Prescription Drug Benefit Plan

Plan Benefits under CVS Caremark

With CVS Caremark, you can purchase covered prescription drugs through a nationwide network of participating pharmacies and/or a Mail Service Program. The CVS Caremark retail network includes over 68,000 participating pharmacies nationwide, including more than 7,500 CVS/pharmacy stores. For a complete listing of CVS Caremark participating pharmacies, visit their website at www.caremark.com.

Out-of-Pocket Cost

Your prescription drug coverage will vary based on the medical plan that you choose. If you are enrolled in the Aetna HealthFund, you will pay a copay for generic drugs or coinsurance (a percentage of the cost of the medication) for brand name drugs. Under the High-Deductible Health Plan (HDHP), the cost will be based on whether a drug is considered to be supporting preventive care or not. Reference the HDHP Preventive Drug List section of this document for more information.

Aetna HealthFund	30-day supply (retail pharmacy)	90-day supply (Mail Service Program or CVS/pharmacy)
Annual deductible	$0	$0
Fully Covered Drug List	$0	$0
Generic	$10 copay	$25 copay
Preferred brand name	20% coinsurance (minimum $25, maximum $85)	20% coinsurance (minimum $62.50, maximum $212.50)
Nonpreferred brand name	30% coinsurance (minimum $40, maximum $160)	30% coinsurance (minimum $100, maximum $400)
Out-of-pocket Maximum	$2,500 for individual $5,000 for family*	

*An individual covered as part of a family plan will only be required to meet the individual out-of-pocket maximum of $2,500 (rather than the family out-of-pocket of $5,000) before receiving 100% coverage.

HDHP	30-day supply (retail pharmacy)	90-day supply (Mail Service Program or CVS/pharmacy)
Annual deductible*	$1,500 individual $3,000 family	
Fully Covered Drug List	$0	$0
Generic	**HDHP Preventive:** $10, no deductible **Nonpreventive:** 20% after deductible	**HDHP Preventive:** $25, no deductible **Nonpreventive:** 20% after deductible
Preferred brand name	**HDHP Preventive:** 20% coinsurance (minimum $25, maximum $85) **Nonpreventive:** 20% after deductible	**HDHP Preventive:** 20% coinsurance (minimum $62.50, maximum $212.50) **Nonpreventive:** 20% after deductible
Nonpreferred brand name	**HDHP Preventive:** 30% coinsurance (minimum $40, maximum $160) **Nonpreventive:** 20% after deductible	**HDHP Preventive:** 30% coinsurance (minimum $100, maximum $400) **Nonpreventive:** 20% after deductible
Out-of-pocket Maximum**	$3,500 for individual $7,000 for family	

*If you cover yourself and at least one dependent, you are subject to the family deductible. Nonpreventive medical and prescription expenses apply toward this deductible.

**If you cover yourself and at least one dependent, you are subject to the family out-of-pocket maximum. All medical and prescription out-of-pocket expenses apply to this maximum.

Out-of-pocket cost considerations:

- If the actual cost of a drug is less than the minimum, you will pay only the actual cost. If your prescription drug costs more than the minimum, you will pay the coinsurance amount. You will never pay more than the maximum coinsurance amount for a prescription.
- When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than a doctor indicating, "dispense as written" or equivalent instructions, you are required to pay the difference between the cost of the brand name drug and the generic drug in addition to the applicable nonprimary copay or coinsurance listed above.
- All brand name nonsedating antihistamines (NSA) and proton pump inhibitors (PPIs) will be considered nonprimary drugs. You will be charged the applicable nonprimary coinsurance or copay based on the prescription plan for which they are enrolled.

Fully Covered Drug List

Vanguard covers 100% of the cost of select generic preventive medications that help improve certain chronic conditions. These generic medications treat some of the health conditions that can be identified through our Health Smart Rewards wellness program, like high cholesterol, hypertension, and diabetes. The Fully Covered Drug List is available on CrewNet.

Affordable Care Act (ACA) Preventive Medications

Under the ACA, certain medications and prescription drugs that prevent illness and disease are covered at no-cost to you. The chart below lists the preventive medications that are covered at 100% under the prescription drug benefit plan, including any age and quantity limits. In order for these medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.

Medication		Eligibility	Quantity limit	Covered at 100%
Aspirin		• Adult men and women • Ages 50 to 59	Quantity limit of 100	Generic or OTC
Aspirin 81mg only		• Adult women • Ages 12 to 59	Quantity limit of 100	Generic or OTC
Oral Fluoride supplements		• Children • Age limit ≤ 5	No quantity limit	Brand or generic
Folic Acid supplements		• Adult women • Age limit ≤ 55	Quantity limit of 100	Generic or OTC
Tobacco Cessation		Adult men and women	Quantity limit of 168 days	• Generic or OTC only on nicotine replacement products • Generic or Single Source Brands**
Vitamin D		• Adult men and women • Age limit ≥ 65	No quantity limit	Brand or Generic or OTC
Bowel Preparation Medicine		Adults ages 50 to 75 years	No quantity limit	• Generics and Single Source Brands • Brand, until generic becomes available
Statins		Adults ages 40 to 75 years	No quantity limit	Generics low to moderate intensity
Women's Preventive Services	**Oral contraceptives**	Adult women	No quantity limit	Generic or single source brands**
	Emergency contraception		No quantity limit	Generic, OTC, or single source brands**
	Injectable contraceptives		Quantity limit of 4 injections per year	Generic or single source brands**
	Implantable/Intrauterine devices and vaginal rings		Quantity limit of 1 per year or 1 per month for 12 per year	Generic or single source brands**
	Transdermal patch		No quantity limit	Generic or single source brands**
	Diaphragm and cervical cap		Quantity limit of 1 per year	Generic or single source brands**
	Female condoms, vaginal sponges, and spermicides		No quantity limit	OTC
	Primary Prevention of Breast Cancer	• Adult women • Age limit ≥ 35	No quantity limit	Generic only

**Single source brands are those brand name drugs that do not have a generic alternative. No-cost coverage typically applies to generics. Single source brands can be utilized until generics become available. To confirm your medication is covered at 100%, sign in or register at www.caremark.com and use the Check Drug Coverage and Cost tool.

Brand Medications Requiring the Use of Generics First

You can save money by using safe, effective generic medications when possible. In some cases, the Plan may require you to try one or two generic medication(s) in a specific drug class prior to covering a brand-name medication in the same drug class. In certain instances, there may be a covered brand-name medication in the same drug class that does not require you to try a generic drug before using it. Please refer to the CVS Caremark's High-Performance Generic Step Therapy list on CrewNet for the most current information and a table showing a list of the drug classes and their corresponding generic and brand-name medications.

Drug Lists of Preferred Brand Name Drugs

The goal of the prescription plan is to provide the highest quality pharmaceutical care that is economical for Vanguard and for you. The following two drug lists, The Performance Drug List (non-specialty) and the Advanced Control Specialty Formulary List (specialty), help to control costs while maintaining quality care. These lists include preferred brand name drugs that are selected based on their ability to meet patient needs at a reasonable cost and also include generic drugs, which are recommended whenever possible.

Ask your doctor to consider prescribing a preferred brand name drug on either the Performance Drug List or Advanced Control Specialty Formulary List when there is no generic available or more than one brand name drug available. You may want to bring the lists with you when you or a family member visits a doctor.

The Performance Drug List (non-specialty) is available on CrewNet and the CVS Caremark website (www.caremark.com). The list is updated quarterly. Medications which are not on the Performance Drug List but do not have a generic or formulary alternative are available to members at the preferred brand name coinsurance.

The Advanced Control Specialty Formulary List (specialty) is available on CrewNet and the CVS Caremark website (www.caremark.com). The list is updated quarterly. Medications which are not on the Advanced Control Specialty Formulary List but do not have a generic or formulary alternative are available to members, but at the non-preferred brand name coinsurance.

Note: CVS Caremark may contact your doctor after receiving your prescription to request consideration of an alternative therapy, a preferred brand name drug on either the Performance Drug List or the Advanced Control Specialty Formulary List, or generic equivalent. This may result in your doctor prescribing a different therapy, brand name product, or generic in place of your original prescription.

HDHP Preventive Drug List

Those enrolled in the HDHP can benefit from lower out-of-pocket costs for preventive drugs that help specific chronic conditions. Preventive care drugs are defined by the IRS as drugs taken by a person who has developed risk factors for a disease that has not yet become a health issue, those taken to prevent the reoccurrence of a disease from which a person has recovered, and those used as part of preventive care procedures such as obesity and tobacco cessation. The complete preventive drug list can be found on CrewNet and the CVS Caremark website (www.caremark.com).

Getting Your Prescription Filled

Retail Network Pharmacy

When filling prescriptions for short-term medications, such as antibiotics, it is important that you use a CVS Caremark participating retail pharmacy. When you need a prescription filled immediately, present your ID card at a participating retail pharmacy. You will receive one ID card from Aetna with both your medical and prescription plan policy information. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender. Pay the applicable copay or coinsurance to receive up to a 30-day supply of medication.

If you are unable to get to a CVS/pharmacy, you can search for a participating retail pharmacy by logging onto www.caremark.com (you must be a registered user) and clicking Find a Pharmacy. You can also call the CVS Caremark Customer Care Center at 866-559-6903.

The prescription plan will allow three 30-day fills (the initial fill, plus two refills) of a long-term maintenance medication at a retail pharmacy. No plan coverage will be provided at participating retail pharmacies after the third fill of a long-term maintenance medication. After you have met the three fills, you are required to use either of the following options – both of which have the same copay:

- Use the Mail Service Program to have a 90-day supply of medication delivered to your home (please see below for details on how to fill your long-term maintenance medication using the Mail Service Program).
- Have the 90-day prescription filled at CVS/pharmacy through the Maintenance Choice program (please see below for details on how to fill your long-term maintenance medication at a CVS/pharmacy.

There is a one fill limit on extended cycle oral contraceptive medications at a participating retail pharmacy before you are required to use either the Mail Service Program or Maintenance Choice program. No plan coverage will be provided at participating retail pharmacies after the initial fill of an extended cycle oral contraceptive medication.

Mail Service Program

The CVS Caremark Mail Service Program can be used to obtain your long-term maintenance medications. You can receive up to a 90-day supply of maintenance medications for the applicable copay or coinsurance for direct delivery to your home.

For new maintenance medications, complete a Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the applicable copay for each prescription. Be sure to include your original prescription, not a photocopy. You can expect to receive your prescription approximately 14 calendar days after CVS Caremark receives your order. The CVS Caremark mail order forms can be found on CrewNet and the CVS Caremark website (www.caremark.com).

In addition, you can contact CVS Caremark FastStart at 800-875-0867 (for TDD assistance, please dial toll-free 800-231-4403) for assistance with transitioning your prescription to mail order. Hours of operation are Monday through Friday 7 a.m. to 7 p.m., Central time. Be prepared to provide your ID number, prescription name, doctor's name and phone number, mailing address, and payment information. The representative will contact your doctor and even fill out the order form for you.

Once you have processed a prescription through the CVS CaremarkMail Service Program, you can obtain refills using the website (www.caremark.com), phone (866-559-6903), or mail. Order your prescriptions three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from CVS Caremark. To make managing your mail service prescriptions even easier, enroll in CVS Caremark's automatic refill and renewal program. Once enrolled in this program, CVS Caremark will automatically mail your prescription to you when you are due for a refill and when your prescription is about to expire, they will reach out to your physician to request a new prescription. To learn more about the refill and renewal program, log onto www.caremark.com and click Refill a Prescription under the Order Prescriptions section of the site.

Note: By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day plan limit – "30 days plus two refills" does not equal one prescription written for "90 days".

CVS/pharmacy Maintenance Choice

As an alternative to the Mail Service Program, you may fill a 90-day supply of long-term maintenance medications at your local CVS/pharmacy. Just have your physician write a 90-day prescription (with refills, if applicable) and take it to your neighborhood CVS pharmacist. You will be charged the same copay or coinsurance as the Mail Service Program.

Non-Participating Retail Pharmacy

In most cases, you will not need to use a pharmacy outside the CVS Caremark network because there are over 68,000 participating pharmacies in the CVS Caremark Retail Network. However, if you choose to go to a non-participating pharmacy, you will pay 100% of the prescription price. Then you will need to submit a paper claim form along with the original prescription receipt(s) to CVS Caremark; the reimbursement will generally be at 50% of the cost of the drug. In most cases, this option will cost you more.

CVS Caremark Specialty Pharmacy

Certain chronic or genetic conditions require special pharmacy products, often in the form of injected or infused medicines. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provided these products directly to covered individuals, along with the supplies, equipment, and care coordination needed.

Common conditions managed by the CVS Caremark Specialty Pharmacy include:

- Acromegaly
- Alcohol/Opioid Dependency
- Allergen Immunotherapy
- Allergic Asthma
- Alpha-1 Antitrypsin Deficiency
- Anemia
- Atopic Dermatitis
- Botulinum Toxins
- Cardiac Disorders
- Coagulation Disorders
- Contraceptives
- Cryopyrin-Associated Periodic Syndromes
- Cystic Fibrosis
- Electrolyte Disorders
- Gastrointestinal Disorders-Other
- Gout
- Growth Hormone & Related Disorders
- Hematopoietics
- Hemophilia, von Willebrand Disease & Related Bleeding Disorders
- Hepatitis
- Hereditary Angioedema
- HIV Medications
- Hormonal Therapies
- Immune (Idiopathic) Thrombocytopenic Purpura
- Immune Deficiencies & Related Disorders
- Infectious Disease
- Infertility
- Inflammatory Bowel Disease
- Iron Overload
- Lipid Disorders - PCSK9 Inhibitors
- Lysosomal Storage Disorders
- Movement Disorders
- Multiple Sclerosis
- Neutropenia
- Oncology-Injectable
- Oncology–Oral/Topical
- Osteoarthritis
- Osteoporosis
- Paroxysmal Nocturnal Hemoglobinuria
- Phenylketonuria
- Pre-Term Birth
- Psoriasis
- Pulmonary Arterial Hypertension
- Pulmonary Disorders–Other
- Rare Disorders - Other
- Renal Disease
- Respiratory Syncytial Virus
- Retinal Disorders
- Rheumatoid Arthritis
- Seizure Disorders
- Systemic Lupus Erythematosus
- Transplant
- Urea Cycle Disorders

Select specialty medications require an additional level of approval through the CVS Caremark Specialty guideline management program. CVS Caremark may request information from your physician to determine if clinical use and safety guidelines are met prior to dispensing the specialty medication. For more information on CVS Caremark Specialty Pharmacy, please call CaremarkConnect toll-free at 800-237-2767 or access the CVS Caremark Specialty Pharmacy site at www.cvscaremarkspecialtyrx.com.

You can help keep your prescription costs down by using lower-cost drugs. CVS Caremark will work with your doctor to identify whether a lower-cost preferred drug may be right for you. If so, your doctor will provide CVS Caremark with a new prescription and CVS Caremark will contact you to help you get started on the new medication.

ExtraCare Health Care Card

Vanguard has partnered with CVS Caremark to provide medical plan enrollees with a discount option on certain health care expenses through the CVS ExtraCare Health card. The ExtraCare Health Care Card provides a 20% discount on thousands of over-the-counter, CVS/pharmacy brand health-related items. You may use the card online or at any local CVS/pharmacy. Please note that sale items do not qualify for the discount. To order a new or replacement card, call 888-543-5938.

Covered Drugs

The following drugs are covered under the prescription drug benefit plan:

- Federal-legend prescription drugs
- Drugs requiring a prescription under the applicable state law
- Contraceptives
- Injectables
- Vitamins requiring a prescription
- Syringes other than insulin
- Smoking cessation drugs
- Emergency Allergy Kits (one copay per kit)
- Diabetic supplies including insulin, insulin syringes, needles, test strips and lancets
- One-Touch Glucose Meter (1 meter per lifetime at no cost to you). Crew member may obtain a blood glucose meter and diabetes test strips and lancets by calling CVS Caremark Diabetic Blood Glucose Monitor Customer Care team at 800-588-4456. Representatives can request and process prescriptions from their physician for these items. The number is for ordering blood glucose meters, test strips and lancets only; crew members must order other diabetic testing supplies by calling their usual Customer Care number (866-559-6903).
- Insulin lancet device (1 device per year)
- Fertility drugs per individual are covered at the Food and Drug Administration (FDA) approved standard doses for up to 4 cycles (60 days) of gonadotropins and 4 cycles (8 days) of human chorionic gonadotropin (also known as HCG) therapy. Once these limits are reached, the member is responsible for 100% of the fertility drug costs.
- Oral Erectile Dysfunction Drugs – 6 pill limit per 30-day supply; 18 pills per 90-day supply (excluding Cialis 2.5 mg, which is not subject to a monthly limit)
- Injectable Erectile Dysfunction Drugs – 6 injection limit per 30-day supply; 18 injections per 90-day supply
- Growth hormones, for medically appropriate diagnoses only
- Anorexiants, for medically appropriate diagnoses only
- Acne Medications

Covered Drugs with Prior Authorization

Prescribed medications may be reviewed by CVS Caremark pharmacists and discussed with the prescriber to ensure proper use based on FDA approved indications and dosing recommendations. Prior authorization ensures proper selection, dosage, drug administration and duration of selected drugs. Certain drugs in the following categories are covered under the prescription drug benefit plan, with prior authorization:

- Compounds (over $300 that are not excluded)
- Diet Medications
- Erectile Dysfunction Medications
- High-Cost Generics (e.g., some forms of metformin ER)
- Nutritional supplements
- Oral Acne Medications
- Topical Acne Medications (if age over 35 years)
- Topical Analgesics, Antifungals, and Immunomodulators
- Transmucosal Immediate-Release Fentanyl Medications (e.g., Subsys, Lazanda)
- Opioid Medications >90 morphine milligram equivalents (MME) per day (based on a 30-day supply)
- First fill of Immediate-Release Opioid Medications >7-day supply for new opioid medication utilizers

Excluded Drugs

The following drugs are not covered under the prescription drug plan:

- Allergy serums and allergy vaccines/toxoids
- Arestin
- Medical Benefit Only Drugs (e.g., Spinraza, Brinurea, Kymriah, Yescarta, Luxturna, Lutathera)
- Certain bulk powders, bases, kits, and patches as part of a compound prescription
- Non-legend drugs other than insulin and certain diabetic supplies
- Therapeutic devices or appliances, support garments, and other non-medical substances
- Respiratory therapy supplies (e.g. spacers)
- Experimental or Investigative drugs
- Prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state, or federal program
- Cosmetic drugs, not including acne medications

The following select drugs are excluded from CVS Caremark's Performance Drug List:

Abilify	Euflexxa	Olux-E
Actemra	Evzio	Olysio
Actos	Exforge	Omnaris
Adderall XR	Exforge HCT	Omnitrope
Adrenaclick	Extavia	Onglyza
Aerospan	Fanapt	Orthovisc
Alcortin A	Fioricet	Oseni
Alevicyn Gel	Fluorouracil 0.5% cream	Oxytrol
Alevicyn Kit	Follistim AQ	Pennsaid
Alevicyn SG	Fortamet	Plavix
Alevicyn solution	Fortesta	Pradaxa
Aloquin	Fosrenol	Pred Forte
Altoprev	Genotropin	Prevacid
Alvesco	Gleevec	Primlev
Amrix	Glumetza	Protonix
Androgel 1%	Helixate FS	Proventil HFA
Apexicon E	Horizant	Qnasl
Apidra	Humalog	Qsymia
Arthrotec	Humalog Mix 50/50	Rayos
Asacol HD	Humalog Mix 75/25	Relistor
Atacand	Humulin 70/30	Rhinocort Aqua
Atacand HCT	Humulin N	Rimso-50
Beconase AQ	Humulin R	Riomet
Benicar	Hyalgan	Rozerem
Benicar HCT	Indocin	Saizen
Bensal HP	Insulin Needles (Non-BD Ultrafine Brands)	Seroquel XR
Betapace	Insulin Syringes (Non-BD Ultrafine Brands)	Sprix
Betapace AF	Intermezzo	Stendra
Blood Glucose Test Strips (Non-One Touch Brands)	Intuniv	Sumavel Dosepro

Butalbital/APAP/Caffeine	Jalyn	Synerderm
Bydureon	Jardiance	Synjardy
Byetta	Kazano	Synjardy XR
Cafergot	Kineret	Synvisc
Carac	Klor-Con/25	Synvisc-One
Cardizem	Kombiglyze XR	Tanzeum
Cardizem CD	Lanoxin tablet (125mcg & 250mcg only)	Tasigna
Cardizem LA	Lantus	Technivie
Carnitor	Lescol XL	Testim
Carnitor SF	Lipitor	Testosterone Gel 1% (Testim and Vogelxo authorized generic)
Clobetasol Spray	Livalo	Tobi
Clobex Spray	Lunesta	Tobi Podhaler
Colazal	Macrodantin	Toujeo
Crestor	Matzim LA	Tricor
Cymbalta	Mavyert	Tudorza
Daklinza	Miacalcin Injection	Uroxatral
Delzicol	Miacalcin Nasal Spray	Valcyte
Detrol LA	Millipred	Valtrex
Dexpak	Millipred DP	Vanoxide-HC
Diovan	Minocin	Venlafaxine HCL ER tablets (except 225mg)
Diovan HCT	Monodox	Ventolin HFA
Doryx	Monovisc	Veramyst
Doryx MPC	Naprelan	Viagra
Dulera	Natesto	Viekira Pak
Dutoprol	Nesina	Vogelxo
Dyrenium	Neupogen	Xeljanz
E.E.S. Granules	Nexium	Xeljanz XR
Edarbi	Nilandron	Xenazine
Edarbyclor	Noritate	Xopenex HFA
Effexor XR	Norvasc	Zegerid
Elelyso	Novacort	Zepatier
Enablex	Nutropin AQ	Zetia
Entyvio	Nuvigil	Zetonna
Eryped	Oleptro	Zonegran

Note: coverage for new drugs will be determined by the Plan Administrator based on FDA guidance and information.

Payment of Claims

If prescriptions are purchased at a participating retail network pharmacy or CVS Caremark Mail Service Pharmacy, you pay the out-of-pocket cost based on the type of drug and health plan you elected. If prescriptions are purchased at non- participating pharmacies, you must pay the full cost of the drug at the pharmacy and submit a reimbursement form to CVS Caremark. Reimbursement will generally be at 50% of the cost of the drug.

Claims Review and Appeals Procedures

You are entitled to a full and fair review of any claims made under the plan. The claims and appeals procedures stated in this appendix are intended to comply with applicable regulations by providing reasonable procedures that govern the filing of claims, notification of benefit decisions, appeals of adverse benefit determinations, and external review of claims involving medical judgment.

Your claim will be processed according to the applicable plan provisions and guidelines. CVS Caremark is the claims and appeals fiduciary and has sole and complete discretionary authority to determine claims and appeals according to the terms of the Plan.

Definitions

The following terms are used throughout this plan booklet and, where capitalized, have the specific meanings given below to describe the claims and appeals review services provided by CVS Caremark:

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

Appeal – A written request to CVS Caremark to reconsider an Adverse Benefit Determination.

Claim – Any request for a plan benefit made in accordance with these claims procedures.

Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the "deemed exhaustion" rules of the ACA.

Pre-Service Claim – A Claim for a medication, service, or product requires approval before the medical care or treatment is received.

Post-Service Claim – Any Claim that is not considered a Pre-Service Claim.

Urgent Care Claim – Any Claim for a medication, service, or product, in which a delay in processing the claim: (i) could jeopardize your life and/or could result in failure for you to regain maximum function, or (ii) in the opinion of your physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without the requested medication, service or product.

Filing a Claim

To make a Claim for benefits under the plan, you or your provider will need to give your new or current prescription to a pharmacist at either a CVS/pharmacy, other participating retail network pharmacy, or by using the Mail Service Program and mailing your prescription to CVS Caremark. For more information on how to get your prescription filled, please refer to the "Getting Your Prescription Filled" section earlier in this Appendix. The types of Claims for benefits are below:

Claim Determinations

Urgent Care Claims

CVS Caremark will notify you of the decision of your Urgent Care Claim, whether it is approved or denied (adverse benefit determination), as soon as possible but no later than 72 hours after the Claim is received.

Pre-Service Claims

There two types of Pre-Service Claim:

- For Pre-Service Claims that require pre-authorization, CVS Caremark will compare your prescription to pre-defined medical criteria specifically related to the medicine requested. CVS Caremark will notify you of the decision of your pre-authorization claim, whether it is approved or denied, as soon as possible but no later than 15 days after receipt of the Claim. If information is needed from your physician for pre-authorization of your prescription, your Claim for benefits will not be considered complete. Your physician will be notified and will be given the opportunity to provide more information to CVS Caremark in order to make your Claim complete.

  If this type of Claim is denied, it is considered an Adverse Benefit Determination (please refer to "What To Do If Your Claim Is Denied" below on how to proceed.

- For administrative Pre-Service Claims, CVS Caremark will compare your prescription to the preferred drug lists or formularies for the plan before your prescription will be filled. CVS Caremark will notify you of the decision of your administrative Pre-Service Claims, whether it is approved or denied, as soon as possible but no later than 15 days after receipt of the Claim.

  If this type of Claim is denied, it is considered an Adverse Benefit Determination (please refer to "What To Do If Your Claim Is Denied" below on how to proceed.

Post-Service Claim

For post-service claims you will be notified of the decision not later than 30 days after receipt of the Claim. If this type of Claim is denied, it is considered an Adverse Benefit Determination (please refer to "What To Do If Your Claim Is Denied" below on how to proceed.

If Your Claim Is Denied

If your Claim is denied in whole or in part, you will receive a written notice of the denial from CVS Caremark. The notice will explain the appeal procedures available to you under the plan as well as detailed information on why your Claim was denied.

What To Do If Your Claim Is Denied

You have the right to file an Appeal if:

- An Adverse Benefit Determination (also referred to as a denial) has been rendered on a Claim, or
- You believe that the benefits to which you are entitled to have not been provided under the plan.

You have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. You may submit written comments, documents, records and other information with respect to your Claim, regardless of whether or not such information was considered during the initial or a prior level of review.

Pre-Service and Post-Service Claim Appeals
Your request to Appeal a pre-service or Post-Service Claim must be made in writing and submitted to CVS Caremark's Appeals Department within 180 days after you receive notification of the adverse benefit determination. The different types of claims appeals, and their corresponding review period, are outlined below:

- For Appeals of Pre-Service Claims that required pre-authorization, CVS Caremark will provide the first-level review of your Appeal. CVS Caremark will notify you of the decision of your Appeal, whether it is approved or denied, as soon as possible but no later than 15 days after receipt of the Appeal. If it is approved, your Claim will be processed as soon as possible. If this Appeal is denied, you may appeal CVS Caremark's decision and request a second-level external review (also referred to as a medical necessity review). This review will be conducted by an Independent Review Organization (IRO).

- For administrative Pre-Service Claims, CVS Caremark provides a single level of appeal. CVS Caremark will notify you of the decision of your Appeal for an administrative Pre-Service Claim whether it is approved or denied, as soon as possible but no later than 15 days after receipt of the Appeal. If it is approved, your Claim will be processed as soon as possible. If this Appeal is denied, you will be issued a Final Internal Adverse Benefit Determination and you will have exhausted your Appeal rights for this type of Claim.

- For administrative Post-Service Claims, CVS Caremark provides a single level of Appeal. CVS Caremark will notify you of the decision of your Appeal for an administrative Pre-Service Claim, whether it is approved or denied, as soon as possible but no later than 60 days after receipt of the Appeal. If it is approved, your Claim will be processed as soon as possible. If this Appeal is denied, you will have exhausted your Appeal rights with this type of Claim.

Your Appeal should include the following:

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

Your written Appeal and supporting documentation may be mailed or faxed to CVS Caremark:

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

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

CVS Caremark's Review

CVS Caremark will review your Appeal and provide you with its decision (in the case of an Urgent Care Claim, CVS Caremark will call your attending physician to notify them of the decision) within the following time periods: (i) 72 hours after receiving such request in the case of an Urgent Care Claim, (ii) 15 days after receiving such request in the case of a Pre-Service Claim, and (iii) 30 days after receiving such request in the case of a post-service claim.

Scope of Review

During its review of an Appeal of an Adverse Benefit Determination on a Claim, CVS Caremark shall:

- Take into account all comments, documents, records and other information you submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable plan documents;
- Follow reasonable procedures to ensure that the applicable plan provisions are applied to you in a manner consistent with how such provisions have been applied to other similarly-situated participants; 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 after review of your Appeal, CVS Caremark upholds the adverse benefit determination, you will receive a final internal Adverse Benefit Determination. Only Urgent Care Claims and Pre-Service Claims that required pre-authorization (Claims that involve medical judgment) that receive a Final Internal Adverse Benefit Determination may be permitted to receive an external review.

For administrative Pre and Post-Service Claims, CVS Caremark shall serve as the final review under the plan and shall have sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the documents or instruments governing the plan, any and all questions arising from:

- Administration of the plan and interpretation of all plan provisions;
- Determination of all questions relating to participant or eligible individuals and eligibility for benefits;
- Determination of all relevant facts;
- Determination of the amount and type of medical benefits to be provided to any eligible individual or covered eligible dependent; and
- Construction of all terms of the plan.

Requesting External Review

If your Claim involving medical judgment is denied you may request, in writing, an external review of such Claim within four months after receiving notice of the final adverse benefit determination.

Your request for external review should include the following:

- Name of the person the external review is filed for;
- Mailing address and daytime phone number of the person the external review is filed for;
- CVS Caremark Identification Number; and
- Copy of the coverage denial

Your request and supporting documentation may be mailed or faxed to CVS Caremark:

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

Timeline for External Review

Preliminary Review

Within five business days of receiving your request for an external review, CVS Caremark will conduct a preliminary review of your request to ensure that it meets the requirements for external review.

In this preliminary review, CVS Caremark will determine whether:

- You are/were covered under the plan at the relevant time;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to your failure to meet the plan requirements for eligibility, as such determinations are not eligible for federal external review;
- You have exhausted the plan's internal appeals process as described in this "Claims Review and Appeals Procedures" section (or you have been deemed to complete the required steps of the internal review process because of CVS Pharmacy's failure to meet the requirements set forth above - with the exception of minor errors attributable to good cause or matters beyond CVS Pharmacy's control); and
- You have provided all paperwork necessary to process the external review.

In addition, CVS Caremark will review your request for external review to determine whether it involves a Claim involving medical judgment. If CVS Caremark determines that the request does not involve a Claim involving medical judgment, it will forward the member's request for external review to an IRO for further review. The IRO will determine whether the member's request for external review involves a Claim that involved medical judgment as soon as possible.

Within one business day after completing its preliminary review, CVS Caremark will notify you, in writing, that: (i) your request for external review is complete and qualifies for external review; (ii) your request is not complete, and additional information is needed (please see next paragraph for more information on what to do if your request for external review is incomplete); or (iii) your request for external review does not meet the requirements for an external review.

If CVS Caremark determines that your request for external review is incomplete, the notification you receive will describe the information or materials needed to make the request complete. CVS Caremark will allow you

to complete your request during the remainder of the four month filing period (the original filing period in which to request external review) or, if later, 48 hours following receipt of notice.

Referral to IRO
If your request qualifies for external review, it will be assigned to one of the qualified IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. You will then have 10 business days to provide the IRO with any additional information the member wants the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made by CVS Caremark. The IRO may consider information beyond the records for your denied Claim, such as:

- Your medical records;
- Your attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating physician;
- The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medicine societies, boards, and associations;
- Any applicable clinical review criteria developed and used by CVS Caremark (unless the criteria are inconsistent with the terms of the plan or applicable law); and
- The opinion of the IRO's clinical reviewer(s) after considering the information described in this notice to the extent the information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of IRO's Determination
The IRO must provide you and CVS Caremark (on behalf of the Plan) with written notice of its final external review decision within 45 days after the IRO receives the request for external review.

After a final external review decision, the IRO must maintain records of all Claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, CVS Caremark, or state and federal oversight agency on request (unless disclosure would violate state or federal privacy laws).

Reversal of the Plan's Prior Decision
If CVS Caremark receives notice from the IRO that it has reversed the prior adverse determination of your Claim, CVS Caremark will immediately provide coverage or payment for your Claim.

Expedited External Review
You may request an expedited external review at the time you receive:

- An Adverse Benefit Determination related to a Claim involving medical judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, and the member has filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination related to a Claim involving medical judgment that involves: (i) a medical condition for which the for completion of a standard External Review would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Immediately upon receiving the request for expedited external review, CVS Caremark will immediately notify you, in writing, that: (i) your request for external review is complete and qualifies for external review; (ii) your request is not complete, and additional information is needed (please see next paragraph for more information on what to do if your request for external review is incomplete); or (iii) your request for external review does not meet the requirements for an external review.

Request for Review
If your request meets the eligibility determination for external review and your situation meets one of the two requirements above that permits an expedited external review, you or your physician may request an expedited external review by calling the Customer Care toll-free at the number on the member's benefit ID card.

Alternatively, a request for expedited external review may be faxed to the attention of the CVS Caremark External Review Appeals Department at: 1-866-443-1172.

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

Referral of Expedited External Review to IRO
If your request qualifies for external review, it will be assigned to one of the qualified IROs with which CVS Caremark has contracted. The IRO must provide you and CVS Caremark (on behalf of the plan) with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and CVS Caremark (on behalf of the Plan) with written confirmation of its decision.

The IRO will conduct its external review without giving any consideration to any earlier determinations made by CVS Caremark.

Coordination of Benefits
CVS Caremark prescription plan does not coordinate benefits with other plans.

Termination of Coverage
Termination of your coverage (and that of a spouse, domestic partner or dependent) terminates under this plan at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The plan or the offered benefits terminates;
- The date the crew member is no longer eligible for the benefit; or
- The date the crew member fails to provide any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Summary Plan Description in Section II.B.7.

For More Information
You may call CVS Caremark Customer Care at 866-559-6903 24 hours a day, 7 days a week or e-mail them at customerservice@caremark.com. You may also call Crew Central at 844-VG1-CREW (844-841-2739) or 1CREW, if you have any questions about your prescription drug benefits, or to get a complete list of what is covered and what is not covered under the program.