually injectable and non-injectable biotech or biological drugs used to treat rare and/or complex conditions with one or moreof several key characteristics, including:

- Potential for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Clinical Operations Prior Authorizations, Exceptions and Appeals Programs

All timeframes and processes contained in this document refer to CVS Caremark® standard protocols based on federal laws and regulations. Timeframes and processes may vary based on client requirements or state regulations.

CVS Caremark may be delegated to perform prior authorizations (PA), exceptions or appeals on behalf of our clients. CVS Caremark and the client will enter a mutually agreed upon written contract, which defines the requirements for processing PAs, exceptions and/or appeals on the client's behalf. The client provides CVS Caremark with a copy of its Summary Plan Description, including the Prescription Benefit section that describes the prescription benefits to plan members. Employees of CVS Caremark may not participate in a PA, exceptions or appeals review if there is a personal, professional or financial conflict of interest with the claimant.
CVS Caremark may, depending on the client's plan, conduct two types of reviews: Clinical and Non-Clinical Reviews.

• An **Initial Clinical Review** is an initial review of a request for a drug covered by the terms of the Plan when clinically appropriate, including but not limited to PA, step therapy, formulary exceptions and quantity limit exceptions. CVS Caremark will conduct an Initial Clinical Review utilizing the rules, guidelines, protocols, or criteria for coverage adopted by or provided by the Plan and as set forth in the Plan Design Document (PDD).

• An **Initial Non-Clinical Review**s an initial review of a request for a drug not covered by the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve an assessment of whether the requested drug is medically necessary.

Initial Clinical Reviews
Prior Authorization Program
PA is available as a stand-alone service to clients. It may also be provided in conjunction with quantity limits or step therapy protocols when a member fails to meet the requirements for these programs. Prescription claims are processed at the point of sale by the adjudication system to determine if the claim is subject to a PA. If the claim is subject to a PA, a reject message will display informing the dispensing pharmacy to have the prescribing practitioner contact the CVS Caremark PA Department.

A PA may be initiated by phone call, fax, electronic request or in writing to CVS Caremark by a member's prescribing physician or his/her representative. A member or pharmacist may initiate a PA by calling the PA department, who will reach out to the prescribing physician to obtain the necessary information, or they will be instructed to have the member's physician or designated representative contact CVS Caremark directly. Phone calls received during regular business hours will be routed directly to the CVS Caremark PA team.

If the call is received outside of business hours, the caller will be prompted to call back during regular business hours if it is a non-urgent request. If the request is urgent, the automated system will advise the caller to hold for the answering service. The service will then contact the PA department for the on-call pharmacist to process the request within the allowable timeframe.

Once CVS Caremark has received a request, the PA department will check to determine if a new PA is still required and will review the member's PA history for duplicate or pending requests.

The PA request is evaluated using client-approved criteria. A decision will be made solely on the clinical information available at the time of the review.
PAs are processed within the following timeframes:

• **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.

• **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

If the information provided is incomplete, and if time permits based on state or federal regulations, the PA department will request the additional information from the physician's office. Once the physician's office provides CVS Caremark with the required information, the original PA is reviewed to decide. If the required information is not provided, the PA will be denied.

If the PA is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.
If the PA does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the PA request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

CVS Caremark PA activity reporting is available, if requested by the client.

Exceptions Program
A standard exceptions program is available to support client requests to make exceptions to certain aspects of a client's plan design. Exception requests will only be considered if, and to the extent that, a plan allows exceptions.
Exceptions are available for covered and non-covered medications. For the latest list of available exceptions, refer to the Clinical Plan Management (CPM) form.

Examples of **exceptions for covered drugs** include but are not limited to the following:
• Brand Penalty: Request to allow a member to waive the dispense as written (DAW) penalty for a brand-name medication
• Contraceptive Zero Copay (Health Care Reform): Request to allow a member to receive a contraceptive product for a zero-dollar member cost share
• Preventive Services Zero Copay (Health Care Reform): Request to allow a member to receive a preventive service product (excluding contraceptives) for a zero-dollar member cost share

Examples of **exceptions for non-covered drugs** include but are not limited to the following:
• Formulary Exceptions: Request to allow a member to have formulary coverage for a drug currently not covered by the CVS Caremark formulary

Exception requests may be initiated by contacting Customer Care or submitting a request in writing to the Exceptions department. If the request is initiated by phone, an exceptions fax form or electronic PA (ePA) request will be sent to the physician's office.

The exception fax form or ePA is completed by the member's physician and returned to the Exceptions department. A letter of medical necessity from the physician is also acceptable for exceptions reviews. The exceptions request is reviewed against the supporting criteria.

If the exception is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.

If the exception does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the exceptions request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial. Exceptions are processed within the following time frames:

• **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.

• **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

Initial Non-Clinical Reviews
An Initial Non-Clinical Review is a request for coverage of medications or benefits that are not subject to a PA or an exception but are not covered by the Plan. Examples include, but are not limited to, non-covered medications, diabetes supplies and medical devices. A decision is based solely on the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve a clinical review or an assessment of whether the requested drug is medically necessary.

Appeals Program
Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeals may be based on an adverse benefit determination from an initial clinical review or an adverse non-clinical determination from an initial non-clinical review. Appeal requests must be submitted to the Appeals department by Fax, Mail or phone within 180 days after receiving an adverse determination notification. Urgent appeals may be submitted by phone or in writing. Non-urgent appeals may be submitted in writing by fax or mail:

Members can call the PA or CVS Caremark Customer Care line 1-877-876-7214 (option 2) and can be transferred to the appeals team to work an urgent appeal over the phone. Preferred method for receiving an appeal is via fax.

Non-specialty PA:
PA fax: 888-836-0730
PA Phone number: 800-294-5979

Specialty PA:
PA fax: 866-249-6155
PA phone number: 866-814-5506

Non-specialty appeals:
Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax 866-443-1172

Specialty Appeals:
CVS Caremark
Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056
Fax 855-230-5548

Appeal Process:

The appeal process can be initiated with a letter of medical necessity via fax or mail written by the doctor stating why the medication should be considered for coverage or additional coverage. The letter of medical necessity should include:

- Patient's date of birth and ID number
- Name of requested drug
- State of why the appeal should be approved or the physician's disagreement with the denial reason
- Reason the medication is medically necessary
- Include any office chart, labs, or other clinical notes

The doctor can call to request an urgent appeal and would be transferred to the appeal department. If you have questions or need help submitting an appeal, please call Customer Care for assistance at 1-877-876-7214 (option 2).

Once an appeal is received, the appeal and all supporting documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal:
  - For plans with one level of appeal: 30 days
  - For plans with two levels of appeal: 15 days
- Post-Service Appeal: 30 days

Review of Adverse Benefit Determinations

First-Level Clinical Appeal

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation submitted by the member or the member's authorized representative. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the member's payment receipt, medical records, etc. The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld by the appeal, a denial notification will be sent to the member with instructions on how to request a second-level Medical Necessity review.

If a member's appeal is urgent, CVS Caremark will perform both the first level and second-level review as a combined appeal review within the designated timeframes. If the first-level request is approved, no further review is needed, and a notice of approval will be sent to the member. If the first-level review cannot be approved, a second-level Medical Necessity review will be initiated automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined to meet the designated urgent appeal timeframe.

Second-Level Medical Necessity Appeals

If the first-level appeal denial is upheld, the member or the member's authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately

qualified reviewer or a sub-delegated medical necessity review organization (MNRO). If a member's appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal timeframe.

For appeals reviewed by the MNRO, the following will occur:

• CVS Caremark will forward applicable medical records, PA and appeals documentation, plan language and specific criteria to the MNRO.

• The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.

• The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.

• The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative.

Review of Adverse Non-Clinical Determinations
CVS Caremark provides a single-level appeal for non-clinical appeals. Upon receipt of a non-clinical appeal, 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 or in the PDD. A non-clinical appeal will not involve an assessment of whether the requested drug or benefit is medically necessary.

Appeal Determination Process
Appeals and associated documentation are stamped with the date and time of receipt. Reviews are conducted within the applicable timeframes previously mentioned in this document. The appeal determination is rendered, and pertinent information is entered into the database. The determination is then communicated in writing to the member or the member's representative.
Communications are written in a manner to be understood by the member or the member's representative. Communications include:
• The specific reason(s) for the determination
• A reference to pertinent Plan provision on which the determination was based
• A notice that the member can submit a written request for the following at no cost: copies of all documents, records and other information relevant to the claim
• A copy of the specific rule, guideline, protocol or other similar criterion that was relied upon in making the determination, if applicable; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request
• An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, if the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity; or a statement that such explanation will be provided free of charge upon written request
• A statement of the member's right to bring action under (Employee Retirement Income Security Act) ERISA Section 502(a), if applicable
• A description of the available internal appeals processes and external review process, if available
• Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 1-877-876-7214 (option 2).

Confidentiality

All member and client appeal documentation are handled in a confidential manner and in accordance with applicable statutes and regulations to protect the member's identity and his or her prescription history. To maintain confidentiality of member information, all appeal information becomes a part of a permanent case file.