# Prescription Drug Benefit Booklet

# For The

# Modine Manufacturing Company

# Group High Deductible Health Plan (HDHP)

Restated Effective: January 1, 2025

# *Contents*

## *INTRODUCTION*

If you are a Member under the Modine Manufacturing Company Group High Deductible Health Plan (the "Plan"), then, in addition to the medical benefits described in the Medical Benefit Booklet, you will be entitled to the prescription drug benefits described in this Prescription Drug Benefit Booklet. Modine Manufacturing Company, the Plan Sponsor, has entered into a contract with CVS Caremark Corporation ("CVS Caremark") to process claims for benefits described in this booklet and to serve as the Plan's Pharmacy Benefit Manager.

For purposes of this Booklet, the terms "Subscriber," "Member," and "Covered Dependent" have the meanings set forth in the Medical Benefit Booklet. The term "You" refers to an individual who is either a Subscriber or a Member, unless otherwise indicated by the context.

**Note**: "Prescription Drugs Administered by a Medical Provider" described in the "Benefits" section of the Medical Benefit Booklet are covered under the terms and conditions set forth in the Medical Benefit Booklet.

## *AVAILABLE BENEFITS*

Participating Network Pharmacies

The Plan provides you with access to an extensive national pharmacy network. CVS Caremark has entered into contractual arrangements with various pharmacies throughout the country called "Participating Network Pharmacies." These Participating Network Pharmacies generally offer Participants access to prescription drugs at discounted rates in exchange for being able to participate in the network. Generally, Participating Network Pharmacies are available to help Members with their short-term medications. (Members will also have access to a mail order service for long-term or maintenance medications, except as prohibited by State Law.) Participating Network Pharmacies are not limited to CVS retail stores. To find a Participating Network Pharmacy, you may log on to www.caremark.com or contact CVS Caremark Customer Service at (800) 378-5675.

Members may also use other pharmacies (pharmacies that are not Participating Network Pharmacies). However, the cost of prescriptions drugs from such a pharmacy may be higher.

Co-payment

A co-payment is the flat dollar amount you pay each time you receive a prescription drug that is covered under the Plan. The High Deductible Health Plan does not have co-payments, all cost sharing is applied through co-insurance. The High Deductible Health Plan does not have minimum/maximum co-payments. Except as noted with respect to preventive medications below, you are responsible for the full cost of the prescription drugs until you meet the deductible as described in the BENEFITS AT A GLANCE schedule below.

Co-insurance

A co-insurance payment is the percentage of the prescription drug expenses that you pay. The percentage of your co-insurance obligation for prescription drug expenses and the percentage of those expenses paid by the Plan are described in the BENEFITS AT A GLANCE schedule below. The co-insurance payment

amount depends on the drug category: Generic; Brand (preferred); Brand (non-preferred); Specialty; or Preventive.

Preventive Medications

Preventive medications, as described on the CVS/Caremark Advanced Control Formulary AND the CVS/Caremark High Deductible Health Plan (HDHP) – Health Savings Account (HSA) Preventive Therapy Drug List, are covered at 100% with no deductible when you are enrolled in the High Deductible Health Plan. For a current list of preventive medications, you may call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com.

Total Out-of-Pocket Maximum

Except as noted below, the amount you pay for prescription drugs, accumulates toward the deductible and out-of-pocket maximum set forth in the High Deductible Health Plan Medical Benefit Booklet. Once you reach the applicable deductible, the Plan will pay 80% of your covered prescription drug expenses; once you reach the applicable out-of-pocket maximum under the Plan, the Plan will pay 100% of your covered prescription drug expenses for the rest of the Plan year. The following expenses do not accumulate toward the out-of-pocket maximum:

- the difference in cost between generic and brand name drugs;
- the difference in cost between Participating Network Provider and non-Participating Network Provider.

## *BENEFITS - GENERALLY*

Your benefits under the Plan will differ depending on the type of prescription drug you take (for example, generic vs. preferred vs. non-preferred vs. specialty), how you buy it (for example, from a Participating Network Provider vs. non-Participating Network Provider, or at a pharmacy vs. through the mail), and the other cost-savings measures implemented by the Plan.

Type of Drug

All prescription drugs that are covered under the Plan fit within one of the following categories:

- *Generic*: A non-brand name drugs that has the same active ingredients as a brand-name drug and is sold for substantially less than the brand-name drug. For a detailed list of the generic drugs covered under the Plan, you may call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com. This list is available at no charge.
- *Preferred*: A drug that is on the list of preferred brand name drugs and requires you to pay less than you would pay for a non-preferred drug. Drugs in this category are based on a combination of factors, including safety, effectiveness and cost. For a detailed list of the preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com. This list is available at no charge.

- *Non-Preferred*: A drug that is not on the list of preferred brand name drugs and requires you to pay more than you would pay for a preferred drug. For a detailed list of the non-preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com. This list is available at no charge.

- *Specialty*: Drugs that are used in the management of chronic or genetic diseases, including injectables or oral medications, or drugs that otherwise require special handling. For a detailed list of the specialty drugs covered under the Plan, you may call CVS Caremark Specialty Customer Service at (800) 237-2767 or visit www.caremark.com. This list is available at no charge.

- *Preventive*: Drugs that are designated on the CVS Caremark High Deductible Health Plan (HDHP) - Health Savings Account (HSA) Preventive Therapy Drug List AND on the CVS/Caremark Advanced Control Formulary drug list are generally covered at 100% with no deductible. For a current list of preventive medications, you may call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com.

The category to which a particular drug belongs may change periodically based on CVS Caremark's formulary. These changes may occur without notice to you. When a change occurs, you may be required to pay more or less for a covered prescription drug, depending on the category to which it is assigned. Because a drug's category may change periodically, you should call CVS Caremark Customer Service at (800) 378-5675 or visit www.caremark.com for the Plan's most current information.

Retail Purchases

The Plan allows you to fill prescriptions at a retail pharmacy. You should use a retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Through a retail pharmacy, you are generally able to receive up to a 30-day supply of medication.

If you receive your prescription drug from a Participating Network Pharmacy, you should show the pharmacist your ID card at the time you submit your prescription. You will be required to pay the applicable amount identified on the schedule below at the time of purchase. The Plan will pay the remaining cost of the prescription drug if there is coverage for that prescription drug under the Plan.

If you fill your prescription at a non-Participating Network Pharmacy, or if you fail to show your ID card at the time of purchase from a Participating Network Pharmacy, you may be required to pay the entire cost of the prescription drug at the time of your purchase. The Plan will pay its share of the cost of the drug once you submit a claim form to the CVS Caremark. You may obtain a claim form from CVS Caremark by calling (800) 378-5675. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

The Plan has a retail refill restriction. You may receive only one initial 30-day (or less) supply of your prescription maintenance medication and two refills on such medication through a retail pharmacy. After that, you must utilize the Plan's mail order service, as described below.

Mail Order Service Purchases

The Plan requires you to fill certain prescriptions through its mail order service. You should use the Plan's mail order service when filling long-term maintenance medications. Maintenance medications are used to treat chronic illnesses such as heart conditions, allergies, high blood pressure, and arthritis. Through the mail order service, you are generally able to receive up to a 90-day supply of your medication. You should inform your prescribing physician that you have a mail order prescription drug program. That information will indicate to your prescribing physician that you can obtain a 90-day supply of your medication. To obtain a prescription through the Plan's mail order service, you must complete an order form and send it to CVS Caremark along with your prescription and your applicable payment amount. It may take up to 2-3 weeks to receive your prescription in the mail. You may later order refills on your prescription through the mail order service by calling (800) 378-5675 or by visiting www.caremark.com. This will reduce the time it takes to receive your refill. Mail order may not be available in certain states due to applicable State Laws. If this is the case, you will have the option to fill a 90-day supply of maintenance medications at any participating retail network pharmacy.

Prior Authorization Requirement

Certain prescription drugs are subject to prior authorization from the Plan. This means that you must obtain approval through CVS Caremark before your medication will be covered under the Plan. The prior authorization criteria are developed in order to ensure safe, effective and appropriate utilization of selected drugs. Your prescribing physician will be required to confirm that you have met the required evidence-based criteria before the Plan will cover your prescription. You will be informed about any prior authorization requirement that applies to your prescription at the time of your purchase. In addition, you may determine whether a prior authorization will apply to your prescription by contacting CVS Caremark Customer Service at (800) 378-5675.

Maintenance Choice

You have the option of receiving long-term maintenance prescription drugs through the Plan's mail order service described above, through Costco and their mail pharmacies, Kroger affiliated pharmacies and their mail pharmacies, CVS affiliated pharmacies and CVS Caremark Mail Service pharmacy. Additionally, there are some select independent pharmacies in certain areas to ensure adequate access to a Maintenance Choice pharmacy. To find a Participating Network Pharmacy, you may also log on to www.caremark.com or contact CVS Caremark Customer Service at (800)378-5675.This program provides you with the flexibility to decide which delivery system is most convenient to you, except as prohibited by State Law. If you utilize a participating Maintenance Choice retail pharmacy, you will have the opportunity to discuss your medication face-to-face with a pharmacist. You will pay the same amount for your 90-day supply of maintenance medication whether you receive it at a local participating Maintenance Choice retail or mail order pharmacy or through the Plan's mail order service.

"Dispense as Written" Restriction

If you or your doctor chooses for you to receive a brand name drug when a generic drug is available (such as when the prescription contains a "dispense as written" restriction), you will be responsible for paying the difference between the cost of the brand name drug and the cost of the available generic drug. You

will also be responsible for paying the applicable co-insurance amount for your prescription, as outlined in the schedule below.

Generic Substitution

The Plan uses a generic substitution program whereby Participating Network Pharmacies and the Plan's mail order service will substitute brand name drugs with generic equivalents, when generic equivalents are available and appropriate. This program will not be applied when the prescription contains a "dispense as written" restriction or when the Participant has requested that only the brand name drug be dispensed.

Specialty Guideline Management

The Plan has adopted the Specialty Guideline Management program, which evaluates the appropriateness of drug therapy for specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This program is available for all specialty conditions, and outreach is made to both the Participant and the prescriber to evaluate the therapy.

The Specialty Guideline Management program requires approval of treatment for select medicines. Under this program, there will be a review of clinical information for approval of treatment with these medicines. Decisions are based on nationally recognized guidelines and are administered by a CVS Caremark clinical specialist.

Advanced Control Formulary™

The Plan has adopted the CVS Caremark Advanced Control Formulary™ program that acts as a guide to encourage physicians to prescribe drugs that are clinically effective and are available at the lowest net cost without sacrificing treatment outcomes. Under this program, the Pharmacy Benefit Manager may exclude certain products. Generics will be considered the first line of prescribing. If there is no generic available, there may be more than one brand name medicine to treat a condition. The Pharmacy Benefit Manager may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription. You may be responsible for the full cost of non-formulary products that are removed from coverage. In most instances, a brand name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product into the marketplace. For specific information regarding your prescription benefit coverage, you can visit www.caremark.com or contact CVS Caremark Customer Service at (800) 378-5675.

Specialty Connect™

The Plan has adopted the CVS Caremark Specialty Connect™ program. A Participant may take advantage of this program by having the Participant's doctor send the prescription to the Plan's specialty mail order service. Additionally, clinical services for Participants taking specialty drugs will be offered through the CVS Caremark CareTeams. The CareTeams are staffed by specialty pharmacy clinicians with up-to-date knowledge on evidence-based protocols. CareTeams will work to help improve Participants' adherence by educating them about taking their medications correctly, reviewing proper medication storage and handling, and troubleshooting medication side effects.

Rebates

At times, the Plan Sponsor may receive rebates from pharmaceutical companies in connection with certain drugs that are covered by the Plan. In such cases, the Plan Sponsor will use such rebates to offset Plan costs.

## *BENEFITS AT A GLANCE*

| | RETAIL PHARMACY 30-day supply | | MAIL ORDER 90-day supply | | MAINTENANCE CHOICE 90-day supply | |
|---|---|---|---|---|---|---|
| **DRUG CATEGORY** | **You Pay** | **Plan Pays** | **You Pay** | **Plan Pays** | **You Pay** | **Plan Pays** |
| Generic | 20% Co-insurance after deductible | 80% | 20% Co-insurance after deductible | 80% | 20% Co-insurance after deductible | 80% |
| Brand (preferred) | 20% Co-insurance after deductible | 80% | 20% Co-insurance after deductible | 80% | 20% Co-insurance after deductible | 80% |
| Brand (non-preferred) | 20% Co-insurance after deductible | 80% | 20% Co-insurance after deductible | 60% | 20% Co-insurance after deductible | 60% |
| Specialty | 20% Co-insurance after deductible | 80% | N/A | | N/A | |
| Preventive* | $0 | 100% | $0 | 100% | $0 | 100% |
| **Deductible** | | | | | | |
| The deductible amount that you must satisfy each Plan Year before you will receive any prescription drug benefits under the Plan | | | In-Network $3,300 individual/$6,600 family<br>See the Medical Benefit Booklet | | | |

| Minimum/Maximum Co-payment | |
|---|---|
| The Plan's minimum co-payment is:<br>The Plan's maximum co-payment is: | Not applicable<br>Not applicable |
| **Total Out-of-Pocket Maximum** | |
| The maximum amount you have to pay out of your pocket each Plan Year for medical expenses and covered prescription drugs | In-Network $5,500 individual/$11,000 family<br>Out-of-Network $11,000 individual/$22,000 family<br>See the Medical Benefit Booklet |
| *For more information, see "Type Of Drug" in the Benefits Generally Section of this document. Preventive Drugs referenced are those designated on the CVS Caremark High Deductible Health Plan (HDHP) - Health Savings Account (HSA) Preventive Therapy Drug List AND on the CVS/Caremark Advanced Control Formulary drug list. | |

| Day Supply Limit | Retail Pharmacy | Mail Order |
|---|---|---|
| The maximum amount you can receive per prescribed order | 30-day supply, except that Maintenance Choice Program allows for 90-day supply | 90-day supply |
| **Refill Limit** | **Retail Pharmacy** | **Mail Order** |
| The maximum amount you can receive per refill order | 30-day supply, except that Maintenance Choice Program allows for 90-day supply | 90-day supply |
| **Use:** | **Retail Pharmacy** | **Mail Order** |
| | Short-term medications or immediate prescription drug needs | Long-term, maintenance and injectable medications |

## *ADDITIONAL COVERAGE*

Care Outside the United States

Prescription drugs purchased outside of the United States are generally not covered under the Plan. However, if you are outside of the United States and need to purchase prescription drugs due to an emergency, such medication will be covered as if you had received it from a Participating Network Pharmacy. In such circumstances, you will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a claim form to CVS Caremark for reimbursement from the Plan.

New Drugs

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, the Plan Sponsor will work with CVS Caremark to determine whether a

particular new drug will be covered under the Plan and whether any coverage restrictions or limitations will apply.

## *EXCLUSIONS FROM COVERAGE*

Certain expenses that Members incur for medications are not covered under the Plan. For a list of excluded drugs, you may log on to www.caremark.com or call the telephone number on the back of your ID card for more information.

## *CLAIMS*

You will receive a Plan identification (ID) card that you may use to purchase prescription drugs from a Participating Network Pharmacy. When you use your Plan ID card at a Participating Network Pharmacy, the Participating Network Pharmacy will generally file a claim on your behalf by submitting information regarding your prescription to the Plan. The Plan will then pay the Participating Network Pharmacy for the Plan's share of the cost (if any) of the prescription drug. You will be responsible for paying any co-payment or co-insurance payment owed in connection with your prescription to the Participating Network Pharmacy at the time of your purchase.

Use of Claim Form

Your Plan ID card will also contain important information, including claim filing directions and contact information for CVS Caremark, the Plan's Pharmacy Benefit Manager. If you use a pharmacy that is not a Participating Network Pharmacy, or if you do not have your Plan ID card at the time of your purchase at a Participating Network Pharmacy, you may be required to pay for the entire cost of the prescription drug at the time of purchase. In that case, you may file a claim to recover from the Plan the amount payable by the Plan (if any) in connection with your prescription drug purchase.

You may obtain a claim form from CVS Caremark by calling (800) 378-5675. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

Furthermore, if you believe you are being denied any rights or benefits under the Plan with respect to prescription drugs and you wish to seek those benefits, you, or your authorized representative on your behalf, must file a written claim and submit it to CVS Caremark at CVS Caremark Claims Department, PO Box 52136, Phoenix, AZ 85072-2136. CVS Caremark will review your claim and notify you of its determination under the procedures described below.

Following Plan Procedures

You should follow the procedures described in this section to request your prescription drug benefits under the Plan. If your request is denied, you may appeal your claim under the claims procedures below.

Decisions on Coverage

All claims and questions regarding your claims under the Plan should be directed to CVS Caremark. It is CVS Caremark that is ultimately responsible for making the final determinations on such claims and for providing a full and fair review of the decision on such claims in accordance with the provisions below and in accordance with applicable law. Benefits under the Plan will be paid after CVS Caremark decides, in its sole discretion, that you are entitled to such benefits. CVS Caremark is a fiduciary of the Plan and has the authority to make decisions involving the use of discretion.

Deadline for Filing

All claims relating to benefits covered under the Plan must be filed within 12-months for non-controlled substances and within 6-months for controlled substances following the date on which the service/prescription drug is filled.

## *CLAIMS PROCEDURES*

Notification of the Plan's Determination

Once your claim is submitted to the Plan, CVS Caremark, the Plan's Pharmacy Benefit Manager, will make a decision with respect to your claim. If your claim is wholly or partially denied, CVS Caremark will notify you of that decision in a writing and the notice will contain: (i) specific reasons for the claim's denial; (ii) specific reference to relevant Plan provisions; (iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (iv) information to allow you to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request and free of charge, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (v) a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and (vi) information as to the steps to be taken if you wish to appeal CVS Caremark's decision and the time limits applicable to such procedures. In the case of a denied claim involving urgent care (described below), the notification also will include a description of the expedited review process applicable to such claims. In addition, you will be notified if your coverage is rescinded. A rescission of coverage refers to a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it results from a failure to pay on a timely basis premiums or contributions towards the cost of Plan coverage. You will also be notified of the steps to be taken if you wish to appeal CVS Caremark's decision regarding your rescission.

In addition to the information above, the notice will also contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination. Also, if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided to you upon written request at no charge.

Timing of Notification

Notification regarding your claim will be given within the following timeframes, depending on the type of claim you submitted:

A. ***Urgent Care Claims*** – within 72 hours after receipt of your claim, unless you do not provide enough information for CVS Caremark to determine whether or to what extent benefits are payable under the Plan. If this occurs, CVS Caremark will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. CVS Caremark will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the period given to you to provide additional information.

An "urgent care claim" is a claim for prescription drugs care or treatment where, in the opinion of your physician or your Covered Dependent's physician, a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

B. ***Pre-Service Claims*** – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of CVS Caremark, but only if CVS Caremark notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which CVS Caremark expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "pre-service claim" is a request for approval of a prescription drug where receipt of the prescription drug is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations for certain prescription drugs.

If you filed a pre-service claim with CVS Caremark and failed to follow the Plan's procedures for filing a pre-service claim, CVS Caremark will notify you of the failure and the proper procedures to be followed as soon as possible but not later than five days after receiving the pre-service claim. CVS Caremark will notify you, however, only if the initial claim identified the (a) the Member for whom the claim is made, (b) a specific medical condition or symptom, and (c) a specific treatment, service, or product for which approval is requested.

C. ***Post-Service Claims*** – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond CVS Caremark's control if CVS Caremark notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which CVS

Caremark expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "post-service claim" is any claim for prescription drug benefits that is not a pre-service claim or an urgent claim.

D. ***Ongoing Treatment*** – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, CVS Caremark will notify you within a reasonable time prior to a reduction or termination of treatments.

Ongoing Urgent Care. If you request to extend urgent care beyond the approved period of time or number of treatments, CVS Caremark will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the timeframes for urgent care claims (discussed above) will apply.

Other Ongoing Care. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service claim or post-service claim, as applicable.

If notice of a benefits determination is not given to you within the applicable period, your claim will be considered denied as of the last day of the applicable Plan review period.

## *INTERNAL APPEAL PROCEDURES*

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal the denial and request a review of your claim. Your appeal must be received by CVS Caremark, the Pharmacy Benefit Manager, within 180 days after your receipt of the notice of denial.

When you submit your appeal, you may also submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeals should include the following information:

- the name of the Member who is the subject of the appeal;
- the Subscriber's CVS Caremark ID number;
- the Member's date of birth
- a written statement of the issue(s) being appealed;
- name of the drug(s) being requested; and

- written comments, documents, records or other information relating to the claim being appealed.

Your appeal and supporting documentation may be mailed or faxed to CVS Caremark as follows:

CVS Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax Number for Appeals: (866) 443-1172

Note that the Plan provides for an expedited review process with respect to urgent care claims. You may request an expedited appeal of an Adverse Benefit Determination orally or in writing. (An "Adverse Benefit Determination" means a rescission of Plan coverage, or a denial, reduction, or termination of, or a failure of the Plan to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan.) The expedited process allows you to transmit and receive information from the Plan by telephone, facsimile or other similar expedited means. [Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.]

Notification of the Plan's Determination; Timing

If your appeal is received by the appropriate deadline, CVS Caremark, the Pharmacy Benefit Manager, will independently review your appeal and any additional information that you submit. CVS Caremark will notify you of its decision regarding your appeal within the following timeframes:

A. ***Urgent Care Claims*** – as soon as possible, but no later than 72 hours after receipt of your appeal.

B. ***Pre-Service Claims*** – within a reasonable period, but no later than 30 days after receipt of your appeal.

C. ***Post-Service Claims*** – within a reasonable period, but no later than 60 days after receipt of your appeal.

With respect to any appeal that is based in whole or in part on a medical judgment, including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, CVS Caremark delegates its fiduciary decision-making authority to one of its outside vendors. In rendering its decision on Plan coverage, the outside vendor, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. CVS Caremark will identify the medical or other experts who provided advice to the Plan with respect to your claim. CVS Caremark currently uses the following vendors for such appeals: Medical Review Institute, MES Solutions, National Medical Review, and Managing Care Managing Costs. However, the outside vendors used by CVS Caremark may change from time to time.

If your appeal is denied, CVS Caremark will send you a statement containing: (i) specific reasons for the denial; (ii) specific references to relevant Plan provisions; (iii) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim; (iv) information to allow you to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (v) a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; (vi) the procedures and time limits for requesting external appeal if your claim denial involved either medical judgment or a rescission of coverage; and (vii) a statement describing your right to bring an action in federal court under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination. If the appeal notice does not contain such explanation, it will contain a statement indicating that this explanation is available upon written request and at no charge.

CVS Caremark will provide to you, free of charge, any new or additional evidence or any new or additional rationale, that is considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. In order to give you an opportunity to respond to such new or additional evidence or the new or additional rationale, this evidence or rationale will be provided to you in advance of the date on which you are to receive a decision on your appeal (as described above). You may review your claim file and present evidence and testimony relevant to your claim.

**You must exhaust your rights to appeal under the terms of the Plan before you may bring an action in federal court.**

## *EXTERNAL APPEAL PROCEDURES*

Possible Right to External Appeal

If your appeal is denied, you may pursue an external review of your claim by an independent, third party if your claim denial involved either medical judgment (such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that the treatment is experimental or investigational) or a rescission of coverage.

Standard External Review

If you wish to pursue an external appeal, you must file a request for an external appeal within four months of the date your appeal was denied.

The request for an external appeal should include:

- the Member's name,

- the Member's contact information including mailing address and daytime telephone number,
- the Subscriber's ID number, and
- a copy of the prior appeal denial.

The request for an external appeal and supporting documentation may be mailed or faxed to CVS Caremark as follows:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-3092
Fax Number: (866) 689-3092

Within five days after its receipt of a request for an external appeal, CVS Caremark will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, CVS Caremark will forward the request to an independent review organization ("IRO"), together with all relevant medical records, all other documents relied upon by CVS Caremark in making a decision on the case, and all other information or evidence that you or your physician has already submitted to CVS Caremark. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include such information with the request for an external appeal.

Except in the case of an expedited external appeal, as described below, the assigned IRO will provide you and the Plan with written notice of its decision on your external appeal within 45 days of its receipt of your request. If the IRO needs additional information to make a decision, this period may be extended as permitted by law. The IRO's notice to you shall also include such other information as required by applicable law, including: (i) a general description of the reason for the request for external review, including information sufficient to identify the claim; (ii) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; (iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (iv) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (v) a statement that the IRO's determination is binding except to the extent that other remedies may be available under ERISA; (vi) a statement that judicial review may be available; and (vii) a statement regarding the availability of, and current contact information for, any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Appeal

The external appeal process will be expedited if you meet the criteria for an expedited external appeal, as defined by applicable law. For example, if you have received an Adverse Benefit Determination that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, you may expedite your external appeal as well. Similarly, if you have received a final denial of your claim under the internal appeal procedures and you

have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or your claim involved an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency treatment, but have not been discharged from a facility, you may expedite your external appeal.

You or your physician may request an expedited external appeal by calling the Customer Care number on your Plan ID card. The request should include:

- the Member's name,
- the Member's contact information including mailing address and daytime telephone number,
- the Subscriber's ID number, and
- a copy of the prior appeal denial.

Alternatively, a request for an expedited external appeal and the supporting documentation may be faxed to CVS Caremark at:

CVS Caremark
External Review Appeals Department
Fax number: (866) 443-1172

All requests for an expedited external appeal must be clearly identified as "urgent" at the time of submission.

Immediately upon its receipt of a request for an expedited external appeal, CVS Caremark will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, CVS Caremark will forward the request to an IRO, together with all relevant medical records, all other documents relied upon by CVS Caremark, as the Pharmacy Benefit Manager, in making a decision on the case, and all other information or evidence that you or your physician has already submitted to CVS Caremark. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an external appeal.

The assigned IRO will provide you and the Plan with notice of its decision on your external appeal as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external appeal. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and the Plan with written confirmation of its decision. The IRO's notice shall also include such other information as required by applicable law, as described above.

Final Decision of IRO

If the final independent decision of the IRO is to approve payment/coverage of the benefit that was previously denied, the Plan will accept the decision and provide coverage for your prescription drug in accordance with the terms and conditions of the Plan. If the final independent decision of the IRO is that

payment/coverage will not be made or provided, the Plan will not be obligated to provide coverage for the prescription drug.

Please contact the Plan Administrator or CVS Caremark, the Pharmacy Benefit Manager, for more information on filing an external appeal.

## *LEGAL ACTION*

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim and appeal procedures provided by the Plan, as described above. If you receive notice that your claim for Plan benefits has been denied and you fail to file an appeal within the period set forth above following receipt of notice that your claim has been denied, you will be barred from pursuing the claim further with CVS Caremark, the Plan, or in court. If you timely file an appeal within that period set forth above and your claim is denied in whole or in part upon appeal, then you may file suit or pursue a legal action provided you do so no later than 12 months after the date of the final determination denying your claim on appeal. If you fail to file suit or legal action within this 12-month period, you will lose all rights to bring any such suit or legal action thereafter.

If CVS Caremark fails to abide by the Claims Procedures set forth above with respect to a claim, the person claiming Plan benefits will be deemed to have exhausted the internal appeal procedures and may pursue an external appeal, as described above, and/or a civil action under federal law under ERISA section 502(a). The internal appeals procedures will not be deemed exhausted based on a de minimis failure to abide by the Claims Procedures that does not cause, and is not likely to cause, prejudice or harm to the claimant if CVS Caremark can demonstrate that the violation was for good cause or due to matters beyond its control and that the failure occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant.

## *COORDINATION OF BENEFITS*

The Plan does not require your outpatient prescription drug benefits to be coordinated with the benefits you receive under any other plan.

## *SUBROGATION AND REIMBURSEMENT*

In certain circumstances, you or your Covered Dependents (or the heirs, executors, or beneficiaries of you or your Covered Dependents) may have an obligation to reimburse the Plan for payments made to or on behalf of you or your Covered Dependents. In particular, if you or your Covered Dependents are entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you (such as under a policy of insurance), the Plan shall, to the extent of such payment, be subrogated to all your rights or your Covered Dependents' rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. In addition, you and your Covered Dependents agree to reimburse the Plan for any benefits paid under the Plan, and any out-of-pocket expenses incurred by the Plan, the Plan Administrator, or the Plan Sponsor, in pursuing such recovery, out of any monies recovered from such third party as the result of judgment, settlement or otherwise. This reimbursement obligation is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement, or judgment and is not

subject to offset or reduction by reason of any legal fees or other expenses incurred by you or your Covered Dependent in securing such recovery.

The subrogation and reimbursement obligation will apply to any full or partial recovery from a third party, even if you or your Covered Dependents have not been "made whole" for the loss accruing because of the alleged negligent, willful or other conduct of the third party. Further, the Plan's right of reimbursement shall be in first priority over you and your Covered Dependents to the extent of any benefits paid under the Plan. If you receive payment as part of a settlement or judgment from any third party as a result of an illness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits paid by the Plan. You and your legal representative acknowledge that the portion of the settlement funds to which the Plan's equitable lien applies is a Plan asset.

**You agree to notify the Plan Sponsor and the Pharmacy Benefit Manager, in writing, of any benefits paid under the Plan that arise out of any illness or injury that was caused by a third party.**

By filing a claim for and/or accepting benefits under the Plan, you and your Covered Dependents are deemed to have consented to such subrogation and right of reimbursement of the Plan. You and your Covered Dependents are also deemed to have agreed to cooperate with the Plan, the Plan Administrator, the Plan Sponsor, and the Pharmacy Benefit Manager in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter into a subrogation and reimbursement agreement with the Plan upon the request of the Plan Administrator, the Plan Sponsor, or the Pharmacy Benefit Manager. You and your Covered Dependents may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your Covered Dependents may be delayed, withheld, or denied unless you and your Covered Dependents cooperate fully and enter into the requested reimbursement agreement.]

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