CVS Caremark Member Website

www.caremark.com

You can easily access the CVS Caremark member website at www.caremark.com through a computer, mobile web browser or mobile app. Once logged in, you can view prescription and benefit information that is specific to your plan. Explore all of the member tools available to help you handle all your prescription needs.

Access Prescription information

- View Order Status
- View/Refill All Prescriptions
- Manage Prescriptions
- Financial Summary
- Start RX Delivery by Mail

Access Plan & Benefits information

- Plan Summary
- Check Drug Cost & Coverage
- Pharmacy Locator
- Print Member ID Card (we recommend using your combined Medical/RX card)
- Drug Savings Opportunities
- Covered Drug Lists
- Reimbursement Claims

Learn about Health Resources

- Drug Reference & Interactions
- Health Information Center
- About Generics
- Email a Pharmacist
- Pharmacist FAQs
- Drug Safety Alerts

How to Register For the First Time:

Step 1 – Navigate to the Website

- Go to www.caremark.com
- Click "Sign In" in the top left corner
- Click "Create an account at the bottom of the page

Step 2 – Create an Account

- Choose to create an account using either your Member ID or Personal information.
- Complete all fields
- Click "Continue"

Step 2 – Create Credentials

- Create a user name
- Create a password
- Continue with remaining fields
- Click "Continue"

Step 3 – Terms and Conditions

- Read the Terms and Conditions
- Click "I Agree and Continue"

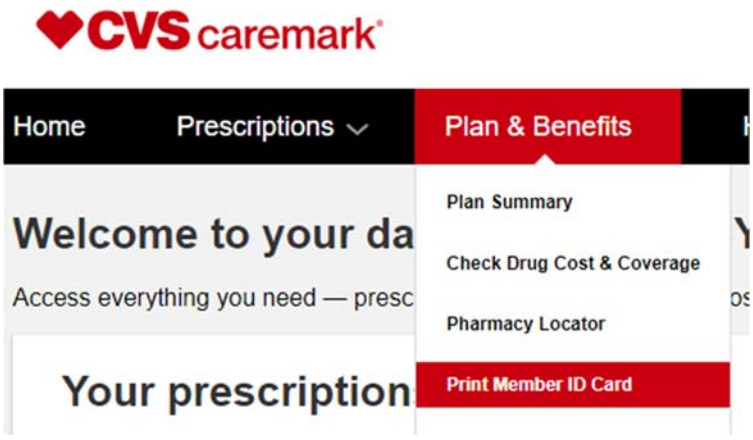
Step 4 – Profile

- Verify that all the information from your registration is correct.
- Explore your new account.

How to Print an ID card:

We recommend using your combined Medical/RX card from Cigna. The back side of this card will show your prescription coverage. You can also log into your CVS Caremark account and print a copy of your prescription insurance card (not combined).

- Click on "Plan & Benefits" and then choose Print Member ID Card from the dropdown menu.
- A copy of your prescription card is displayed on the screen. Click the red button that says "Print Member ID Card"



Coverage at a Glance

Prescription Plan

	RETAIL PHARMACY *For Immediate Medicine Needs or Short-Term Medicine*	**MAIL SERVICE PHARMACY (OR PICK UP AT CVS)** *For Maintenance or Long-Term Medicine*	**SPECIALTY PHARMACY** *For Drugs in the Specialty Category*
Annual Maximum Out-Of-Pocket on Low-Ded *without* incentive: $3,000 per Individual/$6,000 per Family Annual Maximum Out-Of-Pocket on Low-Ded *with* incentive: $2,000 per Individual/$4,000 per Family Annual Maximum Out-Of-Pocket on High-Deductible is combined with Medical Plan.			
You Will Pay	12% for all generic prescription 30% for each brand name* prescription on the primary drug list 50% for each brand name* prescription <u>not</u> on the primary drug list	15% up to a $20 maximum for each generic prescription 30% up to a $120 maximum for each brand name* prescription on the formulary drug list 50% up to a $180 maximum for each brand name* prescription <u>not</u> on the formulary drug list** 50% for Over The Counter (OTC) medicine in the Proton Pump Inhibitor (PPI) Classification (NOTE! Must be filled at a CVS Pharmacy!)	Under Prudent Rx Program, $0 co pay for eligible specialty prescriptions If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions.
Day Supply Limit.....	30-day supply	90-day supply (except specialty pharmacy drug list)	
Refill.....	One initial fill, plus one (1) refill	Must be filled by CVS Caremark	Must be filled by CVS Caremark
This is a short recap of your prescription benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Details about drug prices, options, and the Formulary Drug List can be found at www.caremark.com.			
Updated 1/1/24			

**When a generic is available but the pharmacy dispenses the brand name medicine for any reason, you will pay the difference between the brand name medicine and the generic, plus the brand co-insurance/co-pay.*

***Note that this maximum amount does not include any Dispense as Written penalty for filling a Non-Preferred brand that has a Generic available*

High-Deductible Plan Exception

On the high-deductible Plan, prescriptions that are not for Maintenance Medication, as determined by the IRS, (columns 2 and 4) will need to be paid by employees at 100% until the medical deductible is met. Once the deductible is met, the above schedule will apply. Maintenance medications are not subject to the deductible and will be paid per the above schedule. After the deductible is met, all rules will apply until an employee hits their medical out-of-pocket maximum.

Prescriptions that qualify as IRS Maintenance Medications will be subject to the Coverage at a Glance rules and not your Medical Plan deductibles. If you want to know if your medication qualifies as a Maintenance Medication under IRS guidelines, contact CVS Caremark at the number on the back of your card.

Maintenance Medication

Wayne County and CVS Caremark have implemented various step therapy protocols which may require you to use certain drugs before others are covered. If you feel you need a different drug that is denied due to this step therapy process, you will be given information on how to appeal the decision reached by CVS Caremark.

Avoid Paying Extra

Medications that are required to be provided free of charge per the Affordable Care Act will still require a prescription for coverage, and they must be purchased at a network pharmacy. Where allowed, CVS Caremark has restricted access to only generic or over-the-counter options.

Prescriptions filled at any pharmacy outside the CVS Caremark pharmacy network will not be covered! Remember to use your CVS Caremark card when getting prescriptions filled at retail stores! Maintenance medications can be filled via the CVS Caremark Mail Service Pharmacy or at your local CVS Pharmacy (some are located inside Target Stores).

When an employee uses a coupon for part of their co-pay, that coupon amount will not accumulate towards their deductible or maximum out of pocket.

Some drug companies have developed copay card programs for specific drugs. If you choose to participate in these programs, please know that any co-pays or co-insurance paid through these programs will not be applied to your annual maximum out-of-pocket.

Updated 1/1/24

Making The Most Of Your Prescription Benefit

Save Money

Your prescription benefit is designed to make your drugs more affordable. Through the Estimate Drug Costs tool, available online at www.caremark.com, you can check drug costs based on your specific plan to compare retail to mail and brand-name drugs to generics. You can also determine your copay or coinsurance amount.

CVS Caremark Will Help Support Your Safety and Health

- By filling your mail service prescriptions accurately.
- By making sure that the medicines you receive are high quality, safe and what your doctor prescribed.
- By reviewing your prescription history with every prescription, they fill to identify and prevent any potential problems such as unintended drug interactions.

There Are Two Easy And Convenient Ways To Fill Your Prescriptions:

At Your Local Pharmacy

Simply present your prescription and your benefit ID card at any participating retail pharmacy (your card is accepted at most major pharmacy chains and many independent pharmacies across the country). To find a participating pharmacy near you, visit at www.caremark.com.

Through CVS Caremark Mail Service Pharmacy

If your doctor has prescribed a maintenance drug for you to take regularly to treat chronic conditions like arthritis, diabetes or heart disease, mail order may be right for you. You may be able to have a 90-day supply delivered directly to your home or location of choice from the CVS Caremark Mail Service Pharmacy.

When it's time to get a refill, you can order online or by phone anytime, day or night. This option will not only save you money on your prescriptions, but will also save you a trip to your local pharmacy. And *regular* delivery is at no additional cost. For more information about home delivery, please refer to the following section titled "CVS Caremark Mail Service Pharmacy".

Updated 1/1/2020

CVS Caremark Mail Service Pharmacy

Every year, more people with chronic or genetic conditions are being prescribed *specialty* or *biotech* medicines. People taking these drugs often have complex health conditions such as multiple sclerosis, hemophilia, Crohn's disease or Hepatitis C. CVS Caremark Mail Service Pharmacy offers home delivery of specialty drugs and supplies and provides personalized therapy-specific clinical support to help individuals successfully manage their condition.

CVS Caremark's dedicated team of pharmacists, nurses and pharmacy customer service representatives can address all therapy support needs through CVS Caremark's toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 8 p.m. ET. CVS Caremark's clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

Talk to your Wellness Nurse or HR Director for a list of covered services, visit www.caremark.com or call the toll-free Customer Service number on your CVS Caremark ID card to learn more about CVS Caremark Mail Service Pharmacy.

CVS Caremark Mail Service Pharmacy is staffed by registered pharmacists who perform the same safety checks as your local pharmacist, including a review of your prescription history.

Getting Started with CVS Caremark Mail Service Pharmacy

It's quick and easy! Your prescription benefit offers you the convenient option to get 90-day supplies of your long-term medications delivered to you by mail – at no extra cost. Home Delivery is available for prescriptions used to treat conditions such as high cholesterol, asthma, arthritis, diabetes, heart disease and high blood pressure.

Through CVS Caremark Mail Service Pharmacy, members benefit from:

- **Convenience** – Quick, confidential shipping of maintenance drugs direct to their home, place of work or any other location they choose.
- **Ease of Use** – CVS Caremark's simple, two-step process makes ordering maintenance drugs easy.
- **Quality of Service** – Registered pharmacists check orders for accuracy and are available 24 hours a day, 7 days a week in case of an emergency.
- **Cost Savings** – Depending on the benefit plan, members can save money by using CVS Caremark Mail Service Pharmacy. In addition, standard shipping is always free.

Updated 1/1/2020

Generics

Manage Your Health and Money with Generics!

How can you save money?

To save money on your prescriptions, ask for Generics:

- Ask your doctor to prescribe generics and allow generic substitution at your local pharmacy.
- Say "yes" if your pharmacist asks whether you would like the generic equivalent of the brand-name medicine your doctor prescribed.
- If there is no generic equivalent for a brand-name medicine you are prescribed, ask your doctor if there's a generic alternative available to treat your condition and if it would be right for you.

Why do generic medicines cost less?

Research and development are already complete. Generics cost less because their manufacturers do not have to spend the hundreds of millions of dollars it takes to complete research and development on the new original medicine. The brand manufacturer makes that investment, along with the millions of dollars needed to market and advertise the new medicine. Therefore, it costs the generic manufacturer less to develop the same medicine. The savings are passed on to you! Visit www.caremark.com to view the formulary list and the generic drugs available which treat common conditions.

What is the difference between generic and brand-name medicines?

All the money you save. Each time you fill a prescription, you could save money by asking for a generic medicine. That could add up to big savings in just a short time. Research shows that you can save an average of 30 to 80 percent when you fill your prescriptions with a generic drug instead of a brand-name drug. To see if a generic is available for a drug you are currently taking or considering, visit www.caremark.com to view the formulary list, or you can visit the Check Drug Cost tool, available online at , where you can check drug costs to find out how much you can save.

Are there any other differences between generic and brand-name medicines?

Yes, the name and how they look are different, not how they work. When the patent of a brand-name medication expires, other drug manufacturers can make and sell the same medicine. This medicine is sold under its chemical name, which is why it is called a "generic". Like their brand-name counterparts, all generic medicines are tested and approved by the U.S. Food and Drug Administration (FDA) before they can be sold to consumers.

FDA-approved generic medicines are as safe and effective as brand-name medicines. In the United States, trademark laws do not allow a generic medicine to look exactly like its brand-name counterpart. Therefore, you can expect a generic medicine to be a different color or a different shape than its brand-name counterpart. However, the way it looks has no effect on how the medicine works. In fact, generics are often made by the same company manufacturing the brand-name drug.

Are generics safe and effective?

Yes, the FDA makes sure of it. The FDA puts each generic medicine through a rigorous quality control review process to ensure that generics are as safe and effective as the original brand-name medicine. Both brand-name and generic drug facilities must meet the same standards of good manufacturing practices. The FDA inspects more than 3,500 pharmaceutical manufacturing facilities each year to monitor how the medicines are made, processed, tested, packaged and labeled. To gain FDA approval, generic medicines must prove they are exactly like their brand-name equivalents in:

- Safety
- Identical Active Ingredients
- Performance (how it works in the body)
- Strength (e.g., 10 mg, 20 mg)
- Dosage Form (pill, liquid, cream, etc.)

Summary Plan Description

Wayne County Prescription Benefit Plan

Table of Contents

Contact Information

CVS Caremark Member Services:
1-844-345-2778
24/7 customer service
www.caremark.com

Paper Claim Reimbursement Information:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Mail Service Order Information:
CVS Caremark PBM & Mail Order Pharmacy
www.caremark.com (login not required)
1-800-552-8159

Wayne County HR Director:
Wayne County Commissioners
428 West Liberty Street
Wooster, OH 44691
(330) 287-5409

Wayne County Wellness Nurse:
Wayne County Commissioners
428 West Liberty Street
Wooster, OH 44691
(330) 287-5487

Summary Plan Description

Effective Date: January 2024

This document replaces and supersedes any previous prescription Summary Plan Description

This document summarizes the main provisions of the prescription drug section of the Wayne County pharmacy Benefit Plan (Plan) and serves as the Summary Plan Description (SPD) for these benefits. It describes the prescription drug benefits as they apply to eligible employees. Nothing in the Plan or in this document is intended to provide employees, former employees or dependents with a vested right to any benefits and/or any rights for continued employment. This document replaces and supersedes any previous pharmacy Summary Plan Description.

We encourage you to read this SPD carefully and share it with your family members covered under the Plan. If you have any questions about your benefits, please contact CVS Caremark, the Wellness Nurse, or your HR Director. Contact information is on the first page of this section.

Please note that this SPD is only a summary. Complete details of the prescription drug plan are contained in the legal plan document. If there is any difference between the information in this SPD and in the legal plan document, the legal plan document will govern.

The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Eligibility

You do not enroll specifically for Prescription Coverage. Your eligibility for this benefit will be determined by your eligibility for the Medical Plan. If you are accepted for coverage under the Medical Plan, then you are automatically enrolled in Prescription Coverage.

You can add and/or remove dependents based on the ability to add and/or remove dependents under the Medical Plan.

If you lose eligibility for, or drop, your Medical Insurance, your coverage under this program will end on the same date. If you leave the Plan, and are eligible for and elect COBRA coverage, then you will only receive Prescription Coverage if you also are eligible for, and elect to receive and pay for COBRA for your Medical Coverage.

Employees who enroll dependents are responsible for any payments made on behalf of their dependents. If your dependent is not eligible for benefits, you will be responsible to reimburse the Plan for any payments made on their behalf.

Coverage Effective Date

Your prescription coverage will have the same effective dates as your Medical Coverage.

Plan Coverage and Cost

Depending on the rules adopted by your employer, the following may apply to you. If you are not sure if this section applies to you, please check with your employer. This section will apply to all employees of Wayne County.

This plan is self-funded with contributions from both the employer and eligible employees. The plan also is part of the County's Section 125 Flexible Benefit Plan that allows you to elect health care coverage and pay your contributions on a pre-tax basis. This tax savings advantage allows you to have a portion of your compensation deducted from your paycheck before your taxes are calculated. Because of this, you pay for your coverage with pre-tax dollars, you pay fewer taxes and you take home more pay. CVS Caremark administers the prescription drug benefit described in this document.

> **Important Notice:** See the Important Notice from Wayne County Employee Benefit Plan About Your Prescription Drug Coverage and Medicare behind Tab 10 if you are considering joining a Medicare drug plan.

Coverage at a Glance

SHORT-TERM RETAIL (up to a 30-day supply)	**MEMBER RESPONSIBILITY**
Generic Cost Share	12% For all Generic prescriptions
Formulary/Primary Drug List Cost Share	30% for each Brand Name* prescription on the formulary list
Brand Cost Share	50% for each Brand Name* prescription not on the formulary list
LONG-TERM MAIL SERVICE (up to a 90-day supply)	**MEMBER RESPONSIBILITY**
You can receive these medications:	**Through the mail, or at a CVS retail location**
Generic Cost Share	15% up to a $20 maximum for each Generic Prescription
Formulary Cost Share	30% up to a $120 maximum for each Brand Name* prescription on the Formulary list
Brand Cost Share	50% up to a $180 maximum for each Brand Name* prescription not on the Formulary list *(Note that this maximum amount does not include any DAW (Dispense as Written) penalty for filling a Non-Preferred brand that has a Generic available)*
Prudent Rx Program	$0 copay for eligible specialty prescriptions. If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions,
PPI Class (Proton Pump Inhibitor)	**MEMBER RESPONSIBILITY**
Over The Counter (OTC)	50% for OTC

Updated 10/7/2022

Medications that are required to be provided free of charge per the Affordable Care Act will still require a prescription for coverage, and they must be purchased at a network pharmacy. Where allowed, CVS Caremark has restricted access to only generic or over-the-counter options.

***If you or your doctor chooses for you to receive the brand name drug when a generic drug is available, you will be responsible for paying the difference between the brand name drug cost and the available generic drug cost. You will also be responsible for paying the appropriate cost share for the drug that the doctor prescribes.**

The Low-Ded plan has a separate Annual Maximum Out-of-Pocket from the Medical Benefit. For the Prescription Plan, the maximum out-of-pocket you pay in a calendar year for eligible prescriptions is as follows:

- ☐ $3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family, per calendar year on the Low-Ded Non-incentive Plan.
- ☐ $2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family, per calendar year on the Low-Ded +Incentive Plan.

Prudent Rx

If you require certain eligible drugs in the specialty pharmacy, you will automatically be enrolled in your Plan's co-payment assistance program administered by PrudentRx (but you can choose to opt-out by contacting PrudentRx). The PrudentRx Copay Program will assist you by helping you to enroll in these drug manufacturer copay assistance programs. If you or a covered family member are taking one or more medications included in the PrudentRx Copay Program drug list, PrudentRx will contact you with specific information about the program as it relates to your medication and will let you know if you are required to enroll in copay assistance for any medication that you take. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx to provide any additional information needed to enroll in the copay program.

With copayment assistance for covered specialty prescription drugs, you will pay no cost share. If you choose to not use the program, or don't complete any participation requirements of the program, then you will pay a cost share of 30%, until your *prescription* maximum out-of-pocket is met (Low-Ded plan members have separate out-of-pocket maximums for medical and prescription).

If you are taking a specialty prescription drug, included in the program, we'll contact you. If there are participation requirements, we'll let you know and provide any additional information needed to participate.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

Quantity Limitations

Any quantity limitations are indicated in the Coverage at a Glance chart above.

Coordination of Benefits

There is no coordination of benefits on this plan.

Classification of Medication

All prescriptions are classified into 4 groups: Generics, Preferred Brand, Non-Preferred Brands and Specialty Drugs. A general description of each of these types is as follows:

- ☐ ***Generic –*** A generic drug is a drug product that is comparable to brand/reference listed drug product in dosage form, strength, route of administration, quality and performance

characteristics, and intended use. We only cover A rated generic drugs, and all generic drugs have to receive approval from the FDA before they can be dispensed.

- ***Preferred Brand*** **–** These are generally brands which CVS Caremark has negotiated better rates with the manufacturers. Because these drugs are purchased at better pricing, we reduce your cost to purchase these drugs. This is also referred to as a preferred brand drug.
- ***Non-Preferred Brand*** **–** These are generally brands which CVS Caremark has determined are either costly or clinically non-effective and are considered non-preferred and covered at the highest copay.
  - A brand name drug is a drug that has a trade name and is protected by a patent. When a generic is available, but the pharmacy dispenses the brand name medicine for any reason you will pay the difference between the brand name medicine and the generic plus the brand co-insurance or co-payment.
- ***Over The Counter (OTC)*** **–** These are drugs that are normally available at retail drug stores. For the purposes of this plan, the only OTC drugs that are covered by this plan are those in the Proton Pump Inhibitor (PPI) family of drugs. PPI drugs are commonly used to treat symptoms for ulcers and acid reflux. You will still need a prescription from your doctor to purchase these drugs OTC and have part of the cost covered by your plan.
- ***Specialty*** **–** Specialty drugs generally are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. These drugs are only available through CVS Caremark's Specialty Pharmacy Program.

Prior Authorization

CVS Caremark's prior authorization program supports you and your physician as you make decisions about your care and the use of prescription medications. The program aims to improve the quality of your drug therapy by:

- Promoting the appropriate and cost-effective use of your medications.
- Checking the appropriate length of your drug therapy.

How the program works

When filling your prescription, your prescription drug therapy is checked to see if it meets recommended guidelines:

- If the drug meets these guidelines, your prescription is filled without interruption.
- If the drug does not meet the guidelines, your prescription will not be filled until it has been reviewed.

Review process

You or your pharmacy can notify your physician that a prior authorization is needed for your medication. Your physician can request a prior authorization override through fax, telephone or online through CVS Caremark's secure password protected health care professional website. Forms are also available to your doctor for download through this website.

Once CVS Caremark Pharmacy Management receives your physician's information, its review process will take one to three business days. The decision is communicated to your physician by telephone, fax or e-mail (depending on how the request was received). If the request is denied, CVS Caremark

will fax or mail a follow-up letter to you and your physician within two business days (or as otherwise required by state law). This letter states the reason for denial and explains the appeal procedure. Once entered into the system, the information is immediately available to your pharmacies and your prescription can be filled.

Please refer to the Formulary list at www.caremark.com to see if your medication is subject to prior authorization.

Dispensed As Written Penalty

If you or your doctor chooses for you to receive the brand name drug when a generic drug is available, you will be responsible for paying the difference in cost between the generic and brand drug. You also will be responsible for paying the appropriate cost share for the drug that the doctor prescribes.

Care outside the United States

Prescription drugs purchased outside the United States are not covered under the Plan. However, if you are overseas and need to purchase prescription drugs due to an emergency, eligible prescription drugs that are purchased may be covered.

You will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a paper Claim reimbursement form to CVS Caremark for reimbursement. CVS Caremark will determine the appropriate currency exchange rate to use. Their decision on the exchange rate will be final.

Contraception

The Plan covers Contraceptives as currently required under the Affordable Care Act.

Diabetic Insulin and Supplies

You and your eligible dependents can receive free generic and preferred brand name diabetic insulin and supplies as prescribed by your doctor from CVS Caremark's prescription program; however non-preferred brand name diabetic insulin and supplies will be covered at the normal benefit level. Please check the formulary to determine which drugs are considered free with your plan. If you have questions about this program, please call CVS Caremark or the Wayne County Clinic Manager at the numbers listed at the front of this document. CVS Caremark reserves the right to change from time to time what products or manufacturers are covered under this free program. This program is designed to make complying with your medication and testing needs as easy as possible.

Sexual Dysfunction/Enhancement

The Plan covers dysfunction and enhancement as currently required under the Affordable Care Act.

Tobacco Use

Preventative drugs are covered under the Plan as part of the Employee Health Clinic's Tobacco Cessation program.

Clinical Solutions

Generic Alerts

Generic Launch Letters are announcements that are mailed to you regarding significant new generic launches. If you are taking a brand-name drug that will be available as a generic, you will receive a personalized letter educating you on the lower-cost alternative.

Specialty Pharmacy Guidelines

CVS Caremark requires precertification for specialty drugs. CVS Caremark uses Pharmacy Clinical Policy Bulletins (CPBs) as guides for prescribing physicians and detail criteria for medical exceptions and precertification. CVS Caremark bases criteria on peer-reviewed medical literature and other recognized resources of clinical information. CVS Caremark develops these criteria in consultation with physicians specializing in a particular field of practice and marries them with their medical CPBs.

The NPL is the National Precertification List. This list includes specialty drugs that require advance authorization before dispensing. Drugs included on the NPL are considered "specialty" drugs and are mostly injectable products either self-administered by the patient or administered by a health care professional, and may be covered under either the pharmacy or medical benefit.

Additional details regarding the NPL, including specific drugs and therapeutic classes, is located on www.caremark.com.

If You Have A New Prescription:

To find a network pharmacy near you, call the customer service number on the first page of this section, or go to www.caremark.com, click on the "Pharmacy" tab under "Find Care" and this will redirect you to *Find Care*, where you will add the following search filters:

1. Search for: Pharmacies
2. Type: Retail Pharmacy Locations
3. Search in: Please add your Zip Code and Distance
4. Select Plan: CVS Caremark Rx Managed Network

Short-Term/Retail Prescription Drugs

You can receive a prescription drug at any participating retail network pharmacy. Just give the pharmacist your CVS Caremark ID card along with your prescription. You will pay the applicable cost share listed in the Coverage at a Glance chart at the time of purchase. The Plan pays the remainder. If your charge of the retail drug is less than the minimum requirements, you pay the lesser of the two. If you do not have your CVS Caremark ID card, you will still have coverage. Simply pay the full amount of the prescription and save the original receipt, then complete a paper Claim reimbursement form and submit with your original receipt to the address on the first page of this section. You can receive a paper Claim reimbursement form by contacting Member Services at 1-844-345-2778 or by visiting www.caremark.com. CVS Caremark will then reimburse you for the portion that the plan would pay. CVS Caremark will not reimburse you for any prescriptions filled at any pharmacy that is not in the CVS Caremark retail pharmacy network.

Long-Term/Rx Home Delivery Prescription Drugs

To order a new prescription drug maintenance medication, ask your physician to write two separate prescriptions indicating that refills are allowed:

- ☐ One for a 30-day supply that you can fill right away at a local pharmacy.
- ☐ A second for a 90-day supply, the maximum supply allowed by the Plan, that you can mail to the CVS Caremark Mail Service Pharmacy (or take into a CVS pharmacy) within two weeks of your medicine running out.

You can only receive a maintenance medication for one initial 30-day (or less) prescription, plus one refill, at a participating retail pharmacy. After this, you must utilize the CVS Caremark Mail Service Pharmacy or CVS pick-up (some are located inside Target stores) to fill your maintenance medications.

> **Please Note:** CVS pharmacies are the only pharmacies in which you can receive your maintenance medications, outside of the initial fill.

Rx Home Delivery must be utilized for long-term maintenance medications after the first two fills. Mail order prescriptions cover up to a 90-day fill or refill of that prescription. Tell your prescribing physician that you have a mail order prescription program. That will inform them that you need a 90-day prescription for the medication you need to take.

You need to submit the new 90-day supply prescription(s) along with a completed Prescription delivery form and any applicable copayments or coinsurance for each prescription to the address on the order form in one of the following ways:

- ☐ Download and complete a CVS Caremark Mail Service Pharmacy Prescription mail-order delivery form at www.caremark.com and send it by mail.
- ☐ Have your physician submit the prescription by fax or e-prescription.

You will receive your prescriptions by mail in about two weeks, delivered in sealed, insulated (when necessary), and tamper-evident packaging. Since mail order delivery can take up to two weeks, be sure to have enough medication on hand in between orders.

> **Important Notice:** CVS Caremark Mail Service Pharmacy is staffed by registered pharmacists who perform the same safety checks as your local pharmacist, including a review of your prescription history.

What about Refills?

After the initial form has been submitted, you must refill your maintenance medication prescription by mail using the address on the order form, which can be accessed online at www.caremark.com, through your secured member website, by telephone or interactive voice response (IVR). CVS Caremark's toll-free number and website can be found on the bottle label of each prescription.

If there are no refills remaining, the pharmacy can request a new prescription from the physician, at your request.

Log in to www.caremark.com to learn more about your plan benefits and specific cost-savings opportunities through mail order and to initiate a mail order request via CVS Caremark Mail Service Pharmacy.

Please Note: You may switch from CVS Caremark Mail Service Pharmacy to store pick-up and vice-versa if one or the other is no longer desired, but you cannot constantly bounce back and forth between the two options. Long term maintenance drugs may only be dispensed at a CVS pharmacy.

Exclusions

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, we, in conjunction with CVS Caremark, will assess the feasibility of covering the drug, as well as the application of any coverage restriction or limitation. The plan covers charges for drugs and medicines which, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a physician.

Discretionary Authority

The plan administrator has discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of Claims under the Plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or Claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments.

Plan Modification, Amendment and Termination

The employer, as Plan sponsor, reserves the right, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the official legal plan document, which is available for inspection and copying from the Plan Administrator designated by the employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered prescription expenses incurred prior to the date the Plan terminates.

Termination of Coverage

Your prescription coverage will have the same end date as your Medical Coverage.

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Claims

In the previous section, we explained how you and the plan share responsibility for paying for your eligible health services.

When a Claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think it is wrong.

Claims are processed in the order in which they are received.

Claims Procedures

For Claims involving **out-of-network providers:**

Notice	Requirement	Deadline
Submit a Claim	• You should notify and request a Claim form from your employer. • The Claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the Claim form is not sent on time, CVS Caremark will accept a written description that is the basis of the Claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (Claim)	• A completed Claim form and any additional information required by your employer.	• No later than 90 days after you have incurred expenses for covered benefits. • CVS Caremark will not void or reduce your Claim if you can't send them notice and proof of loss within the required time. But you must send them notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify CVS Caremark.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a Claim is contested by CVS Caremark, the uncontested portion of the Claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the Claim is received.

Types of Claims and Communicating CVS Caremark's Claim Decisions

You or your **provider** are required to send CVS Caremark a Claim in writing. You can request a Claim form from CVS Caremark. CVS Caremark will review that Claim for payment to the provider.

There are different types of Claims. The amount of time that CVS Caremark has to tell you about their decision on a Claim depends on the type of Claim. The section below will tell you about the different types of Claims.

Urgent Care Claim

An urgent Claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent Claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-Service Claim
A Pre-Service Claim is a Claim that involves services you have not yet received and which CVS Caremark will pay for only if they pre-certify the Claim.

Post-Service Claim
A post service Claim is a Claim that involves health care services you have already received.

Concurrent care Claim extension
A concurrent care Claim extension occurs when you ask CVS Caremark to approve more services than they already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent care Claim reduction or termination
A concurrent care Claim reduction or termination occurs when CVS Caremark decides to reduce or stop payment for an already approved course of treatment. CVS Caremark will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from CVS Caremark or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If CVS Caremark upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of Claims and how much time CVS Caremark has to tell you about their decision.

CVS Caremark may need to tell your physician about their decision on some types of Claims, such as a concurrent care Claim, or a Claim when you are already receiving the health care services or are in the hospital**.**

Type of notice	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**	**Concurrent Care Claim**
Initial determination (CVS Caremark)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (CVS Caremark)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*CVS Caremark needs to receive the request at least 24 hours before the previously approved health

care services end.

Adverse Benefit Determinations

CVS Caremark pays many Claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes CVS Caremark pays only some of the Claim. And sometimes CVS Caremark denies payment entirely. Any time CVS Caremark denies even part of the Claim, that is an Adverse Benefit Determination or "adverse decision". It is also an Adverse Benefit Determination if CVS Caremark rescinds your coverage entirely.

If CVS Caremark makes an Adverse Benefit Determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. CVS Caremark will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** They will let you know if they need more information to make a decision.

An Appeal

You can ask CVS Caremark to re-review an Adverse Benefit Determination. This is called an appeal. You can appeal to them verbally or in writing.

Appeals Process

Prior Authorization Review

CVS Caremark will implement the prescription drug cost containment programs requested by Wayne County by comparing your requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that your request for prior authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations

You can appeal CVS Caremark's Adverse Benefit Determination. CVS Caremark will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an Adverse Benefit Determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of Adverse Benefit Determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name.
- The employer's name.
- A copy of the Adverse Benefit Determination.
- Your reasons for making the appeal.
- Any other information you would like CVS Caremark to consider.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell CVS Caremark if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling CVS Caremark that you are allowing someone to appeal for you. You can get this form by contacting CVS Caremark. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision. All requirements for filing appeals will be provided in writing from CVS Caremark, you must comply with those rules in order to file an appropriate and timely appeal

Urgent care or Pre-Service Claim appeals

If your Claim is an urgent Claim or a Pre-Service Claim, your provider may appeal for you without having to fill out a form.

CVS Caremark will provide you with any new or additional information that they used or that was developed by them to review your Claim. They will provide this information at no cost to you before they give you a decision at your last available level of appeal. This decision is called the final Adverse Benefit Determination. You can respond to this information before they tell you what their final decision is.

Timeframes for Deciding Appeals

The amount of time that CVS Caremark has to tell you about their decision on an appeal Claim depends on the type of Claim. The chart below shows a timetable view of the different types of Claims and how much time they have to tell you about their decision.

Type of notice	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
Appeal determinations at each level (CVS Caremark)	36 hours	15 days	30 days	As appropriate to type of Claim
Extensions	None	None	None	

Exhaustion of the Appeals Process

In most situations you must complete the two levels of appeal with CVS Caremark before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent Claim or a Claim that involves ongoing treatment. You can have your Claim reviewed internally and at the same time through the external review process.
- CVS Caremark did not follow all of the Claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond CVS Caremark's control.
  - The violation was part of an ongoing, good faith exchange between you and CVS Caremark.

External Review

External review is a review done by people in an organization outside of CVS Caremark. This is called an external review organization (ERO).

You have a right to external review only if:

- CVS Caremark's Claim decision involved medical judgment.
- CVS Caremark decided the service or supply is not Medically Necessary or not appropriate.
- CVS Caremark decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If CVS Caremark's Claim decision is one for which you can seek external review, they will say that in the notice of Adverse Benefit Determination or final Adverse Benefit Determination they send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To CVS Caremark.
- Within 123 calendar days (four months) of the date you received the decision from CVS

Caremark.
- And you must include a copy of the notice from CVS Caremark and all other important information that supports your request.

CVS Caremark will:
- Contact the ERO that will conduct the review of your Claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow their contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date they receive your request form and all the necessary information.

CVS Caremark will stand by the decision that the ERO makes, unless they can show conflict of interest, bias or fraud.

When an appeal is not eligible for ERO or when the appeal is upheld at the ERO level, CVS Caremark will inform the member of their right to appeal to the plan sponsor for voluntary level of review.

How long will it take to get an ERO decision?
CVS Caremark will tell you of the ERO decision not more than 45 calendar days after they receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call CVS Caremark or send them a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations:
Your provider tells CVS Caremark that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment).

For final adverse determinations:
Your provider tells CVS Caremark that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function;
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of CVS Caremark receiving your request.

Recordkeeping

CVS Caremark will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

CVS Caremark does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Definitions

The following terms are used herein to describe the Claims and appeals review services provided by CVS Caremark:

Adverse Benefit Determination
A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An Adverse Benefit Determination includes a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the Application of a Utilization Review or on a determination of your eligibility to participate in the Plan. An Adverse Benefit Determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative or not Medically Necessary or appropriate.

Claim
A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit Claims.

Medically Necessary (Medical Necessity)
Medications, health care services or products are considered Medically Necessary if:

- ☐ Use of the medication, service or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- ☐ Use of the medication, service or product is based on recognized standards for the health care specialty involved;
- ☐ Use of the medication, service or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services and the place where services are performed; and
- ☐ Use of medication, service or product is not solely for the convenience of you, your family, or your provider.

Post-Service Claim
A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-Authorization
CVS Caremark's Pre-Service Review of your initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by the Plan sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim
A Claim for a medication, service or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for Pre-Authorization.

Urgent Care Claim
A Claim for a medication, service or product where a delay in processing the Claim: (a) could seriously jeopardize your life or health and/or could result in your failure to regain maximum function, or (b) in the opinion of a physician with knowledge of your condition, would subject you

to severe pain that cannot be adequately managed without the requested medication, service or product.