Prescription Benefit Plan Summary

Plan Benefits under CVS Caremark

With CVS/Caremark, you can purchase covered prescription drugs through a nationwide network of participating pharmacies or through their 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, we encourage you to visit their website at www.caremark.com.

Where to fill your prescription

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/Caremark retail network.

- Choose from more than 68,000 network pharmacies nationwide, including independent pharmacies, chain pharmacies and 7,700 CVS/pharmacy locations.
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription, and use a pharmacy in the CVS/Caremark retail network.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions or members also have the option of filling their maintenance prescriptions in 90-day supply at a local CVS pharmacy.

	RETAIL 30-Day Supply	**MAIL ORDER** 90-Day Supply
GENERIC MEDICATIONS Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	$15	$30
PREFERRED BRAND-NAME MEDICATIONS If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	35% Coinsurance $50 Minimum $100 Maximum	$100
NON-PREFERRED BRAND-NAME AND SPECIALTY MEDICATIONS You will pay the most for medications not on your plan's preferred drug list.	50% Coinsurance $100 Minimum $200 Maximum	$200
VALUE-BASED MEDICATIONS For maintenance medications for the treatment of Asthma, Diabetes, Hypertension and Hyperlipidemia.		
GENERIC	$0	$0
PREFERRED BRAND-NAME	12.5% Coinsurance (Min. $0 / Max. $50)	$25
NON-PREFERRED BRAND NAME	50% Coinsurance (Min. $40 / Max. $80)	$80

*CVS/Caremark Specialty medications (medications for conditions such as Hepatitis B & C, RSV, Hemophilia, Immune Deficiency, Osteo & Rheumatoid Arthritis) are only covered through CVS/Caremark Specialty Pharmacy. These are limited to a 30-day supply and may require prior authorization or step therapy. Please call **1-800-237-2767** to access this benefit, M-F 7:30am - 9pm EST. For calls after hours, please call the customer care phone number indicated below. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied by a manufacturer coupon or rebate.

Generic Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.

Out-of-Pocket Costs

Your prescription drug coverage will vary based on the medical plan, as follows:

POS Choice Plan:
The Calendar year Maximum Out-Of-Pocket (OOP) applies to both medical and pharmacy expenses. Each individual family member must meet the individual OOP ($3,500) unless the family OOP ($7,000) has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. Note: Generic dispense as written penalties will not apply to the OOP.

HSA Advantage Plan:
The Calendar year deductible ($1,750 / $3,500) applies to both medical and pharmacy expenses. One member or any combination of family members can meet the family Deductible. Once met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Care and Value-Based Medications bypass the deductible requirement. All prescription expenses (with the exception of Generic Dispense as Written Penalties) accumulate to the plans Out-of-Pocket Maximum ($3,500/$7,000).

HSA Value Plan:
The Calendar year deductible ($2,750 / $5,500) applies to both medical and pharmacy expenses. One member or any combination of family members can meet the family Deductible. Once met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Care and Value-Based Medications bypass the deductible requirement. All prescription expenses (with the exception of Generic Dispense as Written Penalties) accumulate to the plans Out-of-Pocket Maximum ($4,500/$9,000) No one individual within a family will be required to meet more than $7,900 in the family MOOP.

HSA Saver Plan:
The Calendar year deductible ($5,000 / $10,000) applies to both medical and pharmacy expenses. One member or any combination of family members can meet the family Deductible. Once met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Care and Value-Based Medications bypass the deductible requirement. All prescription expenses (with the exception of Generic Dispense as Written Penalties) accumulate to the plans Out-of-Pocket Maximum ($6,750/$13,500) No one individual within a family will be required to meet more than $7,900 in the family MOOP

Customer Care

Diabetes Management Program For members diagnosed with diabetes or pre-diabetes, we offer a voluntary Diabetes Management Program which will provide you with a free cellular/Bluetooth-enabled glucometer and diabetic supplies (lancets, test strips, etc.) when you transmit your routine blood glucose readings to CCS Medical's certified diabetes professionals for clinical monitoring. This confidential program is designed to provide personalized support and coaching and proven to improve A1c control and health outcomes. For more information, or to voluntarily enroll in this program, please contact **1.800.966.2046**, from 8 a.m. to 7 p.m. EST, Monday – Friday.

If you have questions about your prescriptions or benefits, you can contact Member Services toll-free at 1-800-334-8134.

*Covered Medications**

- Legend Drugs (drugs that require a prescription) **Exceptions**: See Exclusion list below.
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script will require prior authorization.
- Contraceptives: Oral, Transdermal, Intravaginal and Injectable; extended cycle products are subject to 3x retail copays for a 90-day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets, Medications (prior authorization may be required.)
- ADD/ADHD Medications (prior authorization required over age 18)
- Androgens (prior authorization required)
- Topical Acne Agents (prior authorization required over age 34)
- Narcolepsy Medications (prior authorization required)
- Growth Hormones (prior authorization required)
- Hypnotics (quantity limits apply)
- Extended Release Controlled Substances (quantity limits apply)
- Gastrointestinal-Antiemetics (quantity limits apply)
- Influenza Agents (quantity limits apply)
- Migraine Medications (quantity limits apply)
- Oral/Intranasal/Topical Fentanyl (prior authorization required)
- Opioids (quantity limits apply)
- Proton Pump Inhibitors (prior authorization may be required)

*Plan Exclusions**

- Biological, blood products, serums, immunoglobulin, and Non-ACA immunization agents
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants and removal products)
- Compounded prescriptions that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Topical Analgesic Pain Patches
- Impotency Medications
- Prescription and OTC smoking cessation
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Anabolic Steroids
- Prescription Vitamins unless listed above
- Anti-obesity/Appetite suppression
- Formulary Exclusion List including low clinical value drugs, new to market drugs, and non-essential drugs.
- Nutritional Supplements (except in NJ or states that require it)
- Over the counter (OTC) medications unless listed above
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

*** This is not an inclusive list but is a representation of the most commonly used medications. Contact Member Services for specific drug coverage information.**

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Customer Service if you have specific drug questions or register at www.caremark.com to check drug costs and coverage.