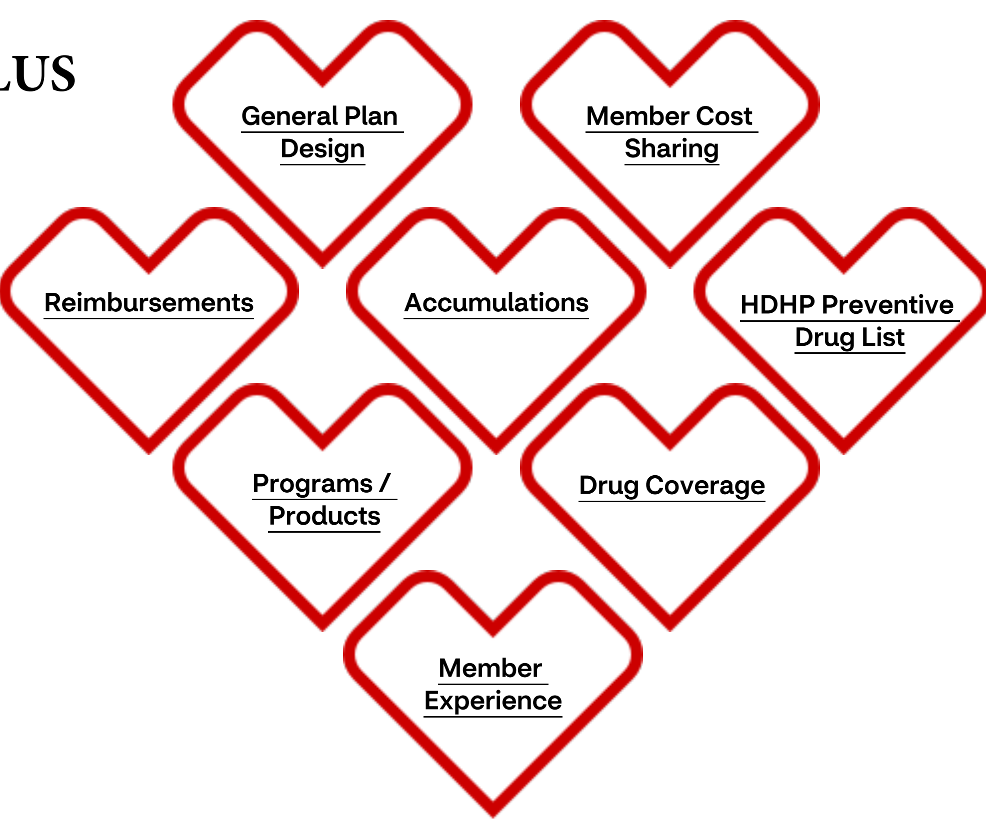
Synchrony RX

Benefit Plan Summary

2023-2024

MC $25

OAEC SAVINGS PLUS



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General Plan Design

Client Approval Sign-off

This benefit plan summary is part of the Plan Design Document referred to in Client's Prescription Benefit Services Agreement with [Caremark, L.L.C./Caremark PCS Health, L.L.C.] and accurately reflects the Client's plan design requirements for the prescription drug benefit program to be administered by CVS/Caremark TM under that Agreement.

I have reviewed the documentation and conclude all information to be correct. (All signatures below are required)

Authorized client e-Signature	Date

Client Information

SYNCHRONY RX - SYNCHRONY

Carrier ID	Plan design name	Plan ID	Effective date
0233	RANDOLPH TS 2 1550	RANDTS 2	07/01/2022

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❤ Member Cost Sharing

Max Day Supply

Mail	Paper	Retail	Different qty. limitation on maintenance meds at retail
90	34	34	No

Member Cost Share

Delivery system	Day Supply	Copay	Coinsurance	Copay minimum	Copay maximum	Copay calculation
GENERIC - TIER 1						
Mail	90	$10.00	N/A	N/A	N/A	
Retail/Paper-In	34	$10.00	N/A	N/A	N/A	
PREFERRED BRAND - TIER 2						
Mail	90	$20.00	N/A	N/A	N/A	
Retail/Paper-In	34	$20.00	N/A	N/A	N/A	
NON-PREFERRED BRAND - TIER 3						
Mail	90	$20.00	N/A	N/A	N/A	
Retail/Paper-In	34	$20.00	N/A	N/A	N/A	

Member pays lower amount if less than copay.

Retail includes paper in network, out of network, foreign and COB if covered and not otherwise listed.

Specific Pharmacy Network Member Cost Share

Used for client pharmacy networks or Retail 90

✓	Plan has specific pharmacy network member cost share

Pharmacy network	Day Supply	Copay	Coinsurance	Copay minimum	Copay maximum	Copay calculation
GENERIC - TIER 1						
1FORRX	34	$10.00	N/A	N/A	N/A	
1FORRX	60	$10.00	N/A	N/A	N/A	
1FORRX	90	$10.00	N/A	N/A	N/A	
PREFERRED BRAND - TIER 2						
1FORRX	34	$20.00	N/A	N/A	N/A	
1FORRX	60	$40.00	N/A	N/A	N/A	
1FORRX	90	$60.00	N/A	N/A	N/A	
NON-PREFERRED BRAND - TIER 3						
1FORRX	34	$20.00	N/A	N/A	N/A	

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Pharmacy network	Day Supply	Copay	Coinsurance	Copay minimum	Copay maximum	Copay calculation
1FORRX	60	$40.00	N/A	N/A	N/A	
1FORRX	90	$60.00	N/A	N/A	N/A	

Drug Specific Member Cost Share

⃠ Plan does NOT have drug specific member cost share

Specialty Member Cost Share

✓ Plan has specialty member cost share that will apply to Enhanced Exclusive Specialty*

Drug Tier	Day Supply	Copay	Coinsurance	Copay minimum	Copay maximum	Copay calculation
GENERIC - TIER 1	30	$10.00	N/A	N/A	N/A	
PREFERRED BRAND - TIER 2	30	$20.00	N/A	N/A	N/A	
NON-PREFERRED BRAND - TIER 3	30	$20.00	N/A	N/A	N/A	

**Copay applies to all drugs in specialty contract at all network pharmacies*

Dispense as Written (DAW)

DAW can be noted on any prescription and means the pharmacist cannot meet a substitution and must dispense the exact drug to the member.
This means that the less costly generic alternative, which maybe clinically viable option for the member, cannot be used. To positively influence both members and physicians to make cost-effective choices, DAW penalties apply a cost penalty to member when a multi-source brand (MSB) medication is dispensed by request over available generic equivalents and can increase generic utilization.

DAW rules apply to ALL drugs, including Specialty, unless otherwise specified.
DAW penalties will apply to ALL delivery channels except paper reimbursement claims due to pharmacy limitations.
For plans with Value Formulary: DAW penalties are not allowed on VF Standard Plans, however, they are permissible on VF Incentivized plans.
CVS utilizes a select list of brand drugs that process at a lower cost to reduce health care expenses. The DAW5-Substitution Allowed Brand Drug Dispensed as a Generic Drug is opt in strategy for mail and Maintenance Choice unless otherwise specified.
DAW Penalty will only apply when there is a MAC cost available

Physician DAW (DAW1)	Member DAW (DAW2)
No penalty to member. Client will pay the cost of the brand name drug. Plan member will pay the Brand cost share for the drug.	No penalty to member. Client will pay the cost of the brand name drug. Plan member will pay the Brand cost share for the drug.

Claim Maximum

✓ Electing a claim maximum

Day Supply	Claim max applies to	Claim max amount	Claim max rule limits	Reject message when claim max is reached
MAIL				
90	Specialty Drugs	$10,000.00	Client Exposure	
RETAIL				
34	Specialty Drugs	$10,000.00	Client Exposure	

When Exclusive specialty benefit is selected Claim Maximum is not applied to Specialty products.

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Refill Threshold

The percent of day supply that must be used before a system will allow a refill. CVS standard defaults are 75% for Retail/Mail. Approval is required to edit standard defaults.

Delivery System	Day Supply	% of Day Supply used
Retail	34	75%
Mail	90	75%

Controlled substances refill threshold is 80%

Point of Sale DUR

Electing Point of Sale DUR

CVS Proprietary Point of Sale DUR Edits

The edits listed below are automatically added for Employer clients unless opting out. Any deviation from the standard edits will require an opt-out and custom request.

A message will alert the pharmacist to the edit but will not cause the claim to reject.
A soft reject will cause the claim to reject, but the reject can be overridden by the dispensing pharmacist.
A hard reject will cause the claim to reject, with no option for override or prior authorization.

If POS HIV DUR program is found, then it will be removed as part of this request.

CVS Proprietary Point-of-Sale (POS) Edits	Reject Acronym	Reject/ Alert	Intervention Type POS DUR Activity Report	Description	Code
Drug-Diagnosis Caution	DIAGCAUT	Message	Drug - Disease Precaution Drug – Pregnancy Alert	This edit “messages” the pharmacist when contraindications based on diagnosis is identified. Identifies contraindications based on the member’s diagnosis. These contraindications are classified as either absolute, potential, or precautionary.	N/A
Cumulative Acetaminophen Edit	APAPCHEK	Soft Reject	Cumulative APAP Check	While the current Medispan maximum daily dose edit (dose check) and quantity limits imposed by the formulary captures members taking more than the maximum daily dose of acetaminophen within a single prescription, the cumulative acetaminophen (cAPAP) edit will identify members exceeding 4 grams (4,000 mg) of acetaminophen across different drugs by calculating the cumulative “acetaminophen ingredient” contribution across multiple active APAP-containing prescriptions (tablets and liquids). The historical look back period will ensure that the days’ supply will overlap with APAP-containing products presented at the point of sale. Soft Reject 88 – PPS CODE REQD: APAP EXCEEDS 4 GM/DAY.	Reason for Service Code: AT
Max Dose Edit Note: This is an enhanced version of dosing/duration edit.	DOSECHEK	Soft Reject	Dose Check Multiplier	The purpose of this edit is to identify doses of medications that greatly exceed the U.S. Food and Drug Administration (FDA) -approved maximum dose. While the base edit triggers at 1.25 times the maximum daily dose assigned by Medispan (which is not necessarily set at the FDA-labeled max dose) and returns a message response, this enhanced functionality adds a multiplier that is configurable to the Medispan maximum daily dose edit. The purpose of this multiplier is to identify egregiously high doses at the point of sale. The default value for the multiplier has been selected at “5” times the maximum daily dose for the claim presented at the point of sale. Applies to ALL drugs, not just controlled substances. Soft Reject 88 – PPS CODE REQD: MAX DOSE EXCEEDED – 5x max.	Reason for Service Code: HD
Multiple Pharmacies Edit	CHKPHARM	Soft Reject	Multiple Pharmacies	Identifies members filling multiple prescriptions within the same drug class (GPI 2) at four or more pharmacies. The goal of this edit is to support a consolidated approach to care by reducing therapeutic duplication, potential drug interactions, and pharmacy shopping. Applies to ALL drugs, not just controlled substances. Soft Reject 88 – PPS CODE REQD: >=4 PHARMACIES/SAME DRUG CLASS.	Reason for Service Code: DM

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CVS Proprietary Point-of-Sale (POS) Edits	Reject Acronym	Reject/ Alert	Intervention Type POS DUR Activity Report	Description	Code
Multiple Prescribers Edit	CHKPRESC	Soft Reject	Multiple Prescribers	Identifies members filling multiple prescriptions within the same drug class (GPI 2) by four or more prescribers within past 30 days. The goal of this edit is to support a consolidated approach to care by reducing therapeutic duplication, potential drug interactions, and doctor shopping. Applies to ALL drugs, not just controlled substances. Soft Reject 88 – PPS CODE REQD: >=4 PRESCRIBERS/SAME DRUG CLASS.	Reason for Service Code: DM
Excessive Controlled Substance Edit Note: This is an enhanced version of Excessive Controlled Substance Screening	EXCCLAIM	Soft Reject	• Excessive Controlled Substances – Multiple Drugs • Excessive Controlled Substances – Number of Therapies	CVS Caremark has had an Excessive Controlled Substances edit for many years. The "base" edit "messages" the pharmacist when four or more claims for the same controlled substance is prescribed within 90 days. The enhanced Excessive Controlled Substance edit targets more egregious potential controlled substance overutilization than the base edit. The enhanced edit will return a soft reject requiring the pharmacist to enter an override. There are two triggers for this edit: • Multiple drugs: This edit targets members taking five or more unique controlled substances within a class of drugs (same GPI 2) within the previous 30 days. This edit is not recommended for long-term care (LTC) plans. • Multiple claims: This edit targets members filling prescriptions for 8 or more claims for the same controlled substance (GPI 10) within the previous 30 days. This edit is not recommended for LTC plans. Soft Reject 88 – PPS CODE REQD: MULTI CII-V IN LAST 30 DAYS.	Reason for Service Code: DM
Cumulative Morphine Milligram Equivalent Edit	CMEDCHEK	Soft Reject	Cumulative Morphine Equivalent Dose	Checks for excessive opioid utilization (GPI-65) via cumulative morphine milligram equivalent (cMME) dose across multiple drugs and prescriptions. This edit will identify all active opioid prescriptions in a member's drug profile and convert the opioid dose to the equivalent dose of morphine. The cMME is calculated as follows: • MME per day is calculated for each opioid prescription. • The cumulative MME is calculated based on all opioid prescriptions in the last 90 days of the member's claim history that are still active on the day of the new opioid claim. • Members in hospice or with a claim for a cancer or sickle cell disease drug in the last 365 days are automatically excluded from this edit. Medicare Part D members in a Long-Term Care facility are also excluded from this edit. The goal of this edit is to identify potentially dangerous levels of opioid use, including potential misuse and prescriber shopping. The edit will return a soft reject if the cMME dose is greater than 90 mg AND the member has remaining supply of opioid prescriptions from three or more prescribers in the previous 90 days. Soft Reject 922/88 – PPS CODE REQD: EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD.	Reason for Service Code: HC
Buprenorphine /Opioid	EXCLTHER	Soft Reject	Buprenorphine with Opioid	Identifies opioid use after the patient has begun opioid use disorder treatment with a buprenorphine product. The patient should not receive any new opioid Rx after they start buprenorphine. After reviewing the patient's medication history, the pharmacist will have the option of: (1) filling the Rx as written based on his/her professional judgment or (2) contacting the prescriber to determine a further course of action. Soft Reject 88 – PPS CODE REQD: HX BUPRENORP, EXCL OPIOID	Reason for Service Code: DM
Multiple Long-Acting Opioids	DUPTHER	Soft Reject	Duplicate Long-Acting Opioids	This edit will be set up to soft reject when prescribed drugs have the same therapeutic effects as medication(s) the patient is currently taking. • Duplicate Therapy (DUPTHER): The Duplicate Therapy Edit checks for two or more medications from the same therapeutic category. If a previous prescription in the same class was dispensed within a given time period of the current prescription, then the alert would be transmitted to the dispensing pharmacy. Soft Reject 88 – PPS CODE REQD: 2 OR MORE LA OPIOIDS ***DO NOT MODIFY THE SOFT REJECT MESSAGE***	Reason for Service Code: TD

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CVS Proprietary Point-of-Sale (POS) Edits	Reject Acronym	Reject/ Alert	Intervention Type POS DUR Activity Report	Description	Code
Opioids and Benzodiazepines	DDI-DTMS	Soft Reject	Opioid /Benzodiazepine Drug-Drug Interaction	This edit will be set up to soft reject the pharmacist when interacting drug combinations are identified. • Checks the member's prescription history for interactions between two or more drugs. Soft Reject 88 – PPS CODE REQD: DRUG INT OPIOIDS AND BENZO ***DO NOT MODIFY THE SOFT REJECT MESSAGE***	Reason for Service Code: DD
Opioid Cough and Cold Products in Children	N/A	Hard Reject		To limit the use of opioid cough and cold medicines containing codeine in children < 12 years of age or hydrocodone in children < 6 years of age because the risk of these medicines outweighs their potential benefits. Hard Reject 60/76 – NO QTY ALLOWED FOR AGE. CONSIDER ALTERNATIVE.	N/A
Codeine and Tramadol Use for Pain in Children	N/A	Hard Reject		To limit the use of codeine or tramadol in children less than 12 years of age. The risk of these medicines outweighs their potential benefits. Hard Reject 60/76 – NO QTY ALLOWED FOR AGE. CONSIDER ALTERNATIVE.	N/A

Reimbursements

Go to member scenarios

Member Submitted Paper Claims

✓ Electing member submitted paper claims

Paper claims covered	Compound claims covered	In-network pharmacy claims are reimbursed based on	Out-of-network pharmacy claims are reimbursed based on	Timeframe to file a claim	Plan coordinates benefits	International claims reimbursed
Yes		Contracted Rate Less Copay	Contracted Rate Less Copay	365	No	No

Coordination of Benefits (COB)

⃠ NOT electing coordination of benefits

Government Agency Submitted Claims

✓ Electing government agency submitted claims

Authorize CVS Caremark to process government agency claims	Contact information of the Party responsible if not CVS Caremark	Permit up to a 90 day supply to pay at the submitted day supply amount for Veterans Affairs*
Yes	N/A	No

If yes, typically copays are stepped by day supply. Coinsurance is not stepped for a 90 day supply

Stepped Member Cost Share for Veterans Affairs (VA) Claims

⃠ Plan does NOT have stepped member cost share for Veterans Affairs (VA) claims

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Go to member scenarios

Accumulations

Medical Integrator Information

⃠	NOT electing a Medical Integrator

Remote Health Reimbursement Account (HRA)

⃠	NOT electing Remote Health Reimbursement Account (HRA)

**Only select medical integrators can support Remote HRA.*
If HRA is Remote(or otherwise known as "Real-Time"). CVSH will specify $1 limit for individual, 2 Party, and Family.
If HRA allows roll over, it will be handled by the HRA administrator (Medical Integrator).
If the claim that utilized Remote HRA is reprocessed, client need to coordinate any HRA differences directly with the HRA administrator (Medical Integrator).

Deductible

⃠	NOT electing a Deductible

Maximum Out of Pocket (MOOP)

✓	Electing a Maximum Out of Pocket

Effective Date	Disp. channel	MOOP applies to	Integrated MOOP	Accum. rule	Accum. type	Carryover Level	Out of pocket amounts		OOP renewal	DAW applies to MOOP	Member pays DAW after MOOP is met	DED applies toward OOP	Skip DED if member meets MOOP before DED is met
							Individual	Family					
01/01/2022	All	All Drugs	No	No cross accumulation	Embedded-Ind|Family	Carrier	$6,200.00	$12,400.00	Annual	No			

Maximum Allowable Benefit (MAB)

⃠	NOT electing a Maximum Allowable Benefit

Accumulation - Drug Specific

⃠	NOT electing an Accumulation Bypass Rule

High Deductible Health Plan (HDHP) Preventive Drug List

⃠	NOT electing HDHP Preventive Drug List

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Programs/Products

Specialty

Typically a high cost medication for treating complex, chronic conditions. Often times, these drugs may require special handling, including temperature control. Patients taking these medications may need ongoing clinical assessment to manage challenging side effects. CVS Health addresses today's evolving specialty landscape with a flexible toolkit of drug management strategies, including a range of specialty plan designs. These plan design options can be layered-on with other strategies to help manage specialty trend with more control.

Specialty Starter Fill Program

This program limits the quantity dispensed for targeted therapies to a 14 or 15 day supply based on product packaging. The program targets high cost therapies that demonstrate poor tolerability due to adverse effects.

NOT electing a Specialty Starter Fill Program

Cost-Effectiveness Plan Design Strategy

CVS Caremark can implement a plan design which excludes specific specialty drugs from coverage if the cost-effectiveness score is above the plan's established threshold.

NOT electing a cost-effectiveness plan design strategy

Specialty Copay Card Enrollment

Copay Optimization can help minimize the impact of specialty copay cards, ensure plan design integrity and reduce spend for payors when prescriptions are adjudicated through the CVS Specialty pharmacy (not recommended for HDHP/CDH or Retiree plans). Advanced Copay Optimization can advance savings by increasing the copay for certain specialty drugs up to the value of the manufacturer copay program.

COPAY OPTIMIZATION

Member cost share will process at the drug and/or therapy level of the non-financial needs based assistance included in the program.

Electing copay optimization with EES

PRUDENTRX

30% member cost share will apply to all specialty drugs dispensed by CVS Specialty for drugs on the PrudentRx drug list. Non-exclusive specialty medications will be processed at the applicable plan member cost share. PrudentRx will help the member enroll in non-needs based assistance cards (copay cards). Non-essential health benefit drugs will bypass and not contribute to the member’s out of pocket. Specialty grace fills will not apply. If Non-CVS Specialty Pharmacy is included, will require pharmacy inclusion into network for PRx COB Override Plan.

NOT electing PrudentRX

Refill Restrictions

NOT electing refill restrictions

ScriptSync

ScriptSync® is a pharmacy capability from CVS Health that aligns a member or caregiver ’ s maintenance medication fill schedules making it easier for them to stay on the therapies they need to effectively manage their conditions.

ScriptSync at retail will allow you to pro-rate copays for less than retail max day supplies

NOT electing ScriptSync

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RxSavingsPlus for Non-Covered Drugs

RxSavingsPlus for Non-covered Drugs allows plan members to purchase certain medications not covered under the prescription plan at the full discounted cost.

⃠	NOT Electing RxSavingsPlus for Non-Covered Drugs

ngTransform Diabetes Care Option: $0 Member Test Strip and Lancet Copay

⃠	Not Electing ngTransform Program

Drug Coverage

Drug Coverage Options

✓	Plan has drug coverage options

Core Compound Services	Coverage	Custom claim message
CVS Core Compound Service	Covered	N/A

If electing CVS Compound Core Service, then Non-Core Compound Services section does not apply

The Compound Core Service includes exclusion of costly bases, bulk compounding ingredients, compounding kits, hormone replacement bulk ingredients, OTC products within compound (if client covers OTC's), etc. and Prior Authorization (PA) for compounds exceeding a $300 threshold. Note: Certain, but not all IVs, Antibiotics and Anti- Infectives bulk ingredients are automatically covered. If client wishes to elect a different PA threshold with the Compound Core Service, refer to CPM form.

The Compound Service will be subject to CVS Caremark mandatory auto-update process.
- *This process allows the addition of new drugs and/or edits, changes to existing drugs and/or edits as well as removal of drugs and/or edits when deemed clinically appropriate.*
- *Auto-update is mandatory for any standard criteria selected by the client.*
- *Auto-update is not available for any custom edit or criteria requested by the client.*

Non Core Compound Services	Coverage	Custom claim message
Bulk Ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients), other ingredients (high cost bases, compound kits, etc)	N/A	N/A
Hormone Replacement Therapy bulk ingredients	N/A	N/A
Certain, but not all IVs Antibiotics and Anti-Infectives bulk ingredients	N/A	N/A
Cover OTC products within compound	N/A	N/A

Drug Categories- all dosage forms	Coverage	Delivery System	Pharmacy Network	Custom claim message
Acne Meds: Differin	Covered			
Acne Meds: Tazorac And Fabior	Covered			
Acne Meds: Tretinoins	Covered			
ADHD/Narcolepsy	Covered			
Anabolic Steroids	Not Covered			
Androgen Steroid	Covered			
Anorexiants	Not Covered			
Anti-Smoking - Rx Required	Not Covered			
Narcolepsy Only	Covered			

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Contraceptives	Coverage	Delivery System	Pharmacy Network	Custom claim message
Contraceptives: Devices (IUD, Diaphragm)	Covered			
Contraceptives: Emergency	Covered			
Contraceptives: Extended Cycle OC	Covered			
Contraceptives: Implants	Covered			
Contraceptives: Injectibles 90DS	Covered			
Contraceptives: Oral	Covered			
Contraceptives: Transdermal	Covered			
Contraceptives: Vaginal Ring	Covered			
Contraceptive Vaginal Contraceptives: pH Modulators	Covered			

Injectable Diabetic Medicines and Supplies	Coverage	Delivery System	Pharmacy Network	Custom claim message
Diabetic Meds & Supplies: Blood Glucose Monitor	Covered			
Diabetic Meds & Supplies: Acetone Test Strips	Covered			
Diabetic Meds & Supplies: Alcohol Swabs	Covered			
Diabetic Meds & Supplies: Amylin Analogs	Covered			
Diabetic Meds & Supplies: Bld Glucose Monitor Sup	Covered			
Diabetic Meds & Supplies: Blood Test Strips	Covered			
Diabetic Meds & Supplies: Cont Bld Glucose Mon/Rec	Covered			
Diabetic Meds & Supplies: Cont Glucose Sensors	Covered			
Diabetic Meds & Supplies: Cont Glucose Supplies	Covered			
Diabetic Meds & Supplies: Cont Glucose Transmitter	Covered			
Diabetic Meds & Supplies: Disp Insulin Pump Sup	Covered			
Diabetic Meds & Supplies: Disposable Insulin Pumps	Covered			
Diabetic Meds & Supplies: Glucagon Emerg Inj Kit	Covered			
Diabetic Meds & Supplies: Glucose (Oral)	Not Covered			
Diabetic Meds & Supplies: Incretin Mimetics	Covered			
Diabetic Meds & Supplies: Insulin	Covered			
Diabetic Meds & Supplies: Insulin Inj Devices	Covered			
Diabetic Meds & Supplies: Insulin Needles/Syringes	Covered			
Diabetic Meds & Supplies: Insulin Pump Supplies	Covered			
Diabetic Meds & Supplies: Insulin Pumps	Covered			
Diabetic Meds & Supplies: Insulin Pump Accessories	Covered			
Diabetic Meds & Supplies: Ketone Test Strips	Covered			
Diabetic Meds & Supplies: Lancet Devices	Covered			
Diabetic Meds & Supplies: Lancets	Covered			

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Injectable Diabetic Medicines and Supplies	Coverage	Delivery System	Pharmacy Network	Custom claim message
Diabetic Meds & Supplies: Urine Testing Strips	Covered			

General Categories	Coverage	Delivery System	Pharmacy Network	Custom claim message
Arestin (Periodontal)	Not Covered			
Cosmetic Drugs: Hair Loss, Anti-Wrinkle & Hair Removal Cream, Other Rx (Includes Botox Cosmetic & Dysport)	Not Covered			
Drug Exclusion Plan Design Strategy -An opt-in plan design strategy providing plan benefit exclusion for drugs with limited clinical value. To enroll, please select to cover this plan design strategy.	Not Covered			
Fluoride (Topical Fluoride Dental: Requires Rx)	Covered			
Hypoactive Sexual Desire Disorder Agents	Covered			
Impotency Drugs (Injectable, Oral, Supp, Kits)	Covered			
All Injectables	Covered			
IV Injectables	Covered			
Migraine Meds (Kit, Nasal Spray, Tabs, Inject)	Covered			
Respiratory Therap Supp: Nebulizers	Not Covered			
Respiratory Therap Supp: Peak Flow Meters	Not Covered			
Respiratory Therap Supp: Spacers	Covered			
Syringes Other Than Insulin	Covered			
Vaccines/Toxoids	Not Covered			
Vitamins: Multiple-Rx Required	Covered			
Vitamins: Pediatric-Rx Required	Covered			
Vitamins: Prenatal-Rx Required	Covered			

Allergy Serums	Coverage	Delivery System	Pharmacy Network	Custom claim message
Allergy Serums: Injectable	Covered			
Allergy Serums: Non-Injectable	Covered			
Emergency Allergy Reaction Kit	Covered			

Nutritional Supplements	Coverage	Delivery System	Pharmacy Network	Custom claim message
Nutritional Suplmt: Dietary Management Products	Not Covered			
Nutritional Suplmt: Inborn Errors of Metabolism	Not Covered			
Nutritional Suplmt: Infant Formulas	Not Covered			
Nutritional Suplmt: Malabsorption	Not Covered			
Nutritional Suplmt: Renal Dysfunction	Not Covered			
Nutritional Suplmt: Tube Feeding	Not Covered			

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Abortifacients	Coverage	Delivery System	Pharmacy Network	Custom claim message
Abortifacient	Not Covered			

Specialty Medications	Coverage	Delivery System	Pharmacy Network	Custom claim message
Fertility: Injectable	Covered			
Fertility: Oral	Covered			
Growth Hormone	Covered			
Specialty Medications HIV (if specialty medications are excluded)	Covered			
Specialty Medications Transplant (if specialty medications are excluded)	Covered			
Specialty Medications	Covered			

Other	Coverage	Delivery System	Pharmacy Network	Custom claim message
OTC Coverage Plan - NSA (non-sed antihistamine)	Not Covered			
OTC Coverage Plan - PPI (Proton Pump Inhibitor)	Not Covered			
Rare Genetic Adipose Tissue Disorder	Not Covered			

The following ARE COVERED, unless specified otherwise:

- All legend drugs are covered unless specified otherwise in this Drug Coverage Options section.
- DESI drugs - These drugs are determined by the FDA as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the drugs' uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today's market place.
- Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medicines as OTC. However, depending on certain state pharmacy laws, the medicines may be considered legend prescription medicines and are, therefore, all covered.
- Single entity vitamins - These vitamins have indications in addition to their use as nutritional supplements. For this reason, we recommend covering these medicines. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system, vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage, and folic acid for the treatment of megaloblastic and macrocytic anemias.

The following are NOT COVERED:

- Therapeutic devices or appliances, including hypodermic needles, support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use.
- Any over-the-counter medicine, unless specified otherwise.
- Any nutritional supplements, unless specified otherwise.
- Blood serum (i.e., albumin, plasma)
- Experimental medicines do not have NDC numbers and therefore, are not covered.
- Select Medical Devices and Artificial Saliva products as listed on the following list ID's: PGPMED01X and PGPMED02X
- Scar Products under the following GPIs
- GPI 4 9093********** *Scar Treatment Products**
- GPI-8 90970070****** *Silicone
- GPI-6 973070******** *Scar Treatments***
- GPI-10 9094990250**** *Silicone-Vitamin E
- Miscellaneous Formulations (part of Core Compound Strategy): Topical Analgesics*, Convenience Multi-product Kits**, Scar Products under the following GPIs, Otic Analgesics and Combinations etc *Topical Analgesics (may include but is not limited to: patches, lotions, creams, ointments, gels, sprays, solutions) containing ingredients (alone or in combination) in strengths typically used in OTC analgesics for temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. **Convenience kits containing 2 or more products to be used separately- may consist of an OTC (e.g., herbal/supplement/topical product).
- Unapproved Drug Management Strategy- Exclusion of all new to market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act. Coverage will remain for select unapproved products that are legally marketed or deemed clinically necessary (e.g., because no alternatives exist). Please note: products may be deemed legally marketed based on information reported by the manufacturer to the Centers for Medicare and Medicaid Services (CMS) and utilized by CMS in making a determination of coverage under the Medicaid program.
- Drugs covered under Medical Benefits (i.e. Spinraza, Brineura)
- Drugs generally not suitable for coverage under a pharmacy/outpatient prescription drug benefit, as determined by Caremark from time to time (e.g., Spinraza, Brineura, CAR-T therapy). A drug which must be infused into a space other than the blood will generally be excluded from the prescription drug benefit. Exceptions may be made for certain drugs, as otherwise noted in this document.

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- Prescription digital therapeutics, unless otherwise specified. Prescription digital therapeutics are software programs or applications intended to prevent, manage, or treat a medical disorder or disease. A prescription is required to access these tools. In the event that a PDT will be covered, Plan will receive advance notice and have the opportunity to opt out.

- **Notations:**
  CVS Caremark maintains a list of unbreakable packages and medications requiring extended day supply dosing. These medications will bypass a plan's standard day supply limitations as necessary to allow fills of these medications. Refills for these medications would still be subject to a plan's specified refill threshold percentage (I.E. a member must still use up 80% of their previous fill before a refill will be allowed, subject to the refill threshold percentage set by the plan).

Value Formulary

Value Formulary is a managed formulary approach that provides significant value for clients and members. VF is clinically comprehensive and covers all disease states and allows for simplified copay tier arrangements. This solution also features robust member outreach to help transition members to lower-cost therapies and supports Health Care Reform. VF is designed to be a two-tier benefit plan that includes all generics and the most clinically-effective brands as determined through robust clinical evidence.

Value Formulary is meant to be a full replacement program (it replaces all utilization management and plan attributes). If client wishes to retain or add any UM that is not in conflict with Value Formulary, these attributes must be identified or they will not be implemented.

NOT electing value formulary

Affordable Care Act (ACA) Coverage

Electing Affordable Care Act Coverage

STANDARD COVERAGE

Standard coverage includes an auto update process whereby new or changes to ACA lists are automatically applied to your benefits.

Drug class	Coverage	Rx /OTC	Brand/Generic	$0 copay	Clinical programs	Exclude ded.	Prior auth.	Age edits	Quantity Limit	Generic drug rule allowed	Gender edits
Aspirin (Cardiovascular Disease and Colorectal Cancer)	Covered	OTC	Generic Only	Y	N	Y	N	50-59	100 units per fill	N/A	N/A
Aspirin (Preeclampsia)	Covered	OTC	Generic Only	Y	N	Y	N	12-59	100 units per fill	N/A	Female Only
Bowel Prep Medication	Covered	Rx Only	Generic and Single Source Brands, Brands until Generics become available	Y	N	Y	N	45-75	N/A	N/A	N/A
Contraceptives: Emergency	Covered	Rx or OTC	Generic and Single Source Brands	Y	N	Y	N	N/A	N/A	Y	Female Only
Contraceptives: Implantable Devices & Vaginal Ring	Covered	Rx Only	Generic and Single Source Brands	Y	N	Y	N	N/A	1 IUD/ Device per 300 days; 13 rings per 300 days	Y	Female Only
Contraceptives: Injectables	Covered	Rx Only	Generic and Single Source Brands, Brands until Generics become available	Y	N	Y	N	N/A	1 inj. per 75 days OR 4 inj. per 300 days	Y	Female Only
Contraceptives: Oral & Extended Cycle	Covered	Rx Only	Generic and Single Source Brands, Brands until Generics become available	Y	N	Y	N	N/A	N/A	N/A	Female Only
Contraceptives: Barrier		Rx									Female

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Drug class	Coverage	Rx /OTC	Brand/Generic	$0 copay	Clinical programs	Exclude ded.	Prior auth.	Age edits	Quantity Limit	Generic drug rule allowed	Gender edits
Methods (diaphragms & cervical caps)	Covered	Only	Generic and Single Source Brands	Y	N	Y	N	N/A	1 per 300 days	Y	Only
Contraceptives: OTC (spermicides, female condoms)	Covered	OTC	Generic and Single Source Brands	Y	N	Y	N	N/A	N/A	N/A	Female Only
Contraceptives: Transdermal Patch	Covered	Rx Only	Generic and Single Source Brands	Y	N	Y	N	N/A	N/A	Y	Female Only
Fluoride Supplements	Covered	Rx Only	Brand & Generics	Y	N	Y	N	5 or under	N/A	N/A	N/A
Folic Acid	Covered	OTC	Generic Only	Y	N	Y	N	55 or under	100 units per fill	N/A	Female Only
Immunization Vaccines for Adults	Covered	Rx Only	N/A	Y	N	Y	N	19 and older	N/A	N/A	N/A
Immunization Vaccines for Children	Covered	Rx Only	N/A	Y	N	Y	N	18 or under	N/A	N/A	N/A
Primary Prevention of Breast Cancer	Covered	Rx Only	Generic Only	Y	N	Y	N	35 and older	N/A	N/A	Female Only
Statins (Cardiovascular Disease)	Covered	Rx Only	Generic Only	Y	N	Y	N	40-75	N/A	N/A	N/A
Tobacco Cessation	Covered	Rx or OTC	Generic Only (Exceptions: Branded Nicotrol NS Nasal Spray, Nicotrol Inhaler System, and Chantix are included)	Y	N	Y	N	N/A	168 DS per calendar year per product & Rx	N/A	N/A
PrEP (Pre-exposure Prophylaxis)	Covered	Rx Only	Brand Truvada until its generic TDF/emtricitabine becomes available	Y	N	Y	N	N/A	1 tab/day	N/A	N/A
Contraceptives - (Vaginal Contraceptives: pH Modulators)	Covered	Rx Only	Generic and Single Source Brands, Brands until Generics become available	Y	N	Y	N	N/A	N/A	N/A	Female Only

This document contains CVS Caremark recommendations to assist clients in making ACA-compliant preventive services coverage decisions as required under federal law. In addition to federal requirements, some clients may be subject to more stringent state requirements. Clients must evaluate applicable state requirements and notify CVS Caremark of any coverage modifications necessary to comply with such requirements.

Immunization Vaccines for Children and Adults (may be covered under medical): This election will add vaccine drug coverage only and does not cover administration of the vaccine. To add administration coverage, client must enroll in the Vaccination Services Program.

For Primary Prevention of Breast Cancer: Clients not enrolled in the ACA Preventive Services Auto Update process should complete this section if they have chosen to waive member cost share for all women ages 35 and older, regardless of diagnosis. There is an optional exceptions process that is available through prior authorization to support validation of diagnosis and is considered a standard implementation for this category. CPM form will be used to implement.

ACA covered OTC products require a prescription.

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Optional Preventative Drug Coverage

If electing CVS Caremark's recommendations for Medication Assisted Treatment (MAT) as a preventive service, the Client understands that this drug category is NOT required under the Affordable Care Act (as described in the Health Care Reform preventive service section) to be offered at $0 cost share. This is an optional plan design edit being recommended by CVS Caremark. Client acknowledges that CVS Caremark may elect to amend its list of MAT-related recommendations at any given time to conform with new guidance and/or recommendations. CVS Caremark will use commercially reasonable efforts to notify Client of any changes to its list of recommended MAT at least 30 days before the changes become effective. The current recommendation consists of the following generic medications:
Buprenorphine sublingual tab, 2 mg; 8 mg; Buprenorphine-naloxone sublingual tab 2 mg-0.5 mg; 8 mg-2 mg Naltrexone tablet 50mg

MEDICATION ASSISTED TREATMENT* (MAT) FOR SUBSTANCE ABUSE DISORDER

Add $0 cost share optional category to coverage with claims bypassing all accumulations.

NOT electing MAT for substance abuse disorder

**CVS Caremark standard: coverage of generics effective 1/1/2019.*
Opting into this strategy will not alter drug coverage edits currently in place. Please note that if there are any plan design changes in the MAT program within UM this will result in the need for updated signed documentation or Care Instructions.

Member Experience

Member Cost Sharing

Accumulations

INDIVIDUAL OR FAMILY COVERAGE WITH NO DEDUCTIBLE AND NON-INTEGRATED, EMBEDDED MAXIMUM OUT-OF-POCKET

Arturo is enrolled as an Individual Only in the plan.

Arturo will pay the member cost share for prescriptions until the $6200.00 Maximum Out-of-Pocket is met in prescription claims. Future prescription claims will cost $0 until the plan year restarts.

Chen is enrolled for Family coverage in the plan.

Chen and family will pay the member cost share for prescriptions until the $12400.00 Maximum Out-of-Pocket is met in prescription claims. Future prescription claims will cost $0 until the plan year restarts. If Chen's dependent Li meets the individual maximum out-of-pocket of $6200.00 in prescription claims before the family maximum out-of-pocket is met then Li will pay $0 for prescriptions until the plan year restarts.

Programs/Products

SPECIALTY COPAY CARD PROGRAM – COPAY OPTIMIZATION

Copay Optimization can help minimize the impact of specialty copay cards, ensure plan design integrity and reduce spend for clients when prescriptions are adjudicated through the CVS Specialty pharmacy. This plan design strategy optimizes program savings by increasing the copay up to the value of the manufacturer program for specific specialty drugs. The member will pay a different cost share outside of the plan's standard specialty member cost share.

Reimbursements

CLAIM PROCESSING REIMBURSEMENT - PAPER

If Cho forgot her insurance prescription card at a Retail pharmacy, she can file a paper claim to be reimbursed by providing a copy of the receipt. See Claim Processing Reimbursements section for more plan details.

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CLAIM PROCESSING REIMBURSEMENT - GOVERNMENT

For members who submit any type of government claims, the government agency submits these claims and CVS Caremark will process these claims the same matter as a member-submitted claim. CVS will handle these claims, unless otherwise specified and the government submitted claims will be handled directly by the client.

Notes applicable to all government claims

- Government agencies, such as State Medicaid agencies, the Veteran's Administration ("VA"), Department of Defense ("DOD") and Indian Health Services ("IHS") are entitled by law to seek reimbursement from healthcare plans for benefits provided to the Plan's members. The government agency submits these claims as an assignee of the plan member, and CVS Caremark generally processes these claims in the same manner as member-submitted claims. Note: there may be exceptions to this general rule for Medicaid Plans and Medicare D Plans.

- Clients may choose to have CVS Caremark process government-submitted claims on their behalf, in which case, they must authorize CVS Caremark to do so below and choose to cover member-submitted paper claims in the preceding section. If the client does not authorize CVS Caremark to process government- submitted claims on its behalf, the government agency may submit such claims directly to the client. Ordinarily, clients plan design edits are taken into account in the processing of government-submitted claims to determine the appropriate reimbursement, if any, to the government agency. Note: some plan design edits are not applicable to the processing of government-submitted claims.

- For quantities exceeding the allowed plan amount, the claim will be prorated or not prorated based on client parameters but must match proration rules for member submitted paper claims.

- All benefits are assumed to be assigned to the respective agency from the beneficiary, and the plan must accept the assignment of benefits to the government.

- Claims will be paid up to 3 years from the original date of fill or as otherwise required by law. Claims may not be denied on the bases of the format of the claim or failure to present proper documentation at the point-of-sale.

Parameters for claims received from the VA, DOD, IHS or State Pharmaceutical Assistance Program (SPAP)

- All VA, DOD, IHS & SPAP claims must be processed as in-network. Therefore, no out-of-network penalties may be applied.

Parameters for claims received from state Medicaid agencies

- Medicaid claim processing will pay the lesser of the amount the Medicaid agency paid for the prescription or the benefit amount allowed by the plan design.

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