

CVS Caremark Prescription Drug Coverage for Participants in Ames Construction, Inc.

Your CVS Caremark Prescription Drug Coverage Summary

Plan Year: 10/1/2026 – 9/30/2027

If you are a participant in an Ames Construction, Inc. medical plan with coverage through Blue Cross Blue Shield of Minnesota (BCBSMN), you are automatically enrolled in prescription drug coverage through CVS Caremark.

This booklet provides details about the prescription drug benefits available to you through CVS Caremark, including covered services, services that are not covered, and limitations and exclusions that apply. This booklet is incorporated by reference into “Ames Construction Health and Welfare Plan Summary Plan Description (SPD)”.

For detailed information about your medical plan, please refer to your medical carrier prepared materials including vendor benefit descriptions and other documents prepared by Blue Cross Blue Shield of Minnesota and incorporated by reference into the “Ames Construction Health and Welfare Plan Summary Plan Description (SPD)”. The SPD provides information on eligibility, electing coverage, plan rules and how the plans are administered.

This booklet, together with the above-referenced “Ames Construction Health and Welfare Plan Summary Plan Description (SPD)” and the medical carrier documents that are all incorporated by reference, are intended to meet the requirements for a Summary Plan Description under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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Terms You Should Know

Aggregate accumulation: A methodology reflecting in the family deductible and out-of-pocket maximum (OOPM), meaning no one individual in the family has satisfied the deductible or OOPM until the entire family amount has been met. If you have single coverage, you only need to meet the individual amounts.

Brand-name drug: A brand-name drug is a medication marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it.

Claims administrator: CVS Caremark and its affiliates who provide certain claim administration services to the plan.

Coinsurance: The *percentage* of the prescription drug cost you must pay at the time you purchase the prescription drug. This summary describes which covered prescription drugs are subject to coinsurance. You will be asked to pay your coinsurance when you fill a prescription.

Company: Ames Construction, Inc. is the plan administrator and sponsor of the prescription medication coverage described in this summary.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or “copay”): The *flat dollar amount* you must pay for prescription drugs. This summary describes which covered prescription drugs are subject to a copayment. You will be asked to provide your copayment when you fill a prescription.

Deductible: The amount you may have to pay for certain services before the plan begins reimbursing claims. The deductible does not apply to prescription drugs unless you are enrolled in one of the HSA plans.

Embedded accumulation: A methodology reflecting individual deductibles and out-of-pocket maximum (OOPM) that applies for all coverage tiers. An individual only needs to meet the individual deductible and OOPM regardless of the coverage tier. In order to meet the family deductible and OOPM, two or more members within the family are needed to satisfy the deductible and OOPM for the entire family amount to be met.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most voluntarily established retirement and health plans in the private industry to provide protection for individuals in these plans.

Formulary: A list of Federal Drug Administration (FDA) approved generic and brand-name prescription drugs that are covered by CVS Caremark.

Generic drug: A generic drug is a medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality and performance characteristics. Generic drugs work the same as brand-name drugs.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Maintenance prescription drug: Prescription drugs commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular use. Examples of maintenance prescription drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Multisource: A brand-name prescription drug that has a generic equivalent.

Patient Protection and Affordable Care Act (ACA): Legislation that constitutes part of the health care reform (HCR) law with the goals of ensuring more people have health insurance, reduce the cost of healthcare, and improve how patients get care.

Plan year: Plan year is the twelve-month period on which the plan is based (i.e., 1/1-12/31 for a calendar year plan).

Prescription drug: Drugs and medications that by law require a prescription.

Specialty drug: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary. Examples include drugs used to treat cancer, multiple sclerosis, rheumatoid arthritis, etc.

CVS Caremark Prescription Drug Benefits

When you enroll in an Ames Construction, Inc. medical plan and select BCBSMN as your medical plan vendor, you are automatically enrolled in CVS Caremark prescription drug coverage. You do not need to make a separate election to receive this coverage.

Under the CVS Caremark prescription drug coverage, you can obtain prescription drugs either through your local participating network pharmacy, at a retail CVS network pharmacy or through CVS Mail Service. If you take **specialty** prescription drugs, you will be required to use your local CVS Pharmacy or CVS Specialty Pharmacy to receive coverage. The specialty network may not be exclusive to CVS in all states. Benefits are paid for prescription drugs purchased in-network only. The plan may not reimburse you for prescription drugs you obtain from out-of-network pharmacies.

For prescription drugs covered under the plan and received at a participating in-network retail pharmacy or a CVS pharmacy, or through CVS Mail Service, the amount you pay varies according to:

- Medical plan option selected and associated plan design provisions and requirements.
- Whether your plan requires you to meet a deductible (all HSA eligible plans require that a deductible be met).
 - If yes, how much of your medical plan deductible you have already paid and whether or not you have reached the out-of-pocket maximum for your medical plan option. The medical plan options with the HSA all require that an annual deductible be met before the plan reimburses non-preventive prescription drugs.
 - If no, whether you have reached the out-of-pocket maximum for your medical plan option. For all plans, once you have reached the out-of-pocket maximum for your medical plan option, all eligible covered expenses are reimbursed at 100%. Filling prescriptions that are brand-name when a generic equivalent is available and filling maintenance or specialty prescription drugs after your allotted retail fills (if allowed) may incur a penalty even after the out-of-pocket maximum is met. For brand-name prescription drugs that have a generic equivalent, the penalty is the cost difference between the brand-name prescription drug and the generic equivalent. For other maintenance or specialty prescription drugs, the penalty may be the full cost of the prescription drug.
- Prescription drug type:
 - Retail vs. CVS Mail Service,
 - Preventive vs. non-preventive,
 - Preferred generic, preferred brand-name, non-preferred generic, or non-preferred brand-name prescription drug.

The medical plan options may feature an annual deductible. Under the plan options that are HSA eligible, prescription drug charges apply to the annual deductible. Under all other options, you do not need to meet the deductible before the plan begins paying for eligible prescription drugs.

Certain preventive prescription drugs are not subject to the deductible and are either covered at 100% (ACA Health Care Reform Preventive) or are subject to applicable copay/coinsurance (non-ACA Health Care Reform Preventive).

Please note if you select a brand-name prescription drug that has a generic equivalent, you may pay the brand drug cost share and have to pay the difference in cost between the generic and the brand-name prescription drug you selected.

For more information on how prescription drug coverage works, please review the following table.

How CVS Caremark Prescription Drug Coverage Works

Please note the plan offers in-network retail and mail order coverage only.

Plan Name	\$3,500 HDHP	\$1,000 PPO Copay
In-Network Only		
Annual Deductible (excludes copays)		
- Individual	\$3,500	\$1,000
- Family	\$7,000	\$2,000
Does Deductible apply to Rx?	Yes	No
Out-of-Pocket Maximum (includes medical and pharmacy expenses, deductible)		
- Individual	\$5,000	\$3,000
- Family	\$10,000	\$6,000
Type of deductible and OOP maximum accumulation method	Embedded	Embedded
Preventive Drugs: Prescription drugs classified as preventive by the Patient Protection and Accountable Care Act (ACA) are covered at 100% and are not subject to the deductible. Other select preventive drugs require copays/cost share but are not subject to the deductible.		
Retail Rx (30-day supply)	Patient pays (after the deductible):	Patient pays:
- Generic	\$10	\$10
- Preferred Brand-Name	\$35	\$35
- Non-Preferred Generic	\$60	\$60
- Non-Preferred Brand-Name	\$60	\$60
Expanded Preventive Prescription Drugs (not subject to the deductible)	\$0 copay generics \$0 copay brand name	N/A
Mail and Retail Rx (90-day supply)	Patient pays (after the deductible):	Patient pays:
- Generic	\$30	\$30

- Preferred Brand-Name	\$105	\$105
- Non-Preferred Generic	\$180	\$180
- Non-Preferred Brand-Name	\$180	\$180
Expanded Preventive Prescription Drugs (not subject to the deductible*)	20%*	N/A
Specialty	30%	\$0 cost share if you enroll in Prudent Rx; or 30%, if not enrolled in the PrudentRx program
Out-of-Network Only		
Paper claim reimbursement (No coverage for Specialty out of network)	Not Covered	Not Covered

Additional Guidelines

For Short-Term Prescription Drugs (up to a 30-day supply)	To view participating in-network retail pharmacies near you, visit www.caremark.com or call CVS Customer Care 1-877-264-2955
For Long-Term, Maintenance Prescription Drugs (up to a 90-day supply)	Visit www.caremark.com , sign in and choose which of your current maintenance prescription drugs you'd like to receive through CVS Mail Service or go to your local CVS Pharmacy.
If Your Prescriber Chooses a Brand-Name Prescription Drug That Has an Available Generic Equivalent	You will pay the brand prescription drug share for the brand-name prescription drug.
If You Choose a Brand-Name Prescription Drug That Has an Available Generic Equivalent	You will pay the brand prescription drug cost share plus the cost difference between the brand-name prescription drug you choose and the available generic prescription drug. The difference in cost does not apply to your out-of-pocket maximum or deductible (if the deductible applies).
Specialty Prescription Drugs	If you receive a prescription designated as a specialty prescription drug by CVS Caremark, you must use a CVS Specialty Pharmacy to receive benefits under this plan. Please note that specialty drugs filled through CVS Specialty Pharmacy can still be picked up at a CVS retail pharmacy, if desired. The specialty network may not be exclusive to CVS in all states. Specialty prescription drugs are filled for up to a 30-day supply and follow the copay structure described in the table on page 7-8. To view Specialty Prescription details, visit www.caremark.com or call CVS Customer Care 1-877-264-2955
Web Services	Register at www.caremark.com to access tools to help you save money and manage your prescription benefits. You will need your prescription card when you register.
CVS Customer Care	Call 1-877-264-2955
To Access CVS Caremark From Your Mobile Device	Use the CVS Caremark mobile app to refill prescriptions, view alerts, search for potential savings, find a local pharmacy and check order status. To download this free app, simply search for CVS Caremark in your mobile device's app store, download it and sign in. Also, go to www.caremark.com http://www.caremark.com for information on the mobile app.

Your Identification (ID) Card

When you first enroll in an Ames Construction, Inc. medical plan, you will receive two prescription drug ID cards from CVS Caremark. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling CVS Caremark Customer Care at 1-877-264-2955. In an emergency, you can print a temporary ID card from the CVS Caremark website, www.caremark.com or from the CVS Caremark Mobile App. It is important to remember to use your CVS Caremark prescription drug coverage ID card at the pharmacy and not your medical plan ID card.

The CVS Caremark Mobile App

Once you enroll in an Ames Construction, Inc. medical plan, you will be able to use the CVS Caremark mobile app to:

- Refill and renew mail service prescriptions for yourself and your enrolled family
- Identify unknown pills with the pill identifier
- Look for potential drug interactions among prescription drugs
- Check order status and view your prescription drug history
- Review prescription drug coverage and cost under your plan
- Find local pharmacies in your plan's network
- View your ID card

You can download this app from the iPhone App Store or from the Android Google Play Store.

When You Need to Fill a Prescription

When you need to fill a prescription, you can choose to go to your local participating in-network retail pharmacy or your local CVS Pharmacy or CVS Mail Service.

If your prescription is for a one-time 30-day supply of a prescription drug or less, the in-network retail option is best. If you are filling a maintenance prescription drug (one that you need for more than 30 days), you can get the original prescription plus two refills at an in-network retail pharmacy, but after that, you will need to refill that prescription through CVS Mail Service or at your local CVS Pharmacy for up to a 90-day supply. If you are filling a specialty prescription drug, you must use CVS Specialty Pharmacy. Please note that specialty drugs filled through CVS Specialty Pharmacy can still be picked up at a CVS retail pharmacy, if desired.

Regardless of whether you choose a local in-network retail pharmacy, the local CVS Pharmacy or CVS Mail Service, generic prescription drugs are used to fill prescriptions whenever possible unless your doctor specifies otherwise. The pharmacist may contact your doctor to suggest a preferred brand-name prescription drug be substituted with a comparable prescription drug from the CVS Caremark formulary. Your doctor decides whether to switch to the formulary prescription drug.

CVS Caremark also provides "safety checks" at both its in-network retail and mail service pharmacies. Examples include checking for possible drug allergies or adverse interactions, incorrect dosage or strength, and age- and sex-appropriate prescription drugs. If there are any problems, CVS Caremark contacts your doctor. CVS Caremark, and not the plan, is solely responsible for these safety checks.

Annual Deductible

There is a combined annual deductible for your medical and prescription drug expenses for the HSA eligible plans (see Prescription Drug Coverage Table above for amounts).

For the HSA eligible options, the plan does not begin reimbursing prescription drug expenses until you have met the deductible. This means you must meet your deductible before the plan begins reimbursing prescription drug expenses **unless your prescription is for select preventive prescription drugs in which case the deductible does not apply**. Please see sections referring to preventive prescription drugs for more information relating to preventive coverage. Any penalties, like extra costs you pay for a brand-name prescription drug when a generic is available and filling specialty at a retail pharmacy, do not count toward your deductible.

For the non-HSA eligible options, you do not need to meet a deductible before your plan begins reimbursing prescription drug expenses.

Annual Out-of-Pocket Maximum

There is a combined annual out-of-pocket maximum for your medical and prescription drug expenses under both medical plan options (see Prescription Drug Coverage Table above for amounts).

This means that once your out-of-pocket costs for covered medical services and prescription drugs satisfy your medical plan's out-of-pocket maximum for the year, your covered prescription drugs will be filled at no additional charge to you for the remainder of that plan year. Any penalties, like extra costs you pay for a brand-name prescription drug when a generic is available and filling specialty at a retail pharmacy, do not count toward your out-of-pocket maximum and continue to apply after you have met the out-of-pocket maximum.

Retail Pharmacies

CVS Caremark has contracted with nearly 68,000 retail pharmacies, including most major drug stores and more than 9,600 local CVS Pharmacy locations. These in-network retail pharmacies in the CVS Caremark network are referred to as "in-network" and "participating pharmacies." To locate a participating pharmacy close to your home or other location, you can call CVS Caremark Customer Care at 1-877-264-2955 or check www.caremark.com. You can purchase up to a 30-day supply at one time at any in-network retail pharmacy.

90-day fills for Maintenance Prescription Drugs

CVS Caremark offers CVS Mail Service to fill your maintenance prescription drugs (for up to a 90-day supply) through mail order. You can also fill your maintenance prescription drugs (for up to a 90-day supply) at your local CVS Pharmacy, CVS retail, Kroger and Kroger affiliates. When you use CVS Mail Service or your local retail pharmacy, you can get a larger supply of your medication at a lower cost than what you would pay for the same amount at a retail (non-CVS) pharmacy. You will also have the convenience of having your medications delivered right to you if you use CVS Mail Service. The cost share you pay for up to a 90-day supply will be the same whether you use CVS Mail Service or your local retail Pharmacy.

Using the CVS Mail Service Program for the First Time

First-time users of CVS Mail Service can sign up for the program either online or by telephone.

If you have a prescription, you can choose one of two ways to sign up:

- Visit www.caremark.com/mailservice or
- Call 1-877-264-2955 for help getting started.

You should receive your prescription drug within seven to ten days of when your order is placed. You may want to ask your doctor to write you a prescription for a 30-day supply at an in-network retail pharmacy and one for up to a 90-day supply to be filled through CVS Mail Service so that you have your prescription drug on hand while your mail order prescription is being filled. You may also bring your 90-day prescription to your local retail pharmacy.

Refilling Prescription Drugs Using CVS Mail Service

You can have your prescription drugs refilled online or by phone for CVS Mail Service. Be sure to reorder your prescription at least three weeks before you expect to run out of your prescription drug. If you miss this deadline, you may ask your doctor to write you a prescription for up to a 30-

day supply of your prescription drug that can be filled at a retail pharmacy while you wait for your prescription from CVS Mail Service.

Covered Prescription Drugs

CVS Caremark prescription drug coverage provides coverage for federal legend drugs which are drug products bearing the legend, "Caution: Federal law prohibits dispensing without a prescription." The plan also covers certain prescription supplies, oral contraceptives and some compounded prescription drugs which contain at least one federal legend drug in a therapeutic amount.

For CVS Caremark to cover a prescription drug, the prescribed item must meet the following requirements:

- It must be a valid prescription written by a licensed physician or other licensed provider.
- It must be approved by the Federal Food and Drug Administration (FDA)
- It must be dispensed by an in-network pharmacy
- It must not be listed as an exclusion under this plan

Prescription drugs covered by the plan are classified as either generic or brand-name prescription drugs. Brand-name prescription drugs are then considered either preferred brand-name (typically tier 2) or non-preferred brand-name (typically tier 3). Certain brands may be covered on tier 1 (typically generic) as determined by CVS Caremark.

ACA Preventive Prescription Drugs Covered at 100%

To comply with the ACA, CVS Caremark will cover the following prescription drugs (with the limitations shown) in full and you do not need to meet a deductible under any plan option. However, please note limitations and certain penalties will apply if you choose a brand-name prescription drug when a generic equivalent is available. This list is illustrative and subject to change as ACA guidelines are updated or modified.

For specific questions about your coverage, you should contact CVS Caremark at 1-877-264-2955 or visit www.caremark.com for more information and to confirm if a prescription drug is considered preventive.

- Aspirin
 - For women at least age 12 to 59 years, after 12 weeks of pregnancy and at high risk for preeclampsia
 - No prior authorization
 - Generic only
 - Over-the-counter and requires a prescription
 - Dosage form of 81 mg
- Bowel Preparations for Colonoscopy
 - For adults age 45 to 75 years
 - No prior authorization or quantity limit
 - Prescription products only
- Breast Cancer Prevention
 - In women age 35 years and older who are at increased risk

- Generic anastrozole
 - Generic exemestane
 - Generic raloxifene
 - Generic tamoxifen
- Diabetes Prevention
 - For adults age 35 to 70 who are overweight or obese
 - Generic metformin 850 mg
- Female Contraceptives
 - FDA-approved contraceptive methods, including generic and certain brand birth control medications, including oral, intrauterine and intravaginal products
- Fluoride for Tooth Decay Prevention
 - For children age 5 or younger whose water is low in fluoride
 - Brand and generics
 - No prior authorization or quantity limit
 - Prescription products only
- Folic Acid
 - For women planning and capable of pregnancy through age 55
 - Generic only
 - Over-the-counter only and requires a prescription
- HIV Pre-Exposure Prophylaxis (PrEP)
 - Prevention only
 - Quantity limit of 1 tablet per day
 - Prescription product
 - Generic only
- Immunizations
 - Vaccines for measles, herpes zoster, mumps and hepatitis A and B, influenza, monkeypox, etc.
- Male Contraceptives
 - Over the counter (OTC) male condoms
- Tobacco Cessation Products
 - For adults age 18 years and older who are not pregnant
 - Tobacco use includes smoking or chewing tobacco
 - Prescription and over-the-counter
 - Bupropion HCl tab SR (12 hours, 150 milligrams)
 - Generic nicotine gum, lozenge and transdermal patch
 - Nicotine inhaler system (Nicotrol® Inhaler)
 - Nicotine nasal spray (Nicotrol® NS)
 - Varenicline tab (Chantix®)

- Statins for Cholesterol
 - For adults age 40 to 75 years who are at risk of serious heart and blood vessel problems
 - Certain generic low to moderate intensity statins

Non-ACA Preventive Prescription Drugs Subject to Copays or Coinsurance

Other preventive (non-ACA) prescription drugs require copays or coinsurance but are not subject to the deductible and may be applicable to your plan.

The prescription drugs classified as preventive are subject to change; other rules and limitations related to dosage, age and quantities may apply. You should contact CVS Caremark at 1-877-264-2955 or visit www.caremark.com for more information and to confirm if a prescription drug is considered preventive.

CVS Specialty Pharmacy Services

Specialty prescription drugs are defined as certain pharmaceutical and/or biotech or biological prescription drugs (including “biosimilars” or “follow-on biologics”) which are used in the management of chronic or genetic disease, including but not limited to injectables, infused, inhaled or oral prescription drugs, or prescription drugs that otherwise require special handling. CVS Specialty Pharmacy, a designated dispensing entity, is the preferred specialty pharmacy under the plan. In some states other non-CVS pharmacies may also be preferred specialty pharmacies. A list of prescription drugs that must be dispensed by CVS Specialty Pharmacy can be found at www.caremark.com. The list is subject to change.

In general, the prescription drugs on the specialty pharmacy list will not be covered at any pharmacy except for CVS Specialty Pharmacy, regardless of their medical necessity, their approval, or if you have a prescription from a physician or other provider. In limited circumstances, coverage may be allowed through an alternate provider. Those circumstances may include:

- Specialty prescription drugs billed by a facility as part of an inpatient hospital stay*
- Specialty prescription drugs billed as part of an emergency room visit*
- Situations where Medicare is the primary carrier*
- Limited distribution specialty drugs where CVS Caremark does not have access to the prescription drug

* Prior approval may be required through your medical provider.

Prior authorization and specialty preferred prescription drug plan design management may be required regardless of the benefit under which the prescription drug is covered or the identity of the provider who is administering the prescription drug. See the section “Prior Authorization” for more information.

In addition, for designated specialty prescription drugs where coverage is still allowed under the medical benefit, the prescription drug, prescription drug dosage and site of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

To contact CVS Specialty Pharmacy, please call Specialty Customer Care at 1-800-237-2767 between 7:30 a.m. and 9:00 p.m., Eastern Time, Monday through Friday, and between 9:00 a.m. and 4:00 p.m., Eastern Time on Saturday.

Financial assistance with PrudentRx – Traditional Copay medical option

If you're enrolled in the Traditional Copay medical option, you may be eligible for the PrudentRx pharmacy program. The PrudentRx Solution assists members in managing the high cost of specialty drugs by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% coinsurance, after satisfaction of any applicable deductible. However, members participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications – in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications, thereby reducing their out-of-pocket expenses. Participation in the program requires certain data be shared with the administrators of these copay assistance programs, but this is done in compliance with HIPAA privacy requirements.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication. If you do not call, PrudentRx will reach out to you to answer any questions and help get you enrolled. If you opt out of the program, you must call 1-800-578-4403. You will then be responsible for the 30% coinsurance on your specialty medications that are eligible for the PrudentRx Solution.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your deductible (if any) or out-of-pocket maximum, unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act will not count toward your deductible or out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. To get more information about drugs not considered "essential health benefits" and any exception process available, as well as to learn more about the PrudentRx Solution, contact PrudentRx at 1-800-578-4403.

When You Need to File a Claim Form

If, for some reason, you are filling a prescription and you do not have your ID card with you and you need to obtain a prescription drug from a participating in-network retail pharmacy, you may be required to pay the full cost of the prescription drug and submit a claim form for reimbursement. You will also need to file a claim form for reimbursement if you go to a non-participating pharmacy to have a prescription filled. You may submit a paper claim form along with original receipts within 12 months from the date of service directly to CVS Caremark for reimbursement of any covered expenses.

To obtain a claim form, call CVS Caremark's toll-free Customer Care line at 1-877-264-2955 or visit www.caremark.com. You should submit your claim form to:

CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

Your claim will be reimbursed according to the regular cost-sharing provisions of your prescription drug coverage as described in this summary.

Limitations

If you are uncertain whether the prescription drug your physician has prescribed is covered under the CVS Caremark prescription drug coverage, please call CVS Caremark at 1-877-264-2955 to confirm. Or visit the website, www.caremark.com.

Supply Limits

Certain prescription drugs are subject to supply limits based on CVS Caremark's criteria. Supply limits, which are subject to periodic review and modification by CVS Caremark, may restrict the amount dispensed per prescription order or refill and/or the amount dispensed for each supply. Limits are based on manufacturer-suggested prescribing guidelines and may change from time to time. This does not affect the day supply limits which are part of the plan design and would only change if the plan design is changed. Currently the days supply limit in place is up to a 30-day supply at any in-network retail pharmacy and, for maintenance prescription drugs, up to a 90-day supply by mail through CVS Mail Service or at a local CVS Pharmacy, and up to a 30-day supply for specialty prescription drugs. Certain specialty prescription drugs may be eligible to be filled for up to a 90-day supply via CVS Mail Service. You may obtain information on maximum dispensing limits by either visiting www.caremark.com or by contacting CVS Caremark at 1-877-264-2955.

Quantity Management

To help promote safe and effective prescription drug therapy consistent with plan limits, certain prescription drugs may have quantity restrictions. These quantity restrictions are based on product labelling or clinical guidelines and are subject to periodic review and change. Examples include prescription anti-migraine drugs, rheumatoid arthritis drugs, sleep aids, and pain management drugs.

Prior Authorization

For certain prescription drugs, CVS Caremark prescription drug coverage requires a coverage review or "prior authorization" by CVS Caremark before benefits will be paid. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective.

There are other prescription drugs that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, CVS Caremark asks your doctor for more information than what is on the prescription before the medication may be covered under your plan.

The list of prescription drugs that require prior authorization will change from time to time. Prescription drugs that do not require prior authorization may require it in the future. To find out whether a prescription drug requires prior authorization, follow these steps:

1. Log in to www.caremark.com
2. Click "Understand My Plan & Benefits" at the top
3. Click "Check Drug Cost & Coverage"
4. Enter the prescription drug name and any other information required

Prior authorizations are typically approved for a one-year period, unless otherwise noted. Your physician may call CVS Caremark at 1-877-264-2955 to request a prior authorization approval.

Prescription drugs may also require a coverage review (prior authorization) based on:

- Whether certain criteria have been met, such as age, sex or condition and/or
- Whether treatment of an alternate therapy or course of treatment has failed or is not appropriate

In either of these instances, CVS Caremark pharmacists will review the prescription to ensure all criteria required for certain prescription drugs have been met. If the criteria have not been met, a coverage review will be required. If so, CVS Caremark will automatically notify the pharmacist, who in turn will tell you the prescription needs to be reviewed for prior authorization.

Step Therapy Requirements

Step therapy is a program designed to help save money by using the most cost-effective clinically appropriate treatments. It requires certain individuals first try a generic prescription drug or in some cases, a brand-name prescription drug to treat their medical condition. Then, based on your doctor's review, if necessary, move to a specific brand-name prescription drug. However, if a brand-name prescription drug is dispensed and there is a generic available, you will pay the tier 1 (typically generic) copay plus the cost difference between the generic and the brand-name prescription drug. Some of the prescription drugs needing prior authorization also fall into this step therapy program. Please contact CVS Caremark Customer Care at 1-877-264-2955 for more specific information on the program.

Prescription Drugs That Are Not Covered

The following are not covered under the CVS Caremark prescription drug coverage:

- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for diabetes management), support garments, ostomy supplies, durable medical equipment and non-medical substances regardless of intended use
- Any over-the-counter medication, unless otherwise specified
- Blood products and blood serum
- Experimental medications since they are not FDA approved
- Medications used for cosmetic purposes
- Medications used for weight loss
- Medications used for fertility
- Prescription drugs that are excluded by the Formulary
- Medical devices, e.g., artificial saliva, wound dressings, and some dermatologicals
- Medications used for abortion services
- Over-the-counter and nutritional supplements
- Respiratory supplies, e.g., nebulizers
- Select high-cost drugs that provide little clinical benefit or value may be excluded from coverage. This list is subject to change.

Prescription Drug Coverage Provided by Your Ames Construction, Inc. Medical Plan

Prescription drugs that are dispensed to you while in a hospital, either as an inpatient or as an outpatient at an approved outpatient facility, or while a patient in your doctor's office, are covered under your Ames Construction, Inc. medical plan. You must follow normal medical plan claim procedures for reimbursement for these prescription drugs.

How to Reach Your Provider

Plan	Telephone Number	Website Address
CVS Caremark Prescription Drug Coverage	1-877-264-2955	www.caremark.com

Claims Procedures

You must use and exhaust this plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

Ames Construction, Inc., as plan sponsor, has delegated claims and appeal authority for this pharmacy plan to CVS Caremark. CVS Caremark, acting on behalf of Ames Construction, Inc., will provide the following claims and appeals review services:

- Prior authorization review and coverage review services
- Pre-service claims and appeals review services
- Post-service claims and appeals review services
- Urgent care claims and appeals services

CVS Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit claims arising under the plan, first-level review of appeals of pre-service clinical claims, and review of post-service clinical claims and administrative denials. CVS Caremark shall have, on behalf of the plan, sole and complete discretionary authority to determine these claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level medical necessity review performed by an IRO (as defined below).

Definitions

The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

Administrative Denial – An adverse benefit determination which is based solely on the terms of the plan, including the preferred drug lists or formularies selected by the plan, and which does not involve a determination of medical necessity.

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 utilization 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.

Claim – A request for a plan benefit that is made in accordance with a plan's established procedures for filing benefit claims.

Medically Necessary (medical necessity) – Medications, health care services or products are considered medically necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed, and

- Use of the medication, service or product is not solely for the convenience of the member, member's family, or provider.

Post-Service Claim – A claim for a plan benefit that is not a pre-service claim.

Pre-Authorization – CVS Caremark's pre-service review of a member's initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria (provided by the plan) to determine whether there is need for the requested medication.

Pre-Service Claim – A claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-service claims include member requests for prior-authorization.

Prior Authorization – CVS Caremark's pre-service review of a member's initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria (provided by Ames Construction, Inc.) to determine whether there is need for the requested medication.

Urgent Care Claim – A claim for a medication, service, or product where a delay in processing the claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the member's attending health care provider as to whether or not the member's claim constitutes an urgent care claim.

The CVS Caremark Claims and Appeals Process

Pre-Authorization Review

CVS Caremark will implement the prescription drug cost containment programs requested by the plan by comparing member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medications or prescription benefits before those prescriptions are filled. If CVS Caremark determines that the member's request for pre-authorization cannot be approved, that determination will constitute an adverse benefit determination.

Review Against the Plan's Terms

A member's request for a particular drug or benefit will be compared against the preferred drug lists or formularies selected by the plan before the member's prescription is filled. If CVS Caremark determines that the member's request for a drug or benefit cannot be approved based on the terms of the plan, including the preferred drug lists or formularies selected by the plan, that determination will constitute an administrative denial.

Responding to Your Initial Claim

Urgent Care Claims: The claims administrator will notify you of its benefit determination (whether adverse or not) within 72 hours after receipt of a claim initiated for urgent care. A decision can be provided to you orally, as long as written or electronic notification is provided to you within three days after the oral notification.

If you fail to provide the claims administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the claims administrator must notify you within 24 hours of receiving your urgent care claim of the specific information needed to

complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The claims administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours — provided the request is made at least 24 hours before the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

Pre-Service and Post-Service Claims:

- For **pre-service claims** (claims that require approval of the benefit before medical care is provided), the claims administrator will notify you of its benefit determination (whether adverse or not) within 15 days after receipt of the claim.
- For **post-service claims** (claims that are submitted for payment after you receive care), the claims administrator will notify you of an adverse benefit determination within 30 days after receipt of the claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.
- For **pre- and post-service claims**, the claims administrator may be allowed a 15-day extension to make a determination, provided the plan administrator determines the extension is necessary due to matters beyond its control. If such an extension is necessary, the claims administrator must notify you before the end of the first 15- or 30-day period of the reason(s) for the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information needed to decide the claim, the notice of extension must *also* specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **pre- and post-service claims** due to your failure to submit necessary information, the plan's time frame for making a benefit determination is stopped from the date the claims administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided

within five days following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, or
- Is a communication that names you, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

If You Receive an Adverse Benefit Determination: The claims administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reasons for the denial
- Information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount (if applicable)
- The specific plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan's standard, if any, used in denying the claim and, in the case of a final adverse determination, a discussion of the decision
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary
- A description of the plan's internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above and that copies of the applicable material will be provided upon request, free of charge
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge
- For a claims denial involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

If you have any questions about a denied claim, contact the claims administrator.

Appeals of Adverse Benefit Determinations

If an adverse benefit determination is rendered on the member's claim, the member may file an appeal of that determination. The member's appeal of the adverse benefit determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, the member and/or the member's attending physician may submit an appeal by calling CVS Caremark.

The member's appeal should include the following information:

- Name of the person the appeal is being filed for

- CVS Caremark identification number
- Date of birth
- Written statement of the issue(s) being appealed
- Drug name(s) being requested, and
- Written comments, documents, records or other information relating to the claim.

The member's appeal and supporting documentation may be mailed or faxed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-866-443-1183.

CVS Caremark's Review

The review of a member's claim or appeal of an adverse benefit determination will be conducted in accordance with the requirements of ERISA and any related laws. Members will be accorded all rights granted to them under ERISA and any related laws.

Review of Adverse Benefit Determinations of Pre-Service Clinical Claims

CVS Caremark will provide the first-level review of appeals of pre-service clinical claims. Such claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the member's first-level appeal is denied, the member may appeal CVS Caremark's decision and request an additional second-level medical necessity review. The review of whether the requested drug or benefit is medically necessary will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

CVS Caremark provides a single level of appeal for administrative denials. Upon receipt of such an appeal, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the plan, including preferred drug lists or formularies selected by the plan.

Timing of Review

Pre-Authorization Review – CVS Caremark will make a decision on a pre-authorization request for a plan benefit within 15 days after it receives the request. If the request relates to an urgent care claim, CVS Caremark will make a decision on the claim within 72 hours.

Pre-Service Clinical Claim Appeal – CVS Caremark will make a decision on a first-level appeal of an adverse benefit determination rendered on a pre-service clinical claim within 15 days after it receives the member's appeal. If CVS Caremark renders an adverse benefit determination on the first-level appeal of the pre-service claim, the member may appeal that decision by providing the information described above. A decision on the member's second-level appeal of the adverse

benefit determination will be made (by the IRO) within 15 days after the new appeal is received. If the member is appealing an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first- and second-level appeals, combined).

Administrative Denial or Post-Service Claim Appeal – CVS Caremark will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim or on an administrative denial within 30 days after it receives such appeal.

Scope of Review

During its pre-authorization review, first-level review of the appeal of a pre-service clinical claim, or review of a post-service claim or administrative denial, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member 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 benefits determination is made in accordance with the applicable plan documents
- Follow reasonable procedures to ensure that the applicable plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members, and
- Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If a member appeals CVS Caremark's denial of a pre-service clinical claim, and requests an additional second-level medical necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual)
- Identify the health care professional, if any, whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, and
- Provide for an expedited review process for urgent care claims.

Notice of Adverse Benefit Determination

Following the review of a member's claim, CVS Caremark will notify the member of any adverse benefit determination in writing. (Decisions on urgent care claims will also be communicated by telephone.) This notice will include:

- The specific reason or reasons for the adverse benefit determination
- References to pertinent plan provisions on which the adverse benefit determination was based
- A statement that the member is entitled to receive and access, upon written request and free of charge, copies of all documents, records and other information relevant to the claim
- A description of the plan's internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, and your right to bring a civil action in federal court following a claims denial on review

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion will be provided free of charge upon written request, and
- If the adverse benefit determination is based on a medical necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

If you have any questions about a denied claim, contact the claims administrator.

Authority as Claims Fiduciary

CVS Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit claims arising under the plan, first-level review of appeals of pre-service clinical claims, and review of post-service claims and administrative denials. CVS Caremark shall have, on behalf of the plan, sole and complete discretionary authority to determine these claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level medical necessity review performed by an IRO.

CVS Caremark ACA-Mandated External Review Procedures

The ACA imposed external review requirements on group health plans and insurers. These requirements, described in this section, are in addition to any internal appeals requirements described earlier in this summary. Under the ACA, a plan member who receives a "final internal adverse determination" (as defined below) of a claim for prescription drug benefits may be permitted to further appeal that denial using the ACA-mandated external review process. The ACA-mandated external review process provides plan members with another option for protesting the denial of their claims. Before the enactment of the ACA, in many cases, a member's only option for protesting a final internal adverse determination of a claim for benefits was to bring a lawsuit in court.

CVS Caremark Federal External Review Services

CVS Caremark administers the federal external review process as described in this section.

Definitions

The following terms are used herein to describe the federal external 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. Such denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) may apply only to clinical (medical) determinations.

Claim – A request for a plan benefit that is made in accordance with the plan's established procedures for filing benefit claims.

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.

Independent review organization (IRO) – An entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to the requirements of the ACA.

Claim involving medical judgment – A claim for prescription drug benefits involving, but not limited to, decisions based on the plan’s standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

Federal External Review Process (Non-Expedited)

Request for Review: A plan member whose claim involving medical judgment is denied, may request, in writing, an external review of such claim within four months after receiving notice of the final internal adverse benefit determination. The member’s request should include the member’s name, contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial. The member’s request for external review and supporting documentation may be mailed or faxed to CVS Caremark at:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax number: 1-866-689-3092

Preliminary Review: Within five days of receiving a plan member’s request for external review, CVS Caremark will conduct a “preliminary review” to ensure that the request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

- The member is or was covered under the plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided
- The adverse benefit determination or final internal adverse benefit determination does not relate to the member’s failure to meet the plan’s requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for the federal external review
- The member has exhausted the plan’s internal appeals process (unless the member’s claim is “deemed exhausted” under the ACA), and
- The member has provided all the information and forms necessary to process the external review.

In addition, CVS Caremark will review the member’s request for external review to determine whether it involves a claim involving medical judgment.

If CVS Caremark determines 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 involving medical judgment as soon as possible. Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that: i) the member’s request for external review is complete and may proceed, ii) the request is not complete and additional information is needed

(along with a list of the information needed to complete the request), or iii) the request for external review is complete, but not eligible for review.

Referral to IRO: If the member's request for external review is complete and the member's claim is eligible for external review, CVS Caremark will assign the request to one of the IRO's with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have ten 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 on behalf of the plan. The IRO may consider information beyond the records for the member's denied claim, such as:

- The member's medical records
- The attending health care professional's recommendations
- Reports from the appropriate health care professionals and other documents submitted by the plan, the member or the member's treating physician
- The terms of the 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 on behalf of the plan (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 all information and documents applicable to the member's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of IRO's Determination: The IRO will provide the member 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.

The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if available) and the reasons for the previous denials)
- The date the IRO received the external review assignment from CVS Caremark and the date of the IRO's decision
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards the IRO considered in making its determination
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied upon by the IRO in making its decision
- A statement the determination is binding except to the extent that other remedies may be available under state or federal law to either the plan or to the member
- A statement the member may still be eligible to seek judicial review of any adverse external review determination, and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist the member.

Reversal of the plan's Prior Decision: If CVS Caremark, acting on the plan's behalf, receives notice from the IRO that it has reversed the prior adverse determination of the member's claim, CVS Caremark will immediately provide coverage or payment for the claim.

Federal External Review Process (Expedited)

A member may request an expedited external review:

- If the member receives 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
- If the member receives a final internal adverse benefit determination related to a claim involving medical judgment that involves i) a medical condition for which the timeframe 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.

Request for Review: If the member's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the member or the member's physician may request an expedited external review by calling the Customer Care toll-free number on the member's benefit ID card. The request should include the member's name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited external review may be faxed; member contact information, coverage denial description and supporting documentation may be faxed to the attention of the CVS Caremark External Review Appeals Department at fax number 1-866-689-3092. All requests for expedited review must be clearly identified as "urgent" at submission.

Preliminary Review: Immediately on receipt of a member's request for expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify the member that i) the member's request for external review is complete and may proceed, ii) the request is not complete and additional information is needed (along with a list of the information needed to complete the request, or iii) the request for external review is complete, but not eligible for review.

Referral to IRO: Upon determining that a member's request is eligible for expedited external review, CVS Caremark will assign an IRO to review the member's claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the member's claim de novo and will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeals process.

Timing of the IRO's Determination: The IRO must provide the member and CVS Caremark, on behalf of the plan, with notice of its determination as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member's request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the member and CVS Caremark, on behalf of the plan, with written confirmation of its decision.

Authority for Review: CVS Caremark will be responsible only for conducting the preliminary review of a member's request for external review, ensuring the member is timely notified of the decision as to eligibility for external review and for assigning the request for external review to an IRO.

The actual external review of a member's appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the external review performed by an IRO.

Requirement to File an Appeal before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless filed within two years of the plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the plan. If your health benefit plan is sponsored by your employer and subject to ERISA and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.