



State of Connecticut

Partnership Prescription Benefit Plan Document
as made available to Participating Employer Groups

Restated as of January 1, 2018

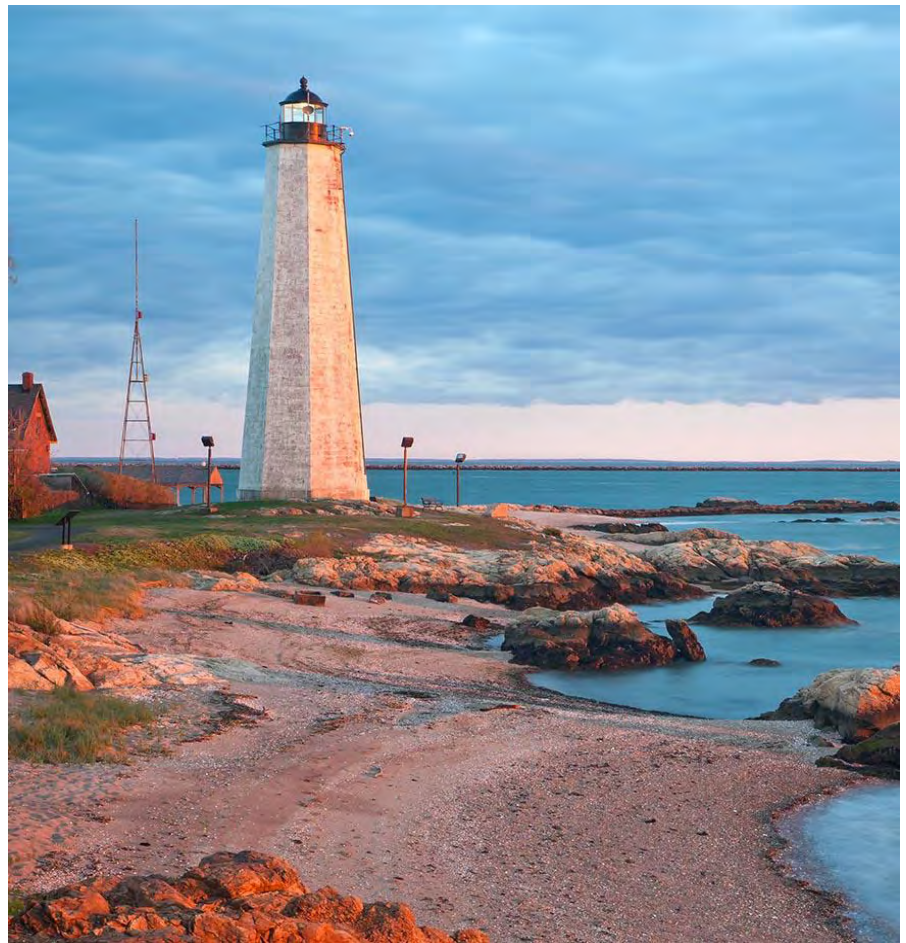


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Introduction

This document describes the State of Connecticut Prescription Drug Partnership Plan (“PRESCRIPTION BENEFIT PLAN”) benefits as made available to PARTICIPATING EMPLOYERS for their employees, retirees and eligible DEPENDENTS. The Prescription Benefit Plan is a self-funded governmental prescription benefit plan that is not subject to the Employee Retirement Income Security Act (“ERISA”). This PLAN DOCUMENT explains the benefits, exclusions, limitations, terms and conditions for coverage, and the guidelines that must be followed to obtain benefits for COVERED SERVICES. All defined terms used in this Plan Document are capitalized the first time they are used. Definitions can be found in the *Glossary*.

This document is restated as of January 1, 2018, and replaces any Plan Document, contract, policy or program of the same or similar coverage that the PLAN SPONSOR may have issued prior to January 1, 2018. Amendments to this Plan Document may occur, as approved by the State of Connecticut, and the EFFECTIVE DATE of such changes shall be noted.

The State of Connecticut has engaged CVS/Caremark to act as Plan Administrator for the Prescription Benefit Plan.

Prescription drug coverage for MEDICARE-eligible retirees and Medicare-eligible dependents is available for Participating Employers electing such coverage under the UnitedHealthcare Group Medicare Advantage (PPO) plan. For more information on prescription drug coverage for Medicare-eligible individuals, see https://www.uhcretiree.com/ct/review_plan_benefits.html.

Participating Employers that choose to join the State of Connecticut Prescription Drug Partnership Plan are bound by the terms and provisions of the Prescription Benefit Plan. The Participating Employer is responsible for determining eligibility for coverage for its employees, retirees and dependents, as set forth in the Addendum. This is subject to the right of the Plan Sponsor to ensure the Participating Employer’s compliance with the conditions under which participation in the Prescription Benefit Plan was approved.

As Plan Sponsor, the State of Connecticut, acting by and through the Office of the State Comptroller, has complete discretionary, binding and final authority, to:

- Interpret ambiguous Prescription Benefit Plan language;
- Implement PRIOR AUTHORIZATION and safety requirements;
- Make factual determinations regarding the payment of CLAIMS or provision of benefits;
- Review denied claims; and
- Resolve complaints by Prescription Benefit Plan participants.

Such authority has been delegated to CVS/Caremark for the purpose of initial claims processing, administration of prior authorization and medical necessity reviews, review of denied claims, and appeals adjudication.

All notices to the Plan Sponsor should be directed as follows:

State of Connecticut Prescription Drug Partnership Plan
c/o Office of the State Comptroller
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06016

Know the Difference

- **Covered Member:** A person who is eligible and enrolled for covered services by virtue of past or present employment with the Participating Employer.
- **Covered Person:** A dependent of a covered member who is enrolled in this Prescription Benefit Plan and eligible for benefits for covered services.

Contacts

| Contact | Phone | Address | Website |
|--|--|---|---|
| Office of the State Comptroller (Plan Sponsor) | 860-702-3480 | Office of the State Comptroller ATTN: Healthcare Policy and Benefit Services Division 55 Elm Street Hartford, CT 06106 | http://www.osc.ct.gov |
| CVS/Caremark | 800-318-2572 Prior authorization: 800-294-5979 Prior authorization fax: 888-836-0730 | Claims: P.O. Box 52136 Phoenix, AZ 85072 | www.caremark.com |
| Connecticut Department of Insurance | 860-297-3910 | P.O. Box 816 Hartford, CT 06142 | http://ct.gov/cid/site/default.asp |

Eligibility

The enrollment application and any other forms or statements as required by the Participating Employer must be received and accepted by CVS/Caremark before the applicant shall be considered covered by the Prescription Benefit Plan. The COVERED MEMBER'S and any covered dependent's right to coverage is subject to the condition that all information the covered member provides to the Participating Employer is true, correct and complete to the best of his/her knowledge and belief.

The covered member is responsible for providing the Participating Employer with notification **within 31 days** after the event of any changes that affect the eligibility of any dependent as well as any change in the name, address or phone number of the covered member or his/her enrolled dependent(s).

Eligible Employees

Only current employees or, if applicable, retired employees of the Participating Employer who meet the Participating Employer's eligibility requirements for participation in its group health PLAN, or former employees who choose to continue coverage as allowed by the health insurance continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA provisions) may be enrolled in the Prescription Benefit Plan.

The following rules apply:

- A newly hired employee must enroll in the Prescription Benefit Plan on or before the 31st day after he/she commences employment in order to be eligible for coverage.
- Coverage under the Prescription Benefit Plan is effective for all covered services except those for which the Plan pays secondary (see *Coordination of Benefits*).
- If the employee/retiree does not enroll by the 31-day deadline, he/she must wait to enroll at the next OPEN ENROLLMENT.
- Active and retired employees of the Participating Employer must be enrolled in the Participating Employer's group health plan in order to be covered under the Prescription Benefit Plan.
- The earliest date of coverage for newly hired employees is determined by the Participating Employer and documented on the eligibility checklist.

Eligible Dependents

The following are eligible for coverage as dependents under the Prescription Benefit Plan:

- **Spouse or recognized CIVIL UNION PARTNER.** The lawful spouse of the covered member under a legally valid, existing marriage or the covered member's recognized civil union partner as defined by the Plan Sponsor. Except as set forth in this section, an individual from whom a covered member is divorced or legally separated is not eligible for coverage.

- **Child of the covered member or spouse of the covered member.** A child of the covered member or covered member's spouse, including a step-child; a child legally placed for adoption; or a legally adopted child.
- **Newborn child.** Coverage under the Prescription Benefit Plan shall be provided for a newborn child of the covered member from the moment of birth.

The covered member must submit a completed enrollment application within 31 days after the date of birth to maintain coverage for the newborn. Eligibility requirements must be met and the enrollment application must be accepted by the Participating Employer.

- **Newborn of a covered dependent child.** A newborn child of an enrolled female dependent child is eligible for coverage from the moment of birth up to and including 31 days immediately following birth. The newborn child of a covered dependent child is not eligible for coverage under the Prescription Benefit Plan beyond the 31-day period.
- **TOTALLY DISABLED child.** A totally disabled child who is incapable of sustaining employment by reason of physical or mental handicap may continue coverage beyond the age limit set forth in the Prescription Benefit Plan, provided he/she:
 - Is incapable of sustaining employment by reason of physical or mental handicap as certified by a physician and for whom the covered member (or his/her spouse or civil union partner) is chiefly responsible for support and maintenance; and
 - Became disabled prior to the limiting age for a dependent child and had comparable coverage as a dependent at the time of enrollment; and
 - If over the age of 26, is unmarried.

PROOF of such incapacity and dependency must be received by the Participating Employer within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at that time or at the time of enrollment by a physician and then no more than annually thereafter.

- **Qualified Medical Child Support Orders.** A dependent child may be covered as a consequence of a domestic relations order issued by a state court to a divorced parent who is a COVERED PERSON or the covered member's spouse, as long as the child is under the age of 26. Enrollment may be required even in circumstances where the child was not previously covered under the Prescription Benefit Plan.

Dependents whose eligibility to participate has expired may elect to continue coverage in the Prescription Benefit Plan as required by applicable sections of COBRA (see *COBRA Continuation Coverage*).

Late Enrollment and Special Enrollment Periods

A LATE ENROLLEE is an eligible employee, retiree and/or dependent who requests coverage under the Prescription Benefit Plan after the Participating Employer's Open Enrollment ends or, if applicable, more than 31 days after the employee's and/or dependent's earliest opportunity to enroll for coverage. Late enrollees will not be eligible for coverage except as provided herein. An eligible employee, retiree and/or dependent shall not be considered a late enrollee if a request for coverage is made and each of the following conditions is satisfied:

- Coverage was not elected when the employee and/or dependent was first eligible under the Prescription Benefit Plan solely because that employee and/or dependent was covered under another group health benefit plan; and
- Coverage was lost under that other group health benefit plan due to:
 - Exhaustion of continuation coverage under COBRA or state continuation coverage;
 - Employment termination;
 - Reduction in hours;
 - Death of a spouse;
 - Divorce;
 - Termination of the employer contribution toward the coverage;
 - The group health benefit plan’s involuntary termination or cancellation by its carrier;
 - A substantial diminution of benefits; or
 - A substantial increase in the cost to the covered member, as determined solely by the Participating Employer; and
- The employee and/or dependent enrolls under the Prescription Benefit Plan within 31 days after the loss of coverage under the other group health benefit plan.

Special Enrollment Periods

A special enrollment period is allowed for newly acquired dependents who have not been covered under other group coverage, following marriage, birth, adoption or placement for adoption.

The new dependent(s) must be enrolled within 31 days after the event, unless the covered member has coverage under the Prescription Benefit Plan that would cover the newly acquired dependent without the payment of an additional premium on the date of the marriage, birth, adoption, placement, or other event that makes the new dependent eligible for coverage. Dependent children other than those described in *Eligible Dependents* are not eligible for the special enrollment period.

Changes Affecting Eligibility

It is the responsibility of the covered member to notify the Participating Employer of any change in the dependent status of enrolled individuals within 31 days of the event that renders the individual ineligible for coverage. Examples of such events include a child’s attainment of age 26, or the entry of a judgment of divorce or legal separation.

Failure to Provide Notice of Status Change

Any covered member who fails to provide notification of a change affecting the eligibility status of an enrolled dependent will be subject to one or more of the following:

- An active employee may be subject to disciplinary action if he or she enrolls or maintains enrollment for a person who is not eligible for coverage as a spouse or dependent;
- The fair market value of coverage provided to an ineligible individual will be reported to the Internal Revenue Service (IRS) as income to the covered member; and
- The Participating Employer may seek to recover from the covered member the value of premiums advanced for coverage of an ineligible ex-spouse or dependent.

Note: Family status changes are events that provide former dependents with the right to continue coverage at their own expense for a limited period of time under a federal law known as COBRA. See *COBRA Continuation Coverage*. Although the Prescription Benefit Plan requires notification and termination of coverage for ineligible individuals within 31 days of the family status change, federal regulations give covered people and/or covered dependent(s) up to 60 days to notify the Participating Employer of the change in status in order to obtain COBRA continuation coverage. If notice of the change in family status is not provided within the 60-day period after the qualifying event, the Plan is not obligated to provide COBRA continuation coverage.

Cost of Coverage

Payment for covered services from a PARTICIPATING PHARMACY shall be made to the participating pharmacy. Payment for covered services from a NON-PARTICIPATING PHARMACY shall be made directly to the covered person or dependent, who shall be responsible for payment to the non-participating pharmacy.

When a dependent child receives covered services from a non-participating pharmacy, CVS/Caremark will send payment directly to the custodial parent, even if that parent is not the covered person.

In order to be considered for payment, claims for covered services provided by non-participating retail or mail order pharmacies must be received by CVS/Caremark within 2 years from the date the covered services were performed. Submit such claims to:

CVS/Caremark, DMR
P.O. Box 52136
Phoenix, AZ 85072

CVS/Caremark will not routinely issue a benefit payment of less than \$1.00 except upon written request from the covered person. Claims for covered services submitted more than two years after the date the services were performed shall not be covered or paid.

Claims for benefits for covered services provided to a covered person will be processed within 30 days of the date the claim is received by CVS/Caremark. If a claim decision cannot be made within the 30-day period, an extension of up to 15 days may be requested. Before the end of the initial 30-day period, CVS/Caremark will send the covered person written notice of the reason(s) for the delay.

If the time to process a claim is extended because the covered person has not submitted requested information, the time period required for the claim processing will be tolled from the date the notice of requested information is sent to the covered person until the date CVS/Caremark receives the covered person's response. CVS/Caremark will make a claim decision within 15 days after receipt of the requested information. The covered person should submit the requested information within 45 days from the receipt of the request.

Maintenance Drugs Filled Outside Mail Order or the Maintenance Drug Network

The covered person and dependents who are subject to mandatory mail order will not be reimbursed for the cost of filling anything other than the first 30-day fill of a MAINTENANCE PRESCRIPTION DRUG at a non-participating retail or mail order pharmacy.

Prescription Drug Coverage

A covered person and covered dependents are entitled to benefits for COVERED DRUGS as described in this section, subject to the eligibility, exclusions and limitations, and schedule of benefits in this Plan Document.

Participating Retail Pharmacy Benefits

When a covered drug is dispensed by a participating retail pharmacy or participating MAINTENANCE DRUG NETWORK pharmacy, the participating pharmacy will accept CVS/Caremark's payment in full. The covered person will not be charged for anything except the applicable COPAY or other COST SHARE. CVS/Caremark will pay the participating pharmacy; except for the cost share, which is paid by the covered person to the pharmacy.

A covered person may locate a participating retail pharmacy or participating maintenance drug network pharmacy by calling the toll-free number listed on their I.D. CARD or by visiting www.caremark.com. To obtain benefits, the covered person or covered dependent(s) should show the participating retail pharmacy pharmacist their I.D. card.

Non-Participating Retail Pharmacy Benefits

When a covered drug is dispensed by a non-participating retail pharmacy, the covered person will pay for the prescription out-of-pocket. Then, the covered person must submit a proper claim for reimbursement to CVS/Caremark. Reimbursement is only available for covered services and is subject to reduction for any applicable cost share or copay. Reimbursement is based on the MAXIMUM ALLOWABLE AMOUNT for non-participating retail pharmacies. Claims must be filed with CVS/Caremark within two years after the covered drug has been filled. The receipt must accompany the claim.

A covered person or dependent(s) subject to mandatory mail order (see *Mandatory Program for Maintenance Medications*) will only be reimbursed for the first 30-day supply of a maintenance prescription drug that is dispensed by a non-participating retail pharmacy or non-participating maintenance drug network retail pharmacy.

Mandatory Program for Maintenance Medications

Filing a maintenance drug at the mail order pharmacy is mandatory for active employees and non-Medicare-eligible retirees. All orders for a 31- to 90-day supply of a maintenance prescription drug must be filled by one of the methods below. The covered person will pay a reduced cost share, shown on the *Schedule of Prescription Drug Benefits*, when they obtain maintenance prescription drugs by using:

- The CVS/Caremark mail order program; or
- Any retail pharmacy participating in the State of Connecticut maintenance drug pharmacy network. This network includes all CVS retail pharmacies, independent pharmacies, other pharmacy chains, including those located in grocery store chains and large retailers. Covered persons may locate a participating pharmacy by calling the toll-free number listed on their I.D. card or by visiting www.caremark.com.

Covered Services

Coverage is provided for MEDICALLY NECESSARY prescription drugs, maintenance prescription drugs and certain PREVENTIVE MEDICATIONS that:

- Qualify as covered drugs;
- Are dispensed by a pharmacy; and
- Are prescribed by a licensed practitioner of the healing arts operating within the scope of his/her particular license, subject to the *Exclusions and Limitations* section.

This Prescription Benefit Plan covers:

- Federal legend drugs;
- Compounded medications when all of the following criteria are satisfied:
 - All active ingredients are federal legend drugs;
 - The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation, unless medically necessary;
 - The compounded medication is specifically produced for use by a covered member to treat a covered condition;
 - The compounded medication, including all sterile compounded products, are made in compliance with Connecticut Statutes; and
 - Prior authorization for such medication has been approved.

NOTE:

- Over-the-counter (OTC) products are not covered;
- Bulk powders, bulk chemicals, and propriety bases used in compounded medications are generally not covered, subject to medical necessity review and appeal;
- Reconstitution of oral powders is not considered COMPOUNDING; and
- The compounding pharmacist must bill the NDC of the product used in the quantity of final reconstituted volume.

Maximum Supply

Unless one of the special exceptions, described below, applies, the maximum supply of a prescription drug (other than a maintenance prescription drug) dispensed at a retail pharmacy is a 30-day supply.¹ The maximum supply of a maintenance prescription drug that can be dispensed by mail order or by a maintenance drug network retail pharmacy is a 90-day supply.

¹ Certain covered drugs have specific quantity limits, as set forth in *Covered Drugs Subject to Quantity Limits* or as determined by State and Federal Statutes, FDA approved labeling for use, and/or drug utilization review. Drug utilization review may include but is not limited to drug-to-drug interaction screening, dosage-range screening, drug-of-preference screening, therapy protocol screening, gender and age-benefit screening, duration of use and monitoring of refills.

Special Exceptions

There are certain circumstances when a special exception to the maximum supply limit may be appropriate. A covered person may qualify for a special exception if the covered person can demonstrate that it will be difficult or impossible for him/her to obtain covered drugs in a regular, timely and appropriate manner.

The covered person should contact the CVS/Caremark Customer Service Department at the number located on his/her I.D. card to determine the applicable quantity for covered drugs or whether, and to what extent, a special exception may be applicable. A special exception may be approved for a maximum period of six calendar months at one time.

Coverage for contraceptive medications. The Prescription Benefit Plan covers contraceptive medications for females for \$0.00 cost share. A 30-day supply of a new contraceptive medication may be filled at a participating retail pharmacy. Thereafter, refills of contraceptive medications must be filled as maintenance medications at the mail order pharmacy or at a maintenance drug network retail pharmacy.

Coverage for Certain Preventive Medications

The following medications will be covered drugs with \$0.00 cost share when prescribed by a licensed provider for a covered person or covered dependent within the designated age/gender for the indicated circumstance or condition.

- **Aspirin to prevent cardiovascular disease (CVD):** For men age 45 to 79 years old, generic aspirin with dosages between 81 and 325 mg will be covered; for women age 55 to 79 years old, generic aspirin with dosage between 81 and 325 mg will be covered.
- **Iron supplementation:** Over the counter iron supplementation for asymptomatic children up to the age of one will be covered.
- **Supplementation with folic acid:** For women to age 55, a daily supplement containing 0.4 to 0.8 mg (400 to 800 MCG) of folic acid will be covered.
- **Smoking cessation:** Over-the-counter generic nicotine replacement products will be covered.
- **Chemoprevention of dental caries (cavities):** For preschool children (between the ages of six months and up to six years of age) whose primary water source is deficient in fluoride, oral forms of brand and generic fluoride will be covered when prescribed by a licensed provider in the following dosages: sodium fluoride tab 0.5 mg; sodium fluoride chew tab 0.25 - 0.5 mg; sodium fluoride soln 0.125 - 0.25 mg/drop; sodium fluoride soln 0.25 mg/0.6 ml; sodium fluoride soln 0.5 mg/ml.
- **Contraceptives and emergency contraception:** Over-the-counter contraceptives and emergency contraception will be covered for females.

Covered Drugs Requiring Prior Authorization

The list of covered drugs for which prior authorization is required, below, is subject to change, based upon (a) the existence of new FDA approved drug products or technologies; or (b) determinations after review by the CVS/Caremark Prescription Pharmacy and Therapeutics Committee for previously FDA approved drug products or technologies. The CVS/Caremark

Pharmacy and Therapeutics Committee will review these medications based on FDA approved indications and nationally recognized treatment guidelines.

| Drugs/Drug Classes requiring Prior Authorization | |
|--|--|
| Compound Medications | Prior Authorization required |
| Rheumatoid Arthritis | Prior Authorization required |
| Growth Hormones | Prior Authorization required (no coverage for ISS) |
| Hepatitis C | Prior Authorization required |
| Psoriasis | Prior Authorization required |
| Infertility | Prior Authorization required |
| IVIG/immune deficiency | Prior Authorization required |
| Oral/Intranasal Fentanyl | Prior Authorization required |
| Non-Steroid Anti-inflammatory Combination Drugs | Prior Authorization required |
| Metformin ER | Prior Authorization required |
| Zergerid/omeprazole-bicarbonat | Prior Authorization required |
| Narcolepsy Agents | Prior Authorization required |

As changes are made to this list in response to the availability of new FDA approved drug products or technologies, and/or review by the CVS/Caremark Pharmacy and Therapeutics Committee, the Plan Sponsor will update the Plan Document. A covered person may contact the Customer Service Department at the number located on his/her I.D. card or CVS/Caremark's website with any questions about prescription drugs that require prior authorization. The inclusion of a new FDA approved drug product or technology on the list of drugs requiring prior authorization is not a guarantee of coverage. Refer to *Prescription Drug Coverage and Exclusions and Limitations* for more information.

Obtaining Prior Authorization

The covered person or covered person's representative must obtain prior authorization in order to receive benefits for certain covered drugs. When a covered drug that requires prior authorization is prescribed for a covered person, the covered person or the covered person's representative must call CVS/Caremark at 800-294-5979 or fax a written request for prior authorization to CVS/Caremark, at 888-836-0730.

Upon receipt of the request for prior authorization, CVS/Caremark will either:

- Deny prior authorization for the prescription drug; or
- Approve benefits for that prescription drug up to any specified quantity limit.

Duration of Prior Authorization

Once coverage for a drug requiring prior authorization has been approved (including coverage that results from an internal review or external appeal) the authorization will be effective for one CALENDAR YEAR from the date of coverage, after which point a new request for prior authorization of that drug must be submitted.

Covered Drugs Subject to Quantity Limits

A list of covered drugs that are subject to quantity limits is included below. The CVS/Caremark Pharmacy and Therapeutics Committee will review these medications based on FDA approved indications and nationally recognized treatment guidelines, as determined by State and Federal Statutes, FDA approved labeling for use, and/or drug utilization review that is reviewed by the State of Connecticut Health Care Cost Containment Committee and approved by the Office of the State Comptroller.

| Drugs/Drug Classes Subject to Quantity Limits | |
|---|--|
| Alsuma | Quantity limit: 8 injectors per 30 days |
| Amerge | Quantity limit: 9 tablets per 30 days |
| Axert | Quantity limit: 12 tablets per 30 days |
| Caverject | Quantity limit: 6 units per 30 days |
| Cialis | Quantity limit: 6 tablets per 30 days |
| Edex | Quantity limit: 6 units per 30 days |
| Frova | Quantity limit: 9 tablets per 30 days |
| Imitrex Nasal inhaler 5mg | Quantity limit: 24 units per 30 days |
| Imitrex Nasal inhaler 20 mg | Quantity limit: 12 units per 30 days |
| Imitrex tablets | Quantity limit: 12 tablets per 30 days |
| Imitrex Vials | Quantity limit: 10 vials (5 ml) per 30 days |
| Migranal nasal inhaler | Quantity limit: 1 kit (8 units) per 30 days |
| Muse | Quantity limit: 6 units per 30 days |
| Relpax | Quantity limit: 12 tablets per 30 days |
| Levitra | Quantity limit: 6 tablets per 30 days |
| Maxalt tablet | Quantity limit: 12 tablets per 30 days |
| Maxalt-MLT tablets | Quantity limit: 12 tablets per 30 days |
| Onzetra Xsail | Quantity limit: 1 kit (8 pouches) per 30 days |
| Stadol Nasal Spray | Quantity limit: 2 bottles per 30 days; available as generic only |
| Staxyn | Quantity limit: 6 tablets per 30 days |
| Stendra | Quantity limit: 6 tablets per 30 days |
| Sumavel DosePro 4mg | Quantity limit: 18 DosePros per 30 days |
| Sumavel DosePro 6mg | Quantity limit 12 DosePros per 30 days |
| Treximet | Quantity limit: 9 tablets per 30 days |
| Viagra | Quantity limit: 6 tablets per 30 days |
| Zembrace SymTouch | Quantity limit: 24 injections per 30 days |
| Zomig Nasal Spray | Quantity limit: 12 inhalers per 30 days |
| Zomig/Zomig ZMT tablets | Quantity limit: 12 tablets per 30 days |
| Topical Lidocaine | Emla (30 gm), Lidocaine 2% gel (30 gm), Lidocaine 4% gel (30 gm), Lidocaine 5% oint (50 gm), Lidocaine 4% soln (50 ml), Pliaglis 7-7% cream (30 gm), Synera 70-70 mg patch (2) per 30 days |
| Albenza | 336 tablets per 365 days |
| Biltricide | 24 tablets per 365 days |
| Emverm | 12 tablets per 365 days |

Other Prescription Drug Benefit Provisions

- The Prescription Benefit Plan may require a covered person to furnish CVS/Caremark with any information about the diagnosis of any injury or illness and about the nature, quality and quantity of the prescribed prescription drug or maintenance prescription drug, and may deny coverage if adequate information is not furnished.
- The Plan Sponsor shall not be liable for any claims, injury, demand or judgment based on tort, product liability or other grounds (including warranty of merchantability), arising out of the coverage, compounding, dispensing, manufacturing or use of any prescription drug or maintenance prescription drug dispensed under the provisions of the Prescription Benefit Plan.
- Benefits for up to six pill(s)/unit(s)/dose(s) per month are available for a covered drug related to the treatment of male or female sexual dysfunctions or inadequacies. See *Covered Drugs Subject to Quantity Limits*.

Schedule of Prescription Drug Benefits

A participant's right to benefits for covered drugs, as provided in this Plan Document, are subject to the terms and conditions of the agreement between the State of Connecticut and CVS/Caremark.

Copays and Cost Shares

Active Employees

| | Acute/Maintenance Medications | | Mail Order | |
|-----------------------------------|-------------------------------|-----------------------------------|--------------------------------------|--|
| | Participating Retail Pharmacy | Non-Participating Retail Pharmacy | Maintenance Medications ¹ | Health Enhancement Program Participants ² |
| Preferred Generic | \$5 copay | 20% coinsurance; Plan pays 80% | \$5 copay | Plan pays 100% |
| Non-Preferred Generic | \$10 copay | 20% coinsurance; Plan pays 80% | \$10 copay | Plan pays 100% |
| Preferred Brand | \$25 copay | 20% coinsurance; Plan pays 80% | \$25 copay | \$5 copay |
| Non-Preferred Brand | \$40 copay | 20% coinsurance; Plan pays 80% | \$40 copay | \$12.50 copay |
| Contraceptives³ | Plan pays 100% | N/A | Plan pays 100% | Plan pays 100% |
| Day Supply Limit | 30 days | 30 days | 90 days | 90 days |

¹ Use of mail order or Connecticut maintenance drug network retail pharmacy required for a 90-day refill of maintenance medications after the first 30-day fill at a retail pharmacy.

² Also includes the following chronic conditions: asthma/COPD, heart failure/heart disease, hyperlipidemia and hypertension and diabetes.

³ Treated as maintenance medication; use of mail order or Connecticut maintenance drug network retail pharmacy required for a 90-day refill after the first 30-day fill at a retail pharmacy.

Prescription Drug Programs and Rules

| | |
|---|---|
| <p>Required Generic Drugs</p> | <p>When a prescription does not specify “No Substitution,” and the order is filled with a BRAND NAME PRESCRIPTION DRUG at the request of the covered person or prescriber, even though a federally approved generic equivalent drug is available, the covered person will be responsible for both the GENERIC PRESCRIPTION DRUG copay amount, as shown on the <i>Schedule of Prescription Drug Benefits</i>, and the difference in cost between the generic prescription drug and the brand name prescription drug</p> <p>When a brand name prescription drug (for which a generic prescription drug is available) is medically necessary to treat a covered person’s specific injury or illness, the prescriber must submit a completed medical necessity form to CVS/Caremark by facsimile. If medical necessity is established, the brand name drug will be dispensed without the covered person having to pay the difference in cost between the generic and the brand name prescription drug</p> <p>In the event that no generic prescription drug is available for the dispensing of a non-maintenance prescription drug, a covered person is required to pay the brand drug copay as shown on the <i>Schedule of Prescription Drug Benefits</i></p> <p>The copay for a non-preferred brand drug may be reduced to the copay applicable to a preferred brand name drug if the prescriber submits a completed medical necessity form to CVS/Caremark by facsimile and medical necessity is found</p> |
| <p>Non-Preferred Drug Utilization</p> | <p>Higher copay required unless prescribing physician submits a coverage exception request attesting that non-preferred brand is medically necessary</p> |
| <p>Prior Authorization</p> | <p>Required for certain drugs. See <i>Covered Drugs Requiring Prior Authorization</i>.</p> |
| <p>Quantity Limits</p> | <p>Required for certain drugs. See <i>Covered Drugs Subject to Quantity Limits</i>.</p> |
| <p>Health Enhancement Program (Chronic Conditions)</p> | <p>Covered persons in the Health Enhancement Program (HEP) may qualify for reduced cost shares for maintenance medications prescribed for the treatment of the following conditions: diabetes, asthma/COPD, high blood pressure, hyperlipidemia, or heart disease/heart failure</p> |
| <p>SPECIALTY DRUGS</p> | <p>Can be dispensed at any retail pharmacy and are not limited to mail order or participating maintenance drug network pharmacies; maintenance drug copays apply to 90-day supplies</p> |
| <p>FORMULARY</p> | <p>CVS/Caremark Preferred Drug List</p> |
| <p>Annual Prescription Drug OUT-OF-POCKET MAXIMUM</p> | <p>Individual: \$4,600 Family: \$9,200</p> |

Exclusions and Limitations

The Prescription Benefit Plan provides no coverage for any prescription drug or maintenance prescription drug that is or has been:

- Dispensed before the covered person's effective date or after his or her termination date.
- The subject of a request for further information by CVS/Caremark (for example, for utilization review purposes) where CVS/Caremark is not provided with the information requested.
- Filled in excess of that specified by the prescribing physician or dispensed/refilled after one year from the original date of the prescription.
- Taken while in or administered by a hospital or any other health care facility or office.
- Covered under Worker's Compensation, Medicare, Medicaid or other (non-Medicare) governmental program, even if the covered person chooses not to claim such benefits.
- Furnished by the U.S. Veterans' Administration, except if this Prescription Benefit Plan is the SECONDARY PLAN; any copay amount a covered person is required to pay may be submitted for reimbursement under the Coordination of Benefits provisions.
- Compounded medications for which prior authorization has not been approved.
- Dispensed or prescribed in a manner contrary to normal medical practice. However, coverage shall not be excluded for any drug prescribed for the treatment of cancer on the grounds that the drug is prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, provided that the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:
 - The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI);
 - The American Medical Association's Drug Evaluations (AMA DE); or
 - The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).
- Considered EXPERIMENTAL OR INVESTIGATIONAL in nature, which includes any drug that requires federal or other governmental agency approval not granted at the time the drug was prescribed, or any drug that is approved by the FDA for controlled studies only.
- All over-the-counter products and medications unless designated as preventive medications under the *Prescription Drug Coverage* section. This includes, but is not limited to, electrolyte replacement, non-specialized infant formula for which no prescription is required, miscellaneous nutritional supplements and all other over-the-counter products and medications.
- Anorexiant.
- Any cosmetic drugs including, but not limited to Renova, skin pigmentation preparations, any drugs or products used for the treatment of baldness, or topical dental fluorides.
- Growth hormones for the treatment of Idiopathic Short Stature (ISS).

- Infertility drugs unless approved for utilization by the carrier for the Medical Benefit Plan in conjunction with a covered infertility procedure.
- Any detergents, shampoos, toothpaste/gels, mouthwash/rinses or soaps that can be dispensed without a prescription.
- An appliance, device, other medical supply or durable medical equipment unless shown under the definition of prescription drug.
- A hypodermic needle, syringe or similar device, except for the administration of covered drugs when prescribed in accordance with the terms and conditions of the Prescription Benefit Plan.
- An allergenic extract or vaccine.
- A contraceptive or contraceptive device, that:
 - Has not been approved by the FDA; and
 - Is not prescribed by a licensed physician.
- Condoms, contraceptive sponges, spermicides and over-the-counter emergency contraceptives, unless prescribed by a licensed physician.
- Drugs or medicines covered under any other plan sponsored by the Participating Employer.
- Vitamins that are used as a dietary supplement, including liquid nutritional supplements, pediatric prescription drug vitamins, and prescribed versions of vitamins A, D, K, B12, niacin and folic acid, except as listed as preventive medications under *Prescription Drug Coverage*.
- Any drug labeled “Caution - Limited by Federal Law for Investigational Use” or experimental drugs.
- Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
- Drugs or medicines needed due to conditions caused, directly or indirectly, by a covered person taking part in a riot or other civil disorder; or the covered person taking part in the commission of a felony.
- Drugs or medicines needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war, or drugs dispensed to a covered person while on active duty in any armed force.
- Any expenses related to the administration of any drug.
- Drugs, medicines or products that are not medically necessary.
- Erectile dysfunction prescription drugs, except as described under *Other Prescription Drug Benefit Provisions*.
- Over-the-counter smoking deterrents, except as listed as preventive medications under *Prescription Drug Coverage*.
- Dispensed in excess of amounts provided under *Prescription Drug Coverage* regarding special exceptions to the maximum supply limit, vacation supplies and replacement of lost, stolen, spilled, broken or dropped prescription drugs up to two times per year.

- Medical foods.
- Drugs covered under the Health Benefit Plan only (e.g., Spinraza, Yescarta, Luxturna, Brineura, etc.).
- Periodontal products (subgingival implants).
- Unapproved products and/or products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act.
- Any other services or items not listed in this Plan Document.

Exclusion of Workers' Compensation

To the extent permitted by law, no benefits shall be provided for covered services that are paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as non-participating retail pharmacy services or which, by law, were rendered without expense to the covered person.

The Prescription Benefit Plan shall be entitled to the following:

- To charge the entity obligated under such law for the dollar value of those benefits to which the covered person is entitled.
- To charge the covered person for such dollar value, to the extent that the covered person has been paid for the covered services.
- To reduce any sum owed to the covered person by the amount that the covered person has received in payment.
- To place a lien on any sum owed to the covered person for the amount the Prescription Benefit Plan has paid for covered services rendered to the covered person, in the event that there is a disputed and/or controverted claim between the Prescription Benefit Plan and the designated Workers' Compensation carrier as to whether or not the covered person is entitled to receive Workers' Compensation benefit payments.
- To recover any such sum owed as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
- If a covered person is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines for coverage under such program in order for this Prescription Benefit Plan to continue to provide benefits for covered services when the Workers' Compensation benefits are exhausted.

Exclusion of Automobile Insurance

To the extent permissible by law, this Prescription Benefit Plan will not pay benefits for covered services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

The Prescription Benefit Plan shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a covered person is entitled;
- To charge the covered person for such dollar value, to the extent that the covered person has received payment from any and all sources, including but not limited to, first party payment.
- To reduce any sum owed to the covered person by the amount the covered person has received from any and all sources, including but not limited to, first party payment.
- Benefits shall be subject to the *Coordination of Benefits* section for covered services a covered person receives under an automobile insurance policy, which provides benefits without regard to fault.
- If a covered person is entitled to benefits under a no-fault or other automobile insurance policy, benefits for covered services will only be provided when a covered person follows all of the guidelines for coverage under that policy. It is necessary to follow all the guidelines under that policy in order for the Prescription Benefit Plan to continue to provide benefits for covered services when the no-fault or other automobile insurance policy benefits are exhausted.

Coordination of Benefits

All benefits provided under this Prescription Benefit Plan are subject to the Coordination of Benefits (COB) process. Penalties imposed on a covered person by the PRIMARY PLAN are not subject to COB.

COB applies to this Prescription Benefit Plan when a covered person has health care coverage under more than one plan. When this Prescription Benefit Plan is a “primary plan,” benefits are determined before those of the other plan and without considering the other plan’s benefits. When this Prescription Benefit Plan is a “secondary plan,” benefits are determined after those of the other plan, and may be reduced by the other plan’s benefits. If a coverage arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

If the covered person is covered by this Prescription Benefit Plan and another plan, the “order of benefit determination rules” shall determine which plan is the primary plan. The benefits of this Prescription Benefit Plan:

- Shall not be reduced when, under the order of benefit determination rules, this Prescription Benefit Plan is the primary plan; but
- May be reduced (or the reasonable cash value of any covered service provided under this Prescription Benefit Plan may be recovered from the primary plan) when, under the order of benefit determination rules, another plan is the primary plan.

The covered person must submit the explanation of benefits from the primary plan to CVS/Caremark within two years of the date of service in order to be eligible for payment under COB.

Order of Benefit Determination Rules

This Prescription Benefit Plan is a secondary plan, which has its benefits determined after those of the other plan, when a covered person:

- Receives covered services by or through this Prescription Benefit Plan (or is otherwise entitled to claim benefits under the Prescription Benefit Plan);
- Has followed all the guidelines and procedures, as specified in this Plan Document; and
- The covered services are a basis for a claim under another plan.

Unless:

- The other plan has rules coordinating its benefits with those described in this Plan Document; and
- Both the other plan’s rules and this Prescription Benefit Plan’s coordination rules require that this Prescription Benefit Plan’s benefits be determined before those of the other plan.

Coordination Rules

The Prescription Benefit Plan determines its order of benefits using the following rules:

- **Other than a dependent.** The plan which covers the person as a covered member, (that is, other than as a dependent), is primary to the plan which covers the person as a dependent;
- **Dependent child/parents not separated or divorced.** When this Prescription Benefit Plan and another plan cover the same child as a dependent of different persons, called “parents,” the plan of the parent whose birthday falls earlier in a year is primary to the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the plan which covered a parent longer is primary. Only the month and day of the birthday are considered.
- **Dependent child/separated or divorced parents.** In the case of a covered dependent child:
 - When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the plan which covers the child as a dependent of the parent with legal custody of the child shall pay benefits before the plan which covers the child as a dependent of the parent without legal custody;
 - When the parents are divorced and the parent with legal custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody shall pay benefits before the plan which covers that child as a dependent of the step-parent; and
 - The plan which covers that child as a dependent of the step-parent shall pay benefits before the plan which covers that child as a dependent of the parent without legal custody.

However, if the specific terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the plan which covers the child as a dependent of the financially responsible parent shall pay benefits before any other plan that covers the child as a dependent.

The provisions of this subsection do not apply with respect to any CLAIM DETERMINATION PERIOD or PLAN YEAR during which any benefits are actually paid or provided before the payor has actual knowledge of the terms of the court order

- **Active/inactive employee.** A plan which covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) is primary to a plan which covers that person as laid off or retired (or as that employee’s dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/shorter/length of coverage.** If none of the above rules determines the order of benefits, the plan which covered a covered member longer is primary to the plan which covered that person for the shorter time.

Effect of this Prescription Benefit Plan on Other Benefits

When the Prescription Benefit Plan is the secondary plan, the Prescription Benefit Plan will provide benefits at the lesser of the amount that would have been paid had it been the primary plan or the balance of the bill. The Plan Sponsor shall never pay more than it would have paid as the primary plan.

If another plan provides that its benefits are “excess” or “always secondary” and if this Prescription Benefit Plan is determined to be secondary under this Prescription Benefit Plan’s COB provisions, the amount of benefits payable under this Prescription Benefit Plan shall be determined on the basis of this Prescription Benefit Plan being secondary.

Right to Receive and Release Needed Information

Certain information is needed to apply these COB rules. The Plan Sponsor has the right to decide which information it needs. By enrolling in the Prescription Benefit Plan, the covered person consents to the release of information necessary to apply the COB rules. Any covered person claiming benefits under this Prescription Benefit Plan must furnish information the Plan Sponsor and/or CVS/Caremark determines is necessary for the COB.

Facility of Payment

A payment made or a service provided under another plan may include an amount which should have been paid or provided under this Prescription Benefit Plan. If it does, the plan may pay that amount to the organization that made the payment. Such amount shall then be considered as though it were a benefit paid under this Prescription Benefit Plan.

Right of Recovery under Coordination of Benefits

If the amount of benefits provided under the Prescription Benefit Plan is more than should have been paid under COB, or if this Prescription Benefit Plan has provided services which should have been paid by the primary plan, the Plan Sponsor may recover the excess or the reasonable cash value of the covered services, as applicable, from one or more of the persons, insurance companies, or other organizations it has paid or for whom it has paid.

The right of the Plan Sponsor to recover from a covered person shall be limited to the ALLOWABLE EXPENSE that the covered person has received from another plan. Acceptance of covered services will constitute consent by the covered person to the Plan Sponsor’s right of recovery. The covered member agrees to take such further action to execute and deliver such documents as may be required and do whatever else is necessary to secure the Plan Sponsor’s rights to recover excess payments. The covered person’s failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

Termination of Coverage

The covered person's enrollment in the Prescription Benefit Plan shall terminate:

- The last day of the month in which required premiums for a covered person's coverage are not paid when due;
- At the covered person's option, during the Participating Employer's Open Enrollment, to be effective as of the renewal date of the Prescription Benefit Plan;
- The day following a covered member's death. When a covered member dies, his/her dependents' coverage shall terminate on the first day of the month following the covered member's death, unless they are eligible and elect to continue coverage pursuant to COBRA or are otherwise eligible for continued coverage under some other benefit plan maintained by the Participating Employer;
- When the covered person ceases to meet the Participating Employer's eligibility requirements as defined in the *Eligibility* section, coverage will end on the first day of the month following the loss of eligibility. When a dependent's eligibility for coverage is lost due to misrepresentation of status, divorce or legal separation, termination of coverage will occur on the first day of the month following the effective date of the divorce or legal separation or discovery of the misrepresentation.
- If and when a covered person permits any other person to use his or her I.D. card to obtain services.
- If and when it is determined that a covered member has enrolled an ineligible person as a dependent under the plan or has failed to provide the Participating Employer with required notification of the occurrence of an event that causes a dependent to no longer be eligible for coverage (e.g., divorce, legal separation or attainment of maximum age).

Notwithstanding anything else above, coverage for an enrolled dependent will terminate on the day after the death of that enrolled dependent.

Member Notification

Pursuant to Connecticut General Statutes, if the Participating Employer cancels or discontinues its participation in the Prescription Benefit Plan with respect to its entire group or a class of employees, the Participating Employer must send the covered member written notification of cancellation or discontinuation of this Prescription Benefit Plan at least 15 days before the effective date of cancellation or discontinuation. Coverage will be terminated regardless of whether the notice was given.

Continuation Options

In the event a covered person loses eligibility under this Prescription Benefit Plan, he/she may be entitled to continue coverage under certain circumstances. Continuation options will be provided under each of the following circumstances for the period indicated or until the covered person becomes eligible for other group coverage, except as otherwise stated in this section.

Note: Notwithstanding anything else in this Plan Document to the contrary, continuation coverage under this Prescription Benefit Plan will terminate upon the expiration of the contract between the State of Connecticut and CVS/Caremark or if required premiums are not paid when due.

COBRA Continuation Coverage

A covered person subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), may continue coverage under this Prescription Benefit Plan to the extent required by law. The Participating Employer or its representative shall administer COBRA continuation benefits. Coverage shall also be available to a child born to or placed for adoption with the covered member while the covered member is receiving COBRA continuation coverage. The right to continuation coverage in this Prescription Benefit Plan will terminate upon termination of the agreement between the State of Connecticut and CVS/Caremark.

Continuation of coverage for up to 36 months shall be available for an enrolled dependent following:

- The death of the covered member;
- The legal separation or divorce from the covered member;
- The covered member’s entitlement for Medicare; or
- The attainment of the limiting age for an enrolled dependent child.

Continuation of coverage for up to 30 months shall be available to a covered member and his/her enrolled dependents following:

- The covered member’s reduction in work hours;
- The covered member’s voluntary resignation;
- Lay off or termination of the covered member for any reason other than gross misconduct.

An additional 11 months shall be available to a covered member or an enrolled dependent who is determined to be disabled under Title II or Title XVI of the Social Security Act at the time he/she becomes eligible for extended continuation of coverage under COBRA or becomes disabled at any time during the first 60 days of COBRA continuation coverage. The covered member or enrolled dependent must provide notice of the disability determination to the Participating Employer no later than 60 days after the date of the Social Security Administration’s determination and before the end of the initial 18 months of COBRA continuation coverage.

- If it is determined that the covered member or dependent is no longer disabled, the extended continuation of coverage period can be terminated on the first of the month following 30 days after the final determination notice.

The continuation of coverage must be equal to the benefits under this Prescription Benefit Plan that are available to a currently employed covered person. A covered person who is eligible for continuation of coverage must be provided with at least 60 days in which to elect such coverage.

A covered person's eligibility for continuation of coverage ends earlier than the above periods if:

- The covered person becomes eligible for benefits under another group health plan as a result of employment, re-employment or marriage, except when the new plan contains any exclusion or limitation relating to any pre-existing condition of the covered person that would affect coverage under this Prescription Benefit Plan; or
- The premium for continuation of coverage is not paid on time; or
- The covered person becomes entitled to Medicare benefits.

Payment Provisions

Claim Overpayments

When CVS/Caremark has made payments for covered services, either in error in excess of the maximum amount of payment necessary to satisfy the provisions of this Prescription Benefit Plan, irrespective of to whom paid, CVS/Caremark, on behalf of the Prescription Benefit Plan, has the right to recover these payments from one or more of the following:

- Any person to or for whom such payments were made;
- Any insurance companies; or
- Any other organization receiving said payment.

The Prescription Benefit Plan's right to recover may include deducting the amount CVS/Caremark has paid in error or in excess from future benefits payments. The covered member personally and on behalf of his/her dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure the Prescription Benefit Plan's right to recover any erroneous or excess payments.

Right of Recovery

The purpose of the Prescription Benefit Plan is to provide coverage for qualified pharmacy expenses that are not covered by a third party. If the Prescription Benefit Plan pays benefits for any claim a covered person incurs as the result of negligence, willful misconduct or other action or omission of a third party, the Prescription Benefit Plan has a right of subrogation. To the extent permitted by law, where the covered person has a right of recovery against third parties for the cost of covered services, the Prescription Benefit Plan shall have a right of recovery against third parties for benefits for covered services provided under the terms of this Prescription Benefit Plan.

Acceptance of covered services will constitute consent by the covered person to the Prescription Drug Plan's right of recovery. The covered person agrees to execute and deliver such additional instruments, and to take such other action as CVS/Caremark or the Prescription Benefit Plan may require to implement this provision. To the extent permitted by law, the Prescription Benefit Plan, or CVS/Caremark acting on its behalf, will have the right to bring suit against such third party in the name of the covered person and in its own name as subrogee. The covered person shall do nothing to prejudice the Prescription Drug Plan's rights under this provision without its consent.

If a covered person receives payment from a third party by suit or by way of settlement for the cost of covered services, such covered person is obligated to reimburse the Prescription Benefit Plan for benefits paid on his/her behalf out of the recovery from the third party or insurer. To the extent permitted by law, the Prescription Benefit Plan has a lien on any amount recovered by the covered person from the responsible third party or insurer whether or not designated as payment for medical expenses. This lien shall remain in effect until the Prescription Benefit Plan is repaid in full, less a prorated share of the reasonable attorney's fees and costs the covered member sustained in obtaining the recovery.

The covered person must notify the Prescription Benefit Plan immediately if he/she begins settlement negotiations with or obtains a judgment against a third party or insurer in connection with an accident or injury for which benefits have been paid by the Prescription Benefit Plan.

Grievance and Appeal Rights

Claim Denials

If benefits are denied, in whole or in part, CVS/Caremark will send the covered person a written notice within the established period described in *Payment Provisions*. The covered person or the covered person's duly authorized representative may appeal the denial as described in *Appeal Process*, below. The adverse determination notice will include the reason(s) for the denial, reference to the Prescription Benefit Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why such information is needed, the claim appeal procedures and applicable time limits.

If the denial involves a utilization review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the covered person upon request and at no charge; and
- That an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental or investigational treatment or a similar limitation is available to the covered person upon request and at no charge.

Appeal Process

A covered person's questions about the Prescription Benefit Plan often can be handled informally and may be addressed by contacting the CVS/Caremark Customer Service Department, using the telephone number provided on the back of the covered person's I.D. card. In addition, information about the appeal process may be obtained by contacting the CVS/Caremark Customer Service Department.

The appeal process is available to the covered person, the covered person's duly authorized representative, the provider of record, or the provider of record's duly authorized representative.

This appeal process is divided into two types of appeals:

1. Adverse utilization review determinations and
2. Adverse NON-UTILIZATION REVIEW DETERMINATIONS.

Utilization review determinations, such as prior authorizations, are determinations based on medical necessity or other criteria related to the nature of the drug or the covered person's condition being treated. Non-utilization review determinations concern issues relating to the covered person's Prescription Benefit Plan that do not involve the exercise of clinical judgment, such as eligibility for benefits, coverage of claims, or claims processing.

Appeal Process for Adverse Medical Necessity Determinations

CVS/Caremark will provide the first internal review for appeals for PRE-SERVICE AND POST-SERVICE CLAIMS. CVS/Caremark will provide an additional second level internal appeal of pre-service and post-service claims. The medical necessity review for a second level internal appeal will be conducted by an independent medical expert, who specializes in the condition involved.

A covered person who receives an adverse second level appeal determination may further appeal by pursuing an external appeal with the Connecticut Department of Insurance within the period set forth in *External Review: Connecticut Department of Insurance*.

Internal Reviews: First and Second Level Appeals

Prior authorization review. CVS/Caremark will administer the Prescription Benefit Plan by comparing covered person's requests for certain medications and/or other prescription benefits against coverage rules, pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS/Caremark determines that the covered person's request for prior authorization cannot be approved, that determination will constitute an ADVERSE BENEFIT DETERMINATION.

First level appeal of Adverse Benefit Determinations. If an Adverse Benefit Determination is rendered on the covered person's claim, the covered person may file an appeal of that determination. The covered person's appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS/Caremark within 180 days after the covered person receives notice of the Adverse Benefit Determination.

The covered person's appeal should include the following information:

- Name of the covered person the appeal is being filed for;
- CVS/Caremark member 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 covered person's appeal and supporting documentation may be mailed or faxed to CVS/Caremark:

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

For URGENT CARE CLAIMS, the covered person or the covered person's provider or authorized representative may request an expedited appeal by calling toll-free 866-443-1183, faxing a written appeal to 866-443-1172, or mailing a written appeal to the address above.

Appeals of prior authorization determinations for compound medications are reviewed by an independent specialist and constitute a second level internal review.

Second level internal review. If an Adverse Benefit Determination is rendered on the covered person's first level appeal, the covered person may file an appeal of that determination. The covered person's second level appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS/Caremark within 180 days after the covered person receives notice of the decision on the first level appeal. The appeal must be in writing and must be sent by mail or facsimile to:

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

For urgent care claims, a covered person or the covered person's authorized representative may request an expedited appeal by calling toll-free 866-443-1183, faxing a written appeal to 866-443-1172 or mailing a written appeal with a copy of the letter providing notice of the denial of the first level appeal to the address above.

External Review: Connecticut Department of Insurance

A covered person whose claim for benefits has been denied after a second level appeal may request, in writing, an external review of his/her claim within 120 days after receiving notice of the Final Internal Adverse Benefit Determination. The covered person's request should include their name, contact information including mailing address and daytime phone number, member I.D. number, and a copy of the coverage denial. The covered person's request for external review and supporting documentation may be mailed to:

Connecticut Department of Insurance
Attn: External Appeals
P.O. Box 816
Hartford, CT 06142
860-297-3910

For overnight delivery services only, send applications for external review to the following street address:

Connecticut Department of Insurance
Attn: External Appeals
153 Market Street, 7th Floor
Hartford, CT 06143
860-297-3910

Any request for an external appeal of an adverse utilization review determination must be received by the Department of Insurance within 120 days from the date of receipt of the final appeal determination.

Contents of external appeal. The following items must be included in the appeal:

- A completed “request for external appeal” form.
- An authorization form allowing the CVS/Caremark and the covered person’s health care professional to release medical information to the INDEPENDENT REVIEW ORGANIZATION.
- Evidence of being enrolled in the Prescription Benefit Plan (photocopy of the I.D. card issued by the Prescription Benefit Plan).
- Copies of all correspondence from CVS/Caremark.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of the summary plan description or explanation of benefits.
- The filing fee of \$25.

In addition to the required items outlined above, the covered person may also submit any additional information relevant to his/her condition.

Urgent/expedited care claims. In an emergency or life threatening situation, a covered person or a provider acting on a covered person’s behalf can file an expedited external appeal without exhausting all of the Prescription Benefit Plan’s internal appeals procedures. The covered person or provider can also apply for an expedited internal appeal of a claim at the same time.

An independent review organization will determine whether the covered person’s appeal will be handled on an expedited basis. If the appeal is not accepted for expedited review, the covered person will be required to exhaust all internal appeals before seeking external review.

Timeline for Decision by CVS/Caremark

Pre-authorization review. CVS/Caremark will make a decision on a prior authorization request for a Prescription Benefit Plan benefit within 48 hours after it receives the request. If the request relates to an urgent care claim, CVS/Caremark will make a decision on the claim within 24 hours, unless extended by law.

Pre-service claim first level appeal. CVS/Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a pre-service claim within 15 days after it receives the covered person’s appeal.

Pre-service claim second level appeal. If CVS/Caremark renders an Adverse Benefit Determination on the first level appeal of the pre-service claim, the covered person may appeal that decision. A decision on the covered person’s second-level appeal of the Adverse Benefit Determination will be made by independent medical experts within 15 days after the second level appeal is received.

Pre-service claim urgent/expedited care appeal. If the covered person 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 second level appeal(s) is received.

Post-service claim appeal. CVS/Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a post-service claim within 30 days after it receives the appeal. If CVS/Caremark renders an Adverse Benefit Determination, a covered person may appeal through the external review process.

External review. If a covered person appeals an Adverse Benefit Determination by requesting an external review with the Department of Insurance, CVS/Caremark will complete a preliminary review of the covered person’s eligibility within five days of receiving the request from the Commissioner of Insurance for a standard external review, and within one day of receiving the request from the Commissioner of Insurance in the case of an expedited external review.

CVS/Caremark’s preliminary review will determine whether:

- The individual is a covered person;
- The service requested is a covered service under the Prescription Benefit Plan;
- The covered person has exhausted all internal grievance procedures; and
- The covered person has provided all the information and forms required to process an external review or an expedited external review.

Within one day of completing the preliminary review, CVS/Caremark shall notify the Commissioner, the covered person and, if applicable, the covered person’s authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The Independent Review Organization (“IRO”) appointed by the Department of Insurance to review the case, shall rend its decision within 45 days after receipt of the assignment from the Commissioner to conduct the review.

| Type of Review | Time for Caremark to Respond ¹ |
|---|---|
| Pre-Service (Prior Authorization) or Concurrent | 48 hours |
| Pre-Service (Urgent) | 24 hours |
| First Level Appeal | |
| Pre-Service Utilization Review | 15 days |
| Pre-Service Utilization Review (Urgent) | 72 hours |
| Post-Service Utilization Review | 30 days |
| Second Level Appeal | |
| Pre-Service Utilization Review | 15 days |
| Pre-Service Utilization Review (Urgent) | 72 hours |
| Post-Service Utilization Review | 30 days |
| External Review (Standard) | CVS/Caremark will complete preliminary review within five days of receipt of request from the Department of Insurance |
| External Review (Expedited) | CVS/Caremark will complete preliminary review within 24 hours of receipt of request from Department of Insurance |

¹ Calculated from time carrier receives all information required to evaluate claim or resolve appeal.

Scope of Review

CVS/Caremark internal review. During its prior authorization review, first-level review of the appeal of a pre-service claim, or review of a post-service claim, CVS/Caremark is required to:

- Take into account all comments, documents, records and other information submitted by the covered person 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 Prescription Benefit Plan provisions are applied to the covered person in a manner consistent with how such provisions have been applied to other similarly-situated covered persons; 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 covered person appeals CVS/Caremark's denial of a pre-service claim, and requests an additional second-level review by an Independent Review Organization (IRO), the IRO shall:

- Review the claim in accordance with the Prescription Benefit Plan's benefit and coverage rules and medical necessity;
- Consult with an appropriate health care professional 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 Prescription Benefit 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 covered person's claim, CVS/Caremark will notify the covered person 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 the pertinent Prescription Benefit Plan provision on which the Adverse Benefit Determination was based;
- A statement that the covered person 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 medical necessity, either the independent medical expert's explanation of the scientific or clinical judgment for the determination, applying the terms of the Prescription Benefit Plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

External Review: Department of Insurance

The external review of a covered person's appeal will be conducted by an assigned Independent Review Organization ("IRO") selected by the Commissioner of the Connecticut Department of Insurance.

The IRO will notify the covered person of its acceptance of the assignment. The covered person will then have ten days to provide the IRO with any additional information the covered person 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 Prescription Benefit Plan or the Plan Sponsor. The IRO may consider information beyond the records for the covered person's denied claim, such as:

- The covered person's medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Prescription Benefit Plan, the covered person, or the covered person's treating physician;
- The terms of the Prescription Benefit Plan to ensure that the IRO's decision is not contrary (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 Prescription Benefit Plan (unless the criteria are inconsistent with the terms of the Prescription Benefit Plan or applicable law); and
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the covered person's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Binding effect of external review decision. An external review decision, whether a standard external review or an expedited external review, shall be binding on the Plan Sponsor and the covered person, except to the extent the Plan Sponsor or covered person has other remedies available under Federal or state law. A covered person or a covered person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same Adverse Benefit Determination or Final Adverse Benefit Determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

Appeal Process for Adverse Benefit Determinations Not Involving Medical Necessity or Clinical Judgement

If a non-utilization review determination results in a denial of coverage, a review may be requested by the covered person or the covered person's authorized representative. The review request can be initiated orally, electronically or in writing within 180 days from the date of the Adverse Benefit Determination. Review requests should be sent by facsimile or mailed to:

CVS/Caremark
Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072
Fax: 866-554-1172

The review request should include copies of any additional supporting documentation.

A review determination will be issued in writing within 30 days from receipt of a request for review. The written determination will be issued within five business days from the date the review decision is made. If the services are denied because they are not a covered benefit under the Prescription Benefit Plan or because the individual is not eligible for coverage under the Prescription Benefit Plan, no external appeal is available.

Right to Information

The covered person is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records and other information relevant to the covered person's claim for benefits. If an internal rule, guideline, protocol or other similar criterion is relied upon, the specific rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request.

If an Adverse Benefit Determination is based on a medical necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the Prescription Benefit Plan to the covered person's medical circumstances will be provided free of charge upon request.

General Provisions

This Plan Document supersedes all other agreements or descriptions of the benefits provided under the Prescription Benefit Plan.

I.D. Cards

I.D. cards issued to a covered person and their covered dependents pursuant to this Prescription Benefit Plan are for identification purposes only. Possession of an I.D. card confers no right to covered services or other benefits. To be entitled to such services or benefits the holder of the I.D. card must, in fact, be a covered member or covered dependent on whose behalf all applicable benefit cost contributions under this Prescription Benefit Plan have been paid. Any person receiving services or other benefits to which he/she is not then entitled pursuant to the provisions of this Prescription Benefit Plan will be liable for the actual cost of such services or benefits. In addition, any covered member who fails to notify the Participating Employer of a change in circumstances that affects covered dependent's eligibility status (including without limitation, divorce, legal separation, a child's attainment of age 26, etc.) may have the fair market value of coverage reported as income and, if actively employed, may be subject to disciplinary action, including termination.

Upon approval by the Participating Employer and provision of address files CVS/Caremark will mail I.D. cards directly to covered members and their enrolled dependents

Notice

Any notice required under this Plan Document to be given to the Participating Employer or Plan Sponsor may be sent by U.S. Mail, first class, postage prepaid to the address listed in *Contacts*. Notice to a covered person will be sent to the last address the Prescription Benefit Plan has for that covered person. A covered person agrees to provide the Participating Employer with notice, within 31 days, of any change of address.

Notice given to the Plan Sponsor must be sent to the Office of the State Comptroller, in care of the Healthcare Policy and Benefit Services Division, 55 Elm Street, Hartford, CT 06106. Notice given to a covered person will be sent to the covered person's address as it appears on the records of the Participating Employer.

Interpretation of the Prescription Benefit Plan

The laws of the State of Connecticut shall be applied to the interpretation of this Prescription Benefit Plan.

Gender

The use of any gender in this Plan Document is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

Modifications

This Plan Document is subject to amendment, modification and termination in accordance with this provision and applicable collective bargaining agreements affecting health care coverage, benefits and services under the State of Connecticut Employee Health Plan.

Clerical Error

Clerical error, whether by the Plan Sponsor or CVS/Caremark with respect to Plan Document or any other documentation issued by CVS/Caremark in connection with the Prescription Benefit Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Policies and Procedures

The Prescription Benefit Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Prescription Benefit Plan with which a covered person shall comply.

Waiver

The waiver by any party of any breach of any provision of the agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Miscellaneous Provisions

Information Practices Notice

The purpose of this Information Practices Notice is to provide notice regarding the Prescription Benefit Plan's standards for the collection, use and disclosure of information gathered in connection with the Prescription Benefit Plan's business activities.

- The Prescription Benefit Plan may collect personal information about a covered person from persons or entities other than the covered person.
- The Prescription Benefit Plan may disclose a covered person's information to persons or entities outside of the Prescription Benefit Plan without the covered person's authorization in certain circumstances including for purposes of treatment, payment or health care operations.
- A covered person has a right of access and correction with respect to all personal information collected by the Prescription Benefit Plan.
- A more detailed notice will be furnished upon request.

Member Obligations Regarding Information

A covered person shall complete and submit to the Participating Employer such applications or other forms or statements as the Participating Employer or Plan Sponsor may reasonably request in connection with enrollment, continuation of enrollment or claims for benefits.

A covered person warrants that all information contained therein shall be true, correct and complete to the best of the covered person's knowledge and belief. And, the covered person accepts that all rights to benefits under this Prescription Benefit Plan are conditional upon those warranties. The submission of false or incomplete information by a covered person or failure to provide notice within 31 days of a change in status that affects eligibility for coverage of any enrolled individual shall subject the covered member and/or the improperly enrolled individual to one or more of the following:

- An active employee may be subject to disciplinary action by the Participating Employer, if he/she enrolls or maintains an enrollment for a person who is not eligible for coverage as a spouse or dependent;
- The fair market value of health benefit coverage provided to an ineligible individual will be reported by the Participating Employer to the Internal Revenue Service as income to the covered member or to the ineligible individual and, as such, will be subject to taxation; and
- The Prescription Benefit Plan may seek to recover from the covered member or the improperly enrolled individual the value of covered benefits provided to said individual.

Filing a Claim

The Plan Sponsor will not be liable under the Prescription Benefit Plan unless proper notice is furnished by CVS/Caremark that covered services have been rendered to a covered person. In no event will the Plan Sponsor be required to accept notice more than two years after covered services are received.

Changes to Benefits or Eligibility Requirements

This Prescription Benefit Plan shall remain in effect unless amended, terminated, rescinded, suspended or cancelled as described herein. The Plan Sponsor has the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The effective date of any changes shall be designated in writing by the Plan Sponsor.

Except with respect to rules on administration of eligibility requirements as set forth in *Eligibility* and incorporated in the Addendum, no agent or representative of the Participating Employer is authorized to change this Prescription Benefit Plan or to waive any provisions of the Plan Document.

Any change to a Participating Employer's eligibility rules so as to modify the size and composition of the covered population approved at the time of Participating Employer's admission to the Prescription Benefit Plan is prohibited. Any eligibility change by a Participating Employer that would have the effect of permitting enrollment of individuals that are neither active nor retired employees of the Participating Employer or eligible dependents is null and void.

Protected Health Information

Unless otherwise permitted by law and subject to obtaining written certification pursuant to this section, the Prescription Benefit Plan may disclose PROTECTED HEALTH INFORMATION (PHI) to the Plan Sponsor provided the Plan Sponsor uses or discloses such PHI only for the following purposes.

- Performing Prescription Benefit Plan administration functions, which the Plan Sponsor performs;
- Obtaining premium bids from carriers for providing coverage;
- Modifying, amending or terminating the group health plan.

Notwithstanding the provisions of the Prescription Benefit Plan to the contrary, in no event will the Plan Sponsor use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Information regarding participation. Notwithstanding this section, the Prescription Benefit Plan may disclose to the Plan Sponsor information regarding participation or enrollment.

Conditions of disclosure. With respect to any disclosure, the Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Prescription Benefit Plan or as required by law.
- Shall ensure that any agents, contractors or subcontractors to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Plan Sponsor.
- Report any use or disclosure of the information that is inconsistent with the use or disclosures provided for of which it becomes aware.
- Make available PHI in accordance with 45 CFR §164.524.
- Make available PHI for amendment, and incorporate any amendments to PHI in accordance with 45 CFR §164.526.
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance with the Prescription Benefit Plan with subpart E of 45 CFR 164.
- If feasible, return or destroy all PHI received that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

- Ensure that adequate separation between Prescription Benefit Plan and the Plan Sponsor, required by 45 CFR §504(f)(2)(iii) is satisfied.
- Reasonably and appropriately safeguard electronic PHI that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Prescription Benefit Plan.

Certification by the Plan Sponsor. CVS/Caremark shall disclose PHI to the Plan Sponsor only upon receipt of certification from the Plan Sponsor that the Plan Document incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in this section. The Prescription Benefit Plan shall not disclose and may not permit CVS/Caremark to disclose PHI to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR §164.504(b)(1)(iii)(C) is included in the appropriate notice.

Adequate separation between the Prescription Benefit Plan and the Plan Sponsor. The Plan Sponsor shall only allow employees of the Office of the State Comptroller, Healthcare Policy & Benefit Services Division, access to PHI to perform the PLAN ADMINISTRATION FUNCTIONS that the Plan Sponsor performs for the Prescription Benefit Plan. In the event that any of these specified employees do not comply with the provisions of this section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor’s employee discipline and termination procedures.

Permitted uses and disclosures of SUMMARY HEALTH INFORMATION.

Notwithstanding anything previously mentioned in this section, the Plan Sponsor may authorize the State’s data warehouse vendor to disclose summary health information to a Participating Employer, provided the Participating Employer requests the summary health information for the purpose of:

- Performing Prescription Benefit Plan administration functions that the Participating Employer provides with respect to its own enrolled population;
- Obtaining premium bids for providing benefit coverage for its own covered persons; or
- Modifying, amending or terminating its participation in the Prescription Benefit Plan.

Disclosures of summary health information are made provided any designee, agent, contractors or subcontractors of the Participating Employer to whom Plan Sponsor provides PHI shall agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

Glossary

Adverse Benefit Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a medication or product based on the application of the Prescription Benefit Plan's benefits, review requirements, or on a determination of eligibility to participate in the Prescription Benefit Plan. An Adverse Benefit Determination also includes a failure to cover a Prescription Benefit Plan benefit because use of the benefit is determined to be experimental, investigative or not medically necessary or appropriate.

Allowable expense: A medically necessary allowable expense, for an item of expense for health care, when the item of expense, including any copay amount, is covered at least in part by one or more plans covering the covered person for whom the claim is made. When this Prescription Benefit Plan provides covered services, the reasonable cash value of each covered service is the allowable expense and is a paid benefit.

Brand name prescription drug: A prescription drug that has a proprietary or trade name selected by the manufacturer and that is used to describe and identify it. The name appears on its container, label or wrapping at the time of packaging.

Calendar Year: A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

Civil union partner: A same sex partner of the covered member who has joined with the covered member in a certified civil union.

Claim: A request for a Prescription Benefit Plan benefit that is made in accordance with the Prescription Benefit Plan's established procedures.

Claim determination period: Claim determination period means a Calendar Year. However, it does not include any part of a Calendar Year during which a person has no coverage under this Prescription Benefit Plan, or any part of a Calendar Year before the date COB provisions or a similar provision takes effect.

Compounding: Combining, mixing or altering the ingredients of one or more drugs or products to create another drug or product.

Copay: A fixed amount per prescription that the covered person is required to pay for covered services. This fee is in addition to premiums paid by and on behalf of the covered person and is payable by a covered person for covered services at the time that those services are rendered.

Cost share: The amount that the covered person is required to pay for covered services.

Covered drug: A medically necessary prescription drug or maintenance prescription drug or certain preventive medications, including:

- Any prescription drug or maintenance prescription drug that is not excluded under this Prescription Benefit Plan;
- Injectable insulin;

- Any medicine which a pharmacy compounds (at least one ingredient of which is a prescription drug) and which is not excluded under this Prescription Benefit Plan. This includes refills of covered drugs; or
- Preventive medications, as defined below.

In addition, in order to be a covered drug, the prescription drug or maintenance prescription drug must be ordered by a duly licensed physician or other licensed health care practitioner acting within the scope of his or her license.

Any prescription drug that requires Federal or other governmental agency approval not granted at the time the prescription drug was prescribed, or any drug that is approved by the Food and Drug Administration (FDA) for controlled studies only is not a covered drug.

Covered member: A person who is eligible and enrolled for covered services by virtue of past or present employment with the Participating Employer.

Covered person: A dependent of a covered member who is enrolled in this Prescription Benefit Plan and eligible for benefits for covered services.

Covered service(s): Prescription drugs and related products that are medically necessary, are described in this Plan Document, and are not listed in *Exclusions and Limitations*.

Dependent: The term dependent means a covered member's lawful spouse under a legally valid existing marriage, a covered member's civil union partner under a legally valid civil union, and any child of either the covered member or his/her spouse who meets the requirements for coverage as set forth in this Plan Document, including the Addendum.

Effective date: The term effective date means the date a covered member and his/her covered dependents, if any, are accepted by the Participating Employer and are eligible to receive benefits for covered services under this Prescription Benefit Plan.

Experimental or investigational: Services or supplies which include, but are not limited to, any treatment, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of the Plan Sponsor to be experimental or investigational.

In making its determination, the Plan Sponsor will deem a service or supply to be experimental or investigational if it satisfies one or more of the following criteria:

- The service or supply does not have final approval by the appropriate government regulatory body or bodies, or such approval for marketing has not been given at the time the service or supply is furnished; or
- A written informed consent form for the specific service or supply being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or

- The services or supply is the subject of a protocol, protocols or clinical trial study, or is otherwise under study in determining its maximum tolerated toxicity dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

Notwithstanding the above, services or supplies will not be considered experimental if they have successfully completed a Phase III clinical trial of FDA for the illness or condition being treated or the diagnosis for which they are being prescribed.

In addition, a service or supply may be deemed experimental or investigational based upon:

- Published reports and articles in the authoritative medical, scientific and peer review literature;
- The written protocol or protocols used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FDA: The United States Food and Drug Administration.

Formulary: The list of drugs selected by the CVS/Caremark Pharmacy and Therapeutics Committee for inclusion on its preferred drug list, which may be updated from time to time.

Generic prescription drug: A prescription drug that is considered non-proprietary and is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand name drug.

Health Enhancement Program (“HEP”): A health incentive program that rewards covered persons who commit to taking an active role in managing of their health. Enrolled HEP participants may qualify for reduced copays for certain medications.

I.D. card: A card issued by CVS/Caremark to a covered member or dependent for identification purposes. The I.D. card must be shown by the covered person to obtain covered services.

Independent Review Organization (IRO): An independent company that consists of a network of practicing physicians and board certified specialists in all fields of medicine. IRO medical experts provide an impartial evaluation of benefit determinations for medical necessity appeals and for the external review process.

Late enrollee: An eligible employee, retiree and/or dependent who requests enrollment following the Participating Employer’s Open Enrollment effective date, if applicable, or more than 31 days after the employee’s, retiree’s and/or dependent’s earliest opportunity to enroll for coverage under any health benefit plan sponsored by the Participating Employer.

Maintenance drug network: A retail pharmacy that has agreed to process prescribed maintenance medications for individuals covered under Prescription Benefit Plan. Pharmacies in the network (which includes all CVS pharmacies) have agreed to accept the maximum allowable amount and will make no charge to the covered person except for any applicable copay or cost share.

Maintenance prescription drug: A prescription drug that is used on a continuing basis for the treatment of a chronic condition or illness, such as heart disease, high blood pressure, arthritis and/or diabetes. It may also include ORAL CONTRACEPTIVES and other medications used on a year-round basis.

Maximum allowable amount: The term maximum allowable amount means, except as otherwise required by law, either:

- An amount agreed upon by CVS/Caremark and a participating pharmacy as full compensation for covered drugs dispensed to a covered person; or
- With respect to a non-participating retail or mail order pharmacy, an amount designated by CVS/Caremark and based on the amount paid to a participating pharmacy for a particular medication.

When applicable, it is the covered person's obligation to pay cost shares as a component of this maximum allowable amount. The amount the Plan Sponsor will pay for covered drugs will be the maximum allowable amount or the billed charge, whichever is lower. The amount the covered person will pay for cost shares will be calculated based on the maximum allowable amount or the billed charges, whichever is lower.

Please note that the maximum allowable amount may be greater or less than the participating pharmacy's billed charges for the covered drug.

Medically necessary (medical necessity): A prescription drug or related item which is prescribed by an appropriately licensed physician or provider; and, which may be a covered service which a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Medicare: Title XVIII of the Social Security Act of 1965, as amended.

Non-participating pharmacy: Any appropriately licensed pharmacy that is not a participating pharmacy under the terms of this Prescription Benefit Plan.

Non-utilization review determination: A review relating to the covered person's Prescription Benefit Plan, such as an individual's eligibility for benefits, coverage of claims or claims processing that do not involve medical necessity or the exercise of clinical judgment.

Open Enrollment: The period of time during which the Participating Employer allows employees (or retirees) to select group health coverage for themselves or their dependents.

Oral contraceptive: A hormonal compound taken orally in order to block ovulation and prevent the occurrence of pregnancy.

Out-of-pocket maximum: The most that a covered person would pay during a coverage period (usually one year) for his or her share of the cost of covered services. Premiums, cost of medications the Prescription Benefit Plan does not cover, and copays or cost sharing are not included in calculating the out-of-pocket maximum.

Participating Employer: A municipality, political subdivision or board of education choosing to secure health benefit coverage under the Prescription Benefit Plan for its active and retired employees (if applicable) and their eligible dependents, and as may be supplemented by the Addendum.

Participating pharmacy: A pharmacy accepted as a participating pharmacy by CVS/Caremark to provide covered drugs to covered persons under the terms of this Prescription Benefit Plan.

Plan: Any of these which provides benefits or services for, or because of, medical or dental care or treatment.

- Group insurance or group-type coverage, whether insured or self-insured. This includes prepayment, HMO, group practice or individual practice coverage, as well as insurance coverage which is not available to the general public and can be obtained and maintained only because of coverage in or connection with a particular organization or group; it does not include student accident or student accident & health coverage for which the student or parent pays the entire premium.
- Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act as now constituted or later amended.
- Medical benefits coverage of group, group-type and individual no-fault and traditional automobile fault contracts.

Each contract or other arrangement for coverage under the first and second bullets is a separate plan.

Plan administrator functions: Administration functions performed by the Plan Sponsor on behalf of the Prescription Benefit Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor. In the normal course, such functions may include monitoring the compliance of Participating Employer's covered persons with the requirements of the Health Enhancement Program or assisting covered persons in resolving complaints regarding the handling or processing of claims or denial of coverage.

Plan Document: The term Plan Document means this document, (including any riders and amendments), which describes the rights, benefits, terms, conditions and limitations of the coverage available to covered members and eligible dependents.

Plan Sponsor: The term Plan Sponsor means the Office of the State Comptroller on behalf of the State of Connecticut.

Plan Year: The term Plan Year means the 12-month period beginning on January 1 and ending on December 31.

Pre-service claim review: Review of a claim for a medication 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 claim review includes a covered person's request for prior authorization.

Prescription Benefit Plan: The prescription drug component of the Partnership Plan as administered by CVS/Caremark.

Preventive medications: Certain over-the-counter medications, which if prescribed by a licensed provider for a covered person of the designated age/gender for the indicated circumstances or conditions, shall be a covered benefit under the Prescription Benefit Plan without copay.

Post-service claim review: Review of a claim for a medication or product that the Prescription Benefit Plan denied, reduced, or failed to provide or pay a benefit.

Primary plan: A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules or it has rules which differ from those stated in this Plan Document; or
- All plans which cover the person use the order of benefit determination rules as stated in this Plan Document, and under those rules the plan determines its benefits first. There may be more than one primary plan (for example, two plans which have no order of benefit determination rules).

When this Prescription Benefit Plan is the primary plan, covered services are provided or covered without considering the other plan's benefits.

Prior authorization: A prior approval that must be obtained from CVS/Caremark before a covered person is entitled to receive benefits for certain covered drugs.

Proof: Any information that may be required by CVS/Caremark or the Participating Employer in order to satisfactorily determine a covered person's eligibility or compliance with any provision of this Prescription Benefit Plan.

Protected Health Information (PHI): Individually identifiable health information that is:

- Received or created by a health care provider, carrier or health plan;
- Relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to the individual; and
- Identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

PHI excludes health information or medical information supplied to the Plan Sponsor in its role as an employer. For example, medical information submitted in support of an application for Family Medical Leave or Disability.

Secondary plan: A plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this Plan Document decide the order in which his/her benefits are determined in relation to each other. The benefits of the secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of this Plan Document, has its benefits determined before those of the secondary plan.

When this Prescription Benefit Plan is the secondary plan, benefits for covered services under the Prescription Benefit Plan may be reduced and the plan may recover from the primary plan, the provider of covered services, or the covered person, the reasonable cash value of the covered services provided by this Prescription Benefit Plan.

Specialty drug: An injectable or non-injectable biotech or biological drug prescribed by a physician having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring;
- Need for intensive patient training and compliance for effective treatment;
- Limited or exclusive product distribution.

Summary health information: Information that summarizes the claims history, claims expenses or types of claims experience by individuals for whom a Plan Sponsor provided health benefits under a health plan and from which the information described in 45 CFR §164.514(b)(2)(i) has been deleted (except for geographic information which only needs to be aggregated to the level of a five-digit zip code).

Totally disabled: Due to an injury or disease the covered member is unable to perform the duties of any occupation for which he/she is suited by reason of education, training or experience. A dependent shall be totally disabled if because of an injury or disease he/she is unable to engage in substantially all of the normal activities of persons of like age and sex in good health. CVS/Caremark will determine if a covered person is totally disabled and shall be entitled to request proof of continued disability at least annually.

Urgent care claim: A claim for a medication, or product where a delay in processing the claim:

- Could seriously jeopardize the life or health of the covered person, and/or could result in the covered person's failure to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's condition, would subject the covered person to severe pain that cannot be adequately managed without the requested medication or product.



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