Schedule
(Prescription Coverage)

(CVS Caremark)
This section of your Benefit Schedule describes your benefits for prescription drug expenses. Your prescription drug benefits are administered by CVS Caremark, Inc.

With respect to your prescription drug benefits, please note that CVS Caremark also has contracts with many retail pharmacies and pharmaceutical companies which permit CVS Caremark to receive certain discounts on the prescription medication that you receive. Pursuant to those contracts, the pharmacies participating in CVS Caremark’s national retail pharmacy network have agreed to fill your prescriptions at specified costs and to process prescription benefit Claims on your behalf.

DEFINITIONS

AFFORDABLE CARE ACT (ACA) PREVENTIVE…..Under the ACA, there are certain drugs that are considered preventative. Examples of these medications include doctor-written prescriptions for women’s health preventive care, including Food and Drug Administration-approved contraceptive methods, preventive aspirin for men and women, iron supplements for children, folic acid for childbearing age or pregnant women, Vitamin D for at-risk adults over age 65, prescribed fluoride supplements for children under age six and tobacco cessation products. All preventive drugs and treatments require a doctor’s prescription under the preventive tier.

FORMULARY DRUG LIST…..means a list of preferred brand drugs that are selected for inclusion on the list based on their ability to meet patient needs at a lower cost; the Formulary Drug List does not guarantee coverage. The Formulary Drug list does not guarantee coverage and is modified from time to time.

GENERIC DRUG…..means a Prescription Drug which is not trademarked but is chemically equivalent to a Brand Name Drug. A generic drug is identical, or bioequivalent, to a brand name drug in dosage, safety, strength, quality, performance characteristics and intended use. You will pay the lowest copayment for generic drugs. Generics are equivalent to their brand-name counterparts, and are ensured by the Food and Drug Administration to be as safe and effective. However, generics are significantly less expensive than the brand name. To be sure you pay the lowest copayment, ask your doctor to prescribe generic medications, when appropriate.

GENERIC PREVENTIVE DRUG LIST…..Farm Credit Foundations understands that some medications can help prevent disease or help manage existing conditions to try and avoid future complications. For this reason, Farm Credit Foundations now offers a preventive drug list, which reduces your cost for select Generic Drugs that help prevent chronic health conditions, when taken regularly. If you take medications on the preventive Generic Drug list, you will have a $0 copayment for these medications even if you have not yet met your annual plan deductible.

LIFESTYLE DRUG…..means Prescription Drugs that are not generally considered medically necessary. You will pay the full cost of the medication after a discount has been applied. Lifestyle drugs are typically drugs that are prescribed for non-medically necessary uses such as cosmetic Botox® and Propecia® for hair loss.

MAIL ORDER DRUG…..means approved drugs and medicines from a Caremark Mail Order Prescription Pharmacy, which provides its services to Participants or Covered Dependents under the Retiree Medical Plan.

MAIL ORDER PHARMACY…..means Caremark, which provides its services to Participants covered under the Retiree Medical Plan.

NETWORK RETAIL PHARMACY…..means a pharmacy or drug store which has entered into a service agreement with Caremark to provide benefits under the Retiree Medical Plan at specified rates to persons covered under the Retiree Medical Plan.

NON-NETWORK RETAIL PHARMACY…..means a pharmacy or drug store which has not entered into a service agreement with Caremark to provide benefits under the Retiree Medical Plan at specified rates to persons covered under the Retiree Medical Plan.

NON-PREFERRED BRAND DRUG…..means a trademarked Prescription Drug that may be on the Formulary Drug List but paid at a higher copayment than other medications. These are medications that have been patented for name and chemical content. Once the patent expires, generic drugs with a different name but the same chemical make-up typically become available. Non-preferred drugs are prescription drugs that are not generic or on the list of preferred drugs. Typically, non-preferred named drugs are the most expensive and/or have a comparable drug that is either generic or on the preferred list. Generally, these are higher-cost medications that have recently come on the market.
These drugs have the highest copayment. In most cases, an alternative preferred medication is available. Depending on your personal health care needs, there may be times when non-preferred drugs are right for you. In these situations, you will need to pay the non-preferred co-payment.

**PREFERRED BRAND DRUG**.....means a trademarked Prescription Drug that is included on Caremark’s Formulary Drug List. Preferred Brand Drugs are brand name drugs that are effective for treating specific condition and are more cost-effective than equivalent non-preferred drugs. Often there is a choice of medications you can take for the same condition. One or more of these medications may be a preferred drug under this plan. They cost generally more than generics, but less than non-preferred brand name drugs.

**PRESCRIPTION DRUGS**.....means:

(i) Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of illness, injury, or pregnancy;

(ii) Insulin, but only when prescribed in writing by a Qualified Prescriber;

(iii) Insulin needles and syringes; and

(iv) Contraceptive devices, implants, supplies, or drugs.

**QUALIFIED PRESCRIBER**.....means a licensed Physician, Dentist, or other health care practitioner who may, in the legal scope of his/her practice, prescribe drugs or medicines.

**RETAIL DRUG**.....means approved drugs and medicines purchased from a retail drug store or pharmacy.

**SPECIALTY / BIOTECH DRUG**.....means a type of Prescription Drug that is used in the management of chronic or genetic disorders and that is often an injectable or infused medicine. These medicines treat far more complex and typically less common conditions and require complex pharmacy management, including the appropriateness of treatment, side effect management, management of additional medicines to aid the main medicine, longer care evaluations, and discussions of disease and medicine.

**PRESCRIPTION DRUG COVERAGE**

The cost of your medication will vary, depending on your Retiree Medical Plan election and the category of medication prescribed.

The Retail Drug expense portion of the Retiree Medical Plan allows you to receive benefits for a short-term supply (up to a 30-day supply) of eligible Prescription Drugs. In addition, a 90-day supply may be purchased at certain Caremark Network Retail Pharmacies.

Benefits will be provided as described below for Covered Expenses incurred for the purchase of approved drugs and medicines from a retail pharmacy. A Retail Drug Copayment will apply before benefits are paid.

The Mail Order Drug expense portion of the Retiree Medical Plan allows you to receive benefits for up to a 90-day supply of eligible Prescription Drugs with refills available for up to one year. Generally, if you use maintenance medication, you should use this provision. Members may also obtain a 90 days’ supply of maintenance medications at a CVS retail location.

Prescriptions for certain medications (i.e., Specialty Drugs) must be filled through CVS Caremark’s Specialty Pharmacy. Specialty Drugs are typically drugs that must be refrigerated, that have a short shelf-life, are bio-tech drugs, and/or are expensive medications that are not typically stocked by other pharmacies. Prescriptions filled through the CVS Caremark Specialty Pharmacy are generally subject to the applicable Retail Drug Copayment.
### Prescription Schedule Consumer Choice 1 and Consumer Choice 2

**WI Consumer Choice 1 and WI Consumer Choice 2**

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<td>• Retail (90-Day Supply Select Pharmacies)</td>
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<td>• Maintenance Choice (90-Day Supply at CVS and Target Pharmacies)</td>
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<td>• Mail Order (90-Day Supply)</td>
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<td>Generic Preventive Drug List</td>
<td>Covered at 100% (Deductible Does Not Apply)</td>
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<td>Lifestyle Drugs</td>
<td>You pay 100% of Discounted Price (Does Not Apply to Deductible or Out-Of-Pocket Maximums)</td>
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- **Note:** When a Generic Drug is available, but the Pharmacy dispenses the Brand Name Drug for any reason other than that the Physician indicated “dispense as written,” you will pay the brand name copayment (Non-Preferred or Preferred, as applicable) plus the difference between the cost of the brand name drug and the Generic Drug.

- **Use of Network Retail Pharmacy versus Non-Network Retail Pharmacy:** You may choose to use any retail pharmacy you wish. If you use a Network Retail Pharmacy and present your ID card, you will pay the applicable amounts noted in the chart above for the option you selected and the pharmacy will file the Claim for you; if you fail to present your ID card, you may be required to pay the full cost of the prescription and then file a Claim with Caremark for reimbursement of eligible expenses within 12 months of purchase. If you use a Non-Network Retail Pharmacy, you will need to file the Claim with Caremark for reimbursement of Covered Expenses within 12 months of purchase. Regardless of whether you have your prescription filled at a Network Retail Pharmacy or at a Non-Network Retail Pharmacy, you will ultimately be responsible for paying the applicable amounts noted in the chart above.

### Diabetic Supplies

Your diabetic supply kit (swabs, lancets, syringes, and strips) are free when ordered with your insulin prescription/refill (mail order and retail). In addition, CVS Caremark has a disease management program available to help you manage your diabetes. Contact CVS Caremark for more information about this program at 1-800-841-5550.

### Compound Drugs

Pharmacy Compounding is a practice in which pharmacists combine, mix or alter drugs and/or ingredients to create unique medications to meet a specific need. Traditional compounding customizes a drug for someone who is allergic to a dye or preservative in an FDA approved medicine, or compounding a liquid dosage form specifically for a younger patient, etc. However, compounding may include mixing or reconstituting commercial products outside of the product’s approved labeling. Compound drugs are subject to pre-authorization or may be excluded from the Formulary Drug List to ensure appropriate utilization based on evidence-based medicine guidelines.
CVS Caremark’s Specialty Pharmacy

Certain medications may need to be filled through CVS Caremark’s Specialty Pharmacy.

**Specialty pharmaceuticals** are drug therapies developed to treat a wide range of complex chronic conditions. They are generally developed to serve a relatively small population of patients, most of whom have progressively severe diseases. Patients tend to be on these medications long-term, most for life (some exceptions include RSV, infertility and Hepatitis C). These drugs may be biologically derived; many require special handling and specialized training for mixing and administration, and are often very expensive—from several thousand to hundreds of thousand per year. Specialty medications must be dispensed by CVS Caremark specialty pharmacies and cannot be obtained through regular CVS Network pharmacies.

**Specialty Guideline Management (SGM)** is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines and consensus statements. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved.

CVS Caremark Specialty Guideline Management extends beyond pre-authorization ensuring the specialty drug is safe and effective for the patient, the drug is properly used, inappropriate utilization is avoided and unsafe or ineffective therapies are discontinued in a timely manner.

Certain specialty drugs are subject to specialty step therapy to encourage the clinically effective lowest cost drug as the first line of therapy. If you have questions regarding step therapy, you or your physician should contact Caremark Specialty at 1-800-237-2767.

Specialty drugs may be prescribed for the following therapies:

- Asthma
- Crohn’s disease
- Cystic fibrosis
- Growth hormone and related disorders
- Hematopoietics
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis C
- HIV
- Hormonal therapies
- Immune disorders
- Infertility
- Lysosomal storage disorders
- Macular degeneration
- Multiple sclerosis
- Oncology
- Osteoarthritis
- Osteoporosis
- Psoriasis
- Pulmonary arterial hypertension
- Pulmonary disorders
- Renal disorder
- Rheumatoid arthritis
- RSV prevention
- Transplant
EXCLUSIONS

Prescription drug expenses which satisfy any of the following conditions are excluded from coverage by Caremark under the prescription benefit program; however, such items may or may not be covered benefits under the medical portion of the Plan administered by BCBSIL:

- Drugs or medicines that are purchased after the date the Participant’s coverage under the Retiree Medical Plan has ceased, for any reason. This is true even though the expenses relate to a condition which began while the Participant was still covered.
- Any substance, except insulin, which may be lawfully obtained without a prescription.
- Administration of any prescription drug, insulin, or other substance.
- Any prescription refill in excess of that specified by the Qualified Prescriber or dispensed more than 12 months after it was prescribed.
- More than a 90-day supply of any one prescription.
- Any investigational or experimental drug or any drug which may not lawfully be dispensed in the United States.
- Any medication to be taken by, or administered to, a person while he/she is a patient at a Hospital, convalescent hospital, or other health care facility which itself operates, or allows to be operated on its premises, a pharmacy or other facility for dispensing drugs.
- Any therapeutic device or appliance, support garments, or prostheses (except following a mastectomy), regardless of the item’s intended use.
- Drugs or medicines for which a Participant is not required to pay.
- Drugs or medicines for which benefits are provided under any other provisions of the Retiree Medical Plan.
- Non-legend drugs or medicines.
- Drugs or medicines delivered or administered by the Qualified Prescriber.
- Obsolete drugs or medicines. (Obsolete drugs or medicines are those drugs or medicines which are no longer produced or have been taken off the market by the manufacturer.)
- Unit dose drugs or medicines. (Unit dose drugs or medicines are those drugs or medicines which are individually packaged when the same drug or medicine is available in a multi-dose container.)
- Any immunization agent, biological serum, blood, or blood plasma.
- Food supplements.
- Immunosuppressants.
- Growth hormones.
- Drugs or medicines which are experimental and/or investigational, or which are prescribed or administered for off-label use.

COORDINATION OF BENEFITS SECTION

This Retiree Medical Plan will not coordinate prescription drug benefits with another plan if coverage under this Retiree Medical Plan is secondary. In other words, if your prescription drug coverage under this Retiree Medical Plan is secondary to your prescription drug coverage under some other health care plan, this Retiree Medical Plan will not provide you any benefits for prescription drug coverage. It is your obligation to notify CVS Caremark of the existence of such other group coverages.

CVS CAREMARK INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

DEFINITIONS

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

Administrative Denial – An Adverse Benefit Determination which is based solely on the terms of the Plan, including the preferred drug lists or formularies selected by the Plan Sponsor, and which does not involve a determination of Medical Necessity.
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 process or on a determination of a Plan member’s 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 the member, member’s family, or 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 a member’s initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria 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 (i) could seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member’s condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the member’s attending health care provider as to whether or not the member’s Claim constitutes an Urgent Care Claim.

CLAIMS AND APPEALS PROCESS

Pre-authorization Review:

CVS Caremark will implement the prescription drug cost containment programs by comparing member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medicines or prescription benefits before those prescriptions are filled. If CVS Caremark determines that the member’s request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.
Review Against the Plan’s Terms:

A member’s request for a particular drug or benefit will be compared against the preferred drug lists or formularies selected by the Employer before the member’s prescription is filled. If CVS Caremark determines that the member’s request for a drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies selected by the Employer, that determination will constitute an Administrative Denial.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on the member’s Claim, the member may file an appeal of that determination. The member’s appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the member and/or the member’s attending physician may submit an appeal by calling CVS Caremark.

The member’s appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The member’s appeal and supporting documentation may be mailed or faxed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
(Fax) 1-866-443-1172

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-855-465-0027.

CVS CAREMARK’S REVIEW:

The review a member’s Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of the terms of the Plan and any applicable laws. Members will be accorded all rights granted to them under the terms of the Plan and any applicable laws.

Review of Adverse Benefit Determinations of Pre-Service Clinical Claims

CVS Caremark will provide the first-level review of appeals of Pre-Service clinical Claims. Such Claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the member’s first-level appeal is denied, the member may appeal CVS Caremark’s decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

CVS Caremark provides a single level of appeal for Administrative Denials. Upon receipt of such an 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 or formularies selected by the Employer.
Timing of Review:

- **Pre-Authorization Review** – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

- **Pre-Service Clinical Claim Appeal** – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service clinical Claim within 15 days after it receives the member’s appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the member may appeal that decision by providing the information described above. A decision on the member’s second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first- and second-level appeals, combined).

- **Administrative Denial or Post-Service Claim Appeal** – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim or on an Administrative Denial within 60 days after it receives such appeal.

Scope of Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service clinical Claim, or review of a Post-Service Claim or Administrative Denial, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;

- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;

- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members; and

- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a member appeals CVS Caremark’s denial of a Pre-Service clinical Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);

- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and

- Provide for an expedited review process for Urgent Care Claims.
Notice of Adverse Benefit Determination:

Following the review of a member’s Claim, CVS Caremark will notify the member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO’s explanation of the scientific or clinical judgment for the IRO’s determination, applying the terms of the Plan to the member’s medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

AUTHORITY AS CLAIMS FIDUCIARY:

In its capacity as Claims Administrator of the prescription benefit component of the Plan, CVS Caremark shall serve as the claims fiduciary with respect to preauthorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Service clinical Claims, and review of Post-Service Claims and Administrative Denials. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO.

CVS CAREMARK EXTERNAL REVIEW PROCEDURES

CVS Caremark Federal External Review Services

A Plan member who receives a Final Adverse Benefit Determination (as defined below) of a Claim for prescription drug benefits may be permitted to further appeal that denial using the Federal External Review Process that is described below. This external review process provides Plan members with another option for protesting the denial of their Claim for prescription benefits. CVS Caremark will administer Plan Sponsors’ Federal External Review process as described herein.

DEFINITIONS

The following terms are used herein to describe the Federal External 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. Such denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations. However, only Adverse Benefit Determinations of a Claim Involving Medical Judgment will be eligible for External Review.

Claim – A request for a Plan benefit that is made in accordance with the Plan’s established procedures for filing benefit claims.
Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the “deemed exhaustion” rules of the Patient Protection and Affordable Care Act (ACA).

Independent Review Organization (IRO) – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Claim Involving Medical Judgment – A Claim for prescription drug benefits involving, but not limited to, decisions based on the Plan’s standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

FEDERAL EXTERNAL REVIEW PROCESS (NON-EXPEDITED)

Request for Review:

A Plan member whose Claim Involving Medical Judgment is denied may request, in writing, an External Review of such Claim within four months after receiving notice of the Final Internal Adverse Benefit Determination. The member’s request should include the member’s name, contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial. The member’s request for external review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
(Fax): 1-866-443-1172

Preliminary Review:

Within five days of receiving a Plan member’s request for external review, CVS Caremark will conduct a “preliminary review” to ensure that the request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

- The member is or was covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the member’s failure to meet the Plan’s requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
- The member has exhausted the Plan’s internal appeals process (unless the member’s Claim is “deemed exhausted” within the meaning of the ACA); and
- The member has provided all the information and forms necessary to process the external review.

In addition, CVS Caremark will review the member’s request for external review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that the request does not involve a Claim Involving Medical Judgment, it will forward the member’s request for external review to an IRO for further review. The IRO will determine whether the member’s request for external review involves a Claim Involving Medical Judgment as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that: (i) the member’s request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.
Referral to IRO:

If the member’s request for external review is complete and the member’s Claim is eligible for external review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have 10 days to provide the IRO with any additional information the member wants the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan and the Plan Sponsor. The IRO may consider information beyond the records for the member’s denied Claim, such as:

- The member’s medical records;
- The attending health care professional’s recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the member, or the member’s treating physician;
- The terms of the Plan to ensure that the IRO’s decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medicine societies, boards, and associations;
- Any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- The opinion of the IRO’s clinical reviewer(s) after considering all information and documents applicable to the member’s request for external review, to the extent such information or documents are available and the IRO’s clinical reviewer(s) considers it appropriate.

Timing of IRO’s Determination:

The IRO will provide the member and CVS Caremark (on behalf of the Plan) with written notice of its final external review decision within 45 days after the IRO receives the request for external review.

The IRO’s notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount [if available], and the reasons for the previous denials);
- The date the IRO received the external review assignment from CVS Caremark, and the date of the IRO’s decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO’s decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the member;
- A statement that the member may still be eligible to seek judicial review of any adverse external review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist the member.

Reversal of the Plan’s Prior Decision:

If CVS Caremark, acting on the Plan’s behalf, receives notice from the IRO that it has reversed the prior adverse determination of the member’s Claim, CVS Caremark will immediately provide coverage or payment for the Claim.
FEDERAL EXTERNAL REVIEW PROCESS (NON-EXPEDITED)

A member may request an expedited external review if:

- The member receives an Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function, and the member has filed a request for an expedited internal appeal; or

- The member receives a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves: (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Request for Review:

If the member’s situation meets the definition of urgent under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, the member or the member’s physician may request an expedited external review by calling the Customer Care toll-free at the number on the member’s benefit ID card or contacting the benefits office. The request should include the member’s name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited external review may be faxed. Member contact information, a coverage denial description, and supporting documentation may be faxed to the attention of the CVS Caremark External Review Appeals Department at fax number 1-866-443-1172.

All requests for expedited review must be clearly identified as “urgent” at submission.

Preliminary Review:

Immediately on receipt of a member’s request for expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify the member that: (i) the member’s request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to IRO:

Upon determining that a member’s request is eligible for expedited external review, CVS Caremark will assign an IRO to review the member’s Claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the member’s Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.
Timing of the IRO’s Determination:

The IRO must provide the member and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as the member’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member’s request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the member and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review:

CVS Caremark will be responsible only for conducting the preliminary review of a member’s request for external review, ensuring that the member is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO.

The actual external review of a member’s appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the external review performed by an IRO.