



**STATE OF CONNECTICUT
PARTNERSHIP PHARMACY BENEFIT PLAN DOCUMENT**

**AS MADE AVAILABLE TO
PARTICIPATING EMPLOYER GROUPS**

Restated as of January 1, 2016

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INTRODUCTION

This document describes the State of Connecticut Partnership Plan Prescription Drug benefits (“Benefit Plan”) as made available to Participating Employers for their employees, retirees and eligible Dependents. The Benefit Plan is a self-funded governmental pharmacy benefit plan that is not subject to the Employee Retirement Income Security Act, known as ERISA. This Plan Document explains the benefits, exclusions, limitations, terms and conditions of membership, and the guidelines which must be followed to obtain benefits for Covered Services. All the defined terms used in this Plan Document have been capitalized and have the meanings set forth below.

This document is restated as of January 1, 2016, and replaces any Plan Document, contract, policy or program of the same or similar coverage that the Plan Sponsor may have issued prior to the effective date of this Plan Document. Amendments to this Plan Document may occur, as approved by the State of Connecticut, and the effective date of such changes shall be noted.

The State of Connecticut has engaged CVS Caremark to act as administrator for its Pharmacy Benefit Plan, as made available to Participating Employers in the State of Connecticut Partnership Plan. For Medicare-Eligible Retirees and their Medicare-Eligible dependents SilverScript Insurance Company, a subsidiary of CVS Caremark, administers an Employer Group Waiver Plan (“EGWP”) under Title I of the Medicare Prescription Drug Improvement and Modernization Act. For Medicare enrollees CVS Caremark will provide benefits to the extent that Coverage for such Services is not provided under Medicare Parts B or D.

As a Participating Employer, a municipality, political subdivision or board of education that has chosen to join the State of Connecticut Partnership Plan is bound by the terms and provisions of the Plan. The Participating Employer is responsible for determining eligibility for coverage for its employees, retirees and their dependents as set forth in Section IV, and the Addendum hereto, subject to the right of the Plan Sponsor to ensure the Participating Employer’s compliance with the conditions under which its participation in the Partnership Plan was approved.

As Plan Sponsor, the State of Connecticut, acting by and through the Office of the State Comptroller, has complete discretionary, binding and final authority, to interpret ambiguous Plan language, to implement prior authorization and safety requirements, to make factual determinations regarding the payment of Claims or provision of benefits, to review denied Claims and to resolve complaints by Plan Participants. Such authority has been delegated to CVS Caremark for the purpose of initial claims processing, administration of prior authorization and medical necessity reviews, review of denied claims, and appeals adjudication.

All notices to the Plan Sponsor should be directed as follows:

State of Connecticut Health Benefit Plan
c/o Office of the State Comptroller
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06016

CONTACT INFORMATION

CVS Customer Service Active Employees & Non-Medicare Retirees

For information and assistance, a Member may call CVS Caremark. The telephone number for Customer Services is printed on the Member's Identification Card, and written below:

Customer Service Telephone: 1-800-318-2572.

Customer Service Hours: 24 hours a day

Web-site Address: www.caremark.com

SilverScript Customer Service Medicare Retirees

Customer Service Telephone: 866-693-4624

Customer Service Hours: 24 hours per day

Web-site Address: <http://stateofconnecticut.silverscript.com>

Please see the Schedule of Prescription Drug Benefits for the applicable Co-payments that are your responsibility.

Please see Exhibit A for a list of medications that have quantity limits and/or require Prior Authorization.

II. SCHEDULE OF PRESCRIPTION DRUG BENEFITS

A Member's rights to benefits for Covered Drugs as provided in this Plan Document are subject to the terms and conditions of the agreement between the State of Connecticut and CVS Caremark.

Active Employee Plans—Co-payments and Cost Shares				
Active Employees	Acute Medications Participating Retail	Acute Medications Non-Participating Pharmacy	Maintenance Medications (Mail Order Required after 1st 30-day fill at retail)*	Health Enhancement Program Members ***Chronic Condition-Related Maintenance Medications At Mail Order
Generic	\$5.00	20%	\$5.00	\$0.00
Preferred	\$20.00	20%	\$10.00	\$5.00
Non Preferred	\$35.00	20%	\$25.00	\$12.50
Contraceptives**	\$0.00	N/A	\$0.00	\$0.00
Day Supply Limit	30	30	90	90

*Use of Mail Order or CT Maintenance Drug Network Pharmacy required for a 90-day refill of Maintenance Medications

** Treated as Maintenance Medication (single fill of first prescription only at retail)

*** Asthma/COPD, Heart Failure/Heart Disease, Hyperlipidemia and Hypertension and Diabetes

Retiree Plans—Co-payments and Cost Shares:				
Retirees	Acute Medications Participating Retail	Acute Medications Non-Participating Pharmacy	Maintenance Medications (Mail Order Required after 1st 30-day fill at retail)*	Health Enhancement Program Members ***Chronic Condition-Related Maintenance Medications At Mail Order
Generic	\$5.00	20%	\$5.00	\$0.00
Preferred	\$20.00	20%	\$10.00	\$5.00
Non Preferred	\$35.00	20%	\$25.00	\$12.50
Contraceptives**	\$0.00	N/A	\$0.00	\$0.00
Day Supply Limit	30	30	90	90

* Includes refills obtained at pharmacies participating in the State of CT Maintenance Drug Network.

** Treated as Maintenance Medication (single fill of first prescription only at retail)

*** Asthma/COPD, Heart Failure/Heart Disease, Hyperlipidemia and Hypertension and Diabetes

RULES APPLICABLE TO ALL PLANS	
Brand Drugs as substitutes for available Generic Drugs	The same co-payment you would pay for a Generic Drug, plus the difference in price between the Generic Drug and the Brand Drug ♦
Generic Substitution	Required unless Prescribing Physician submits a Coverage Exception Request, attesting that Brand Drug is Medically Necessary
Non-Preferred Drug utilization	Higher co-pay required unless Prescribing Physician submits a Coverage Exception Request attesting that Non-Preferred Brand is Medically Necessary
Prior Authorizations and Other Clinical Programs	Required for Certain Drugs—See Exhibit A
Quantity Limits	Required for Certain Drugs—See Exhibit A
Benefit Period	One Calendar Year
Diabetes Co-pay	None
Chronic Conditions Health Enhancement Program	Co-pays may be waived or reduced for medications to treat: Asthma, Diabetes, COPD, Hyperlipidemia, Hypertension, heart failure or heart disease
Refill Policy	Per Plan Sponsor standard guidelines
Specialty Drugs	Can be dispensed at any retail pharmacy and are not limited to mail or participating Maintenance Drug Network pharmacies ; maintenance drug copays apply to 90 day supplies
Formulary	CVS Caremark Preferred Drug List
Maximum out of Pocket per Year	\$4600 Individual/ \$9200 Family

♦If the Co-payment is greater than the Maximum Allowable Amount (see definition below) or the billed charge for the medication, the Member will pay the lower amount.

COVERED BENEFITS

Prescription Drugs
Maintenance Prescription Drugs
Certain Preventive Medications
Specialty Drugs

BENEFITS BY PHARMACY TYPE

Participating Retail Pharmacy Benefits

When a Covered Drug is dispensed by a Participating Pharmacy, the Participating Pharmacy will accept the Maximum Allowable Amount and will make no charge to the Member except for any applicable Co-payment or Cost-Share. Payment will be made to the Participating Pharmacy by CVS Caremark, except for Co-payments or Cost-Shares that are payable by Member at the Participating Pharmacy.

Non-Participating Pharmacy Benefits

When a Covered Drug is dispensed by a Non-Participating Retail Pharmacy the Member shall pay for the prescription out-of-pocket, and then will be reimbursed upon submitting a proper claim for reimbursement to CVS Caremark. Reimbursement is only available for Covered Services less any applicable Co-payment or Cost-Share, after review and approval of the claim. Reimbursement is based on the Maximum Allowable Amount (defined below) for Non-Participating Pharmacies. Claims must be filed with CVS Caremark within 2 years after the prescription for the Covered Drug has been filled. The receipt must accompany the claim.

Maintenance Medications (Mandatory Mail Order, CVS/Caremark or Maintenance Drug Network Service)

Use of Caremark's Mail Order Service or the State of Connecticut Maintenance Drug network is mandatory for 31-90-day fills of Maintenance Drugs for Active Employees and retired Members under the age of 65. A Member will get one 30-day fill of a new Maintenance Drug at retail. Thereafter, all refills for Maintenance Drugs must be dispensed by (1) the CVS Mail Order Service; (2) a CVS retail Pharmacy; or (3) a retail pharmacy that that has agreed to process Maintenance Medications for Members of the State of Connecticut Pharmacy Benefit Plan (Maintenance Drug Network). A list of pharmacies participating in the network is found at www.caremark.com. The Member will get a 90-day fill of a Maintenance Medication for single co-pay.

III. DEFINITIONS

BENEFIT PERIOD: The period of time that we pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

BRAND NAME PRESCRIPTION DRUG:

The term Brand Name Prescription Drug means a Prescription Drug that has a proprietary or trade name selected by the manufacturer and that is used to describe and identify it and which appears on its container, label or wrapping at the time of packaging.

CALENDAR YEAR: The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CIVIL UNION PARTNER: The term Civil Union Partner means a same sex partner of the Covered Person who has joined with the Covered Person in a certified civil union.

CODE: The term Code means the Internal Revenue Code of 1986, as amended or replaced from time to time. Reference to any section or subsection of the Code includes references to any regulations thereunder and any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

COMPOUNDING: The term Compounding means combining, mixing, or altering the ingredients of one or more drugs or products to create another drug or product.

CO-PAYMENT: The term Co-payment means an amount that the Member is required to pay for Covered Services, which may be either (a) a fixed amount per prescription or (b) a percentage of the Maximum Allowable Amount for the prescription. This fee is in addition to premium equivalents paid by and on behalf of the Member and is payable by a Member for Covered Services at the time that those services are rendered. Co-payments are listed in the Schedule of Prescription Drug Benefits.

COST-SHARE: The term Cost-Share means the amount that the Member is required to pay for Covered Services.

COVERED DRUG: The term Covered Drug means a Medically Necessary Prescription Drug or Maintenance Prescription Drug or certain Preventive Medications, as defined below.

A Covered Drug includes any of the following:

Any Prescription Drug or Maintenance Prescription Drug that is not excluded under this Benefit Program;

Injectable insulin;

Any medicine which a Pharmacy compounds (at least one ingredient of which is a

Prescription Drug) and which is not excluded under this Benefit Program. This includes refills of Covered Drugs; or

Preventive Medications, as defined below.

In addition, in order to be a Covered Drug, the Prescription Drug or Maintenance Prescription Drug must be ordered by a duly licensed physician or other licensed health care practitioner acting within the scope of his or her license.

Any Prescription Drug that requires federal or other governmental agency approval not granted at the time the Prescription Drug was prescribed, or any drug that is approved by the Food and Drug Administration (FDA) for controlled studies only is not a Covered Drug.

COVERED PERSON: The term Covered Person means a person who becomes eligible for Covered Services under this Pharmacy Benefit Plan by virtue of past or present employment with the Participating Employer and whom the Participating Employer has enrolled in this Pharmacy Benefit Plan and in whose name an Identification Card is issued.

COVERED SERVICE(S): The term Covered Service(s) means Prescription Drugs and related products that are Medically Necessary, are described in this Plan Document, and are not listed in Section VI (Exclusions and Limitations) of this Plan Document.

DATE OF PLACEMENT: The term Date of Placement means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of adoption of the child.

DEPENDENT: The term Dependent means a Covered Person's lawful spouse under a legally valid existing marriage, a Covered Person's Civil Union Partner under a legally valid civil union, and any child of either the Covered Person or his or her spouse who meets the requirements for coverage as set forth in Section IV of this Plan Document, including the Addendum hereto.

EFFECTIVE DATE: The term Effective Date means the date a Covered Person and his or her Covered Dependents, if any, are accepted by the Participating Employer and are eligible to receive benefits for Covered Services under this Pharmacy Benefit Plan.

EXPERIMENTAL OR INVESTIGATIONAL: The term "Experimental" or "Investigational" means services or supplies which include, but are not limited to, any treatment, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of the Plan Sponsor to be Experimental or Investigational.

In making its determination, the Plan Sponsor will deem a service or supply to be Experimental or Investigational if it satisfies one or more of the following criteria:

1. The service or supply does not have final approval by the appropriate government regulatory body or bodies, or such approval for marketing has not been given at the time the service or supply is furnished; or

2. A written informed consent form for the specific service or supply being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or
3. The services or supply is the subject of a protocol, protocols or clinical trial study, or is otherwise under study in determining its maximum tolerated toxicity dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III clinical trial of the federal Food and Drug Administration for the illness or condition being treated or the diagnosis for which they are being prescribed.

In addition, a service or supply may be deemed Experimental or Investigational based upon:

1. Published reports and articles in the authoritative medical, scientific and peer review literature; or
2. The written protocol or protocols used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FDA: The term "FDA" means the United States Food and Drug Administration.

FORMULARY: The term Formulary means the list of Brand Name Drugs that have been selected by the CVS Caremark Pharmacy and Therapeutics Committee for inclusion on its Preferred Drug List, which may be updated from time to time.

GENERIC PRESCRIPTION DRUG: The term Generic Prescription Drug means a Prescription Drug that is considered non-proprietary and is not protected by a trademark. It is required to meet the same bioequivalency test as the original Brand Name drug.

HEALTH ENHANCEMENT PROGRAM: The term Health Enhancement Program (HEP) is a health incentive program that rewards Members who commit to taking an active role in management of their health. Enrolled HEP Members may qualify for reduced co-pays for certain medications.

IDENTIFICATION CARD: A card issued by Caremark or, where applicable, by SilverScript to a Covered Person or Dependent for identification purposes which must be shown by the Member to obtain Covered Services.

LATE ENROLLEE: The term Late Enrollee means an eligible employee, retiree and/or

Dependent who requests enrollment following the Participating Employer's Open Enrollment Period Effective Date, if applicable, or more than 31 days after the employee's, retiree's and/or Dependent's earliest opportunity to enroll for coverage under any health benefit plan sponsored by the Participating Employer.

MAINTENANCE DRUG NETWORK: The term Maintenance Drug Network means a retail pharmacy that has agreed to process Prescribed Maintenance Medications for Members of the State of Connecticut Partnership Plan. Pharmacies in the network (which includes all CVS pharmacies) have agreed to accept the Maximum Allowable Amount and will make no charge to the Member except for any applicable Co-payment or Cost-Share.

MAINTENANCE PRESCRIPTION DRUG: The term Maintenance Prescription Drug means a Prescription Drug that is used on a continuing basis for the treatment of a chronic condition or illness, such as heart disease, high blood pressure, arthritis and/or diabetes. It may also include oral contraceptives and other medications used on a year-round basis.

MAXIMUM ALLOWABLE AMOUNT: The term Maximum Allowable Amount means except as otherwise required by law, either (a) an amount agreed upon by CVS Caremark and a Participating Pharmacy as full compensation for Covered Drugs dispensed to a Member; or (b) with respect to a Non-Participating Retail or Mail Order Pharmacy, an amount designated by CVS Caremark and based on the amount paid to a Participating Pharmacy for a particular medication. When applicable, it is the Member's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount. The amount the Plan Sponsor will pay for Covered Drugs will be the Maximum Allowable Amount or the billed charge, whichever is lower. The amount the Member will pay for Cost-Shares will be calculated on the basis of the Maximum Allowable Amount or the billed charges, whichever is lower.

Please note that the Maximum Allowable Amount may be greater or less than the Participating Pharmacy's billed charges for the Covered Drug.

MAXIMUM OUT OF POCKET

The term "Maximum Out of Pocket" means the most that a Covered Member would pay during a coverage period (usually one year) for his or her share of the cost of covered services. The following are not included in calculating the Maximum Out-of-Pocket: premiums, cost of medications the plan does not cover, and co-payments or cost-sharing.

MEDICALLY NECESSARY (MEDICAL NECESSITY): The term Medically Necessary (Medical Necessity) means a Prescription Drug or related item which is Prescribed by an appropriately licensed Physician or provider; and which may be a Covered Service which: a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that is: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that

patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

MEDICARE: The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

MEMBER: The term Member means either a Covered Person or Dependent enrolled in this Pharmacy Benefit Plan and eligible for benefits for Covered Services under this Pharmacy Benefit Plan.

MEMBERSHIP: The term "Membership" means the status of being a Member.

NON-PARTICIPATING PHARMACY: The term Non-Participating Pharmacy means any appropriately licensed Pharmacy that is not a Participating Pharmacy under the terms of this Pharmacy Benefit Plan.

OPEN ENROLLMENT PERIOD: The term Open Enrollment Period means the period of time during which the Participating Employer allows employees (or retirees) to select group health coverage for themselves or their Dependents.

ORAL CONTRACEPTIVE: The term Oral Contraceptive means a hormonal compound taken orally in order to block ovulation and prevent the occurrence of pregnancy.

PARTICIPATING EMPLOYER: The term Participating Employer means a municipality, political subdivision or board of education choosing to secure health benefit coverage under the Partnership Plan for its active and retired employees (if applicable) and their eligible Dependents as described herein, and as may be supplemented by the Addendum hereto.

PARTICIPATING PHARMACY: The term Participating Pharmacy means a Pharmacy accepted as a Participating Pharmacy by CVS Caremark to provide Covered Drugs to Members under the terms of this Pharmacy Benefit Plan.

PHARMACY: The term Pharmacy means a licensed retail establishment where Prescription Drugs or Maintenance Prescription Drugs are compounded and dispensed by a licensed pharmacist.

PHARMACY BENEFIT PLAN: The prescription drug component of the Partnership Plan as administered by CVS Caremark, or, as applicable that portion of the prescription drug component of the Plan administered by SilverScript for Medicare-eligible retirees.

PLAN: The term Plan means any of these which provides benefits or services for, or because of, medical or dental care or treatment.

(i) Group insurance or group-type coverage, whether insured or self-insured. This

includes prepayment, HMO, group practice or individual practice coverage, as well as insurance coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group; it does not include student accident or student accident & health coverage for which the student or parent pays the entire premium.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act as now constituted or later amended.

(iii) Medical benefits coverage of group, group-type and individual no-fault and traditional automobile fault contracts.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan.

PLAN DOCUMENT: The term Plan Document means this document, (including any Riders and amendments), which describes the rights, benefits, terms, conditions and limitations of the coverage available to Covered Persons and eligible Dependents.

PLAN SPONSOR: The term Plan Sponsor means the Office of the State Comptroller on behalf of the State of Connecticut.

PLAN YEAR: The term Plan Year means the 12-month period beginning on January 1 and ending on December 31.

PRESCRIPTION DRUG(S): The term Prescription Drug means insulin and those drugs, biologicals, and compounds which can be dispensed legally only upon written authorization by a Physician, which are required by law to bear the legend "Caution: Federal Law prohibits dispensing without a prescription," and which are listed in one or more of the following publications: United States Pharmacopeia, The National Formulary, or Accepted Dental Remedies.

PREVENTIVE MEDICATIONS: The term Preventive Medication means certain over-the-counter medications, which if prescribed by a licensed provider for a Member of the designated age/gender for the indicated circumstances or conditions shall be a Covered benefit under the Plan without Co-payment.

PRIOR AUTHORIZATION: The term Prior Authorization (Prior Authorized) means a prior approval that must be obtained from CVS Caremark **before** a Member is entitled to receive benefits for certain Covered Drugs.

PROOF: The term Proof means any information that may be required by CVS Caremark,

SilverScript or the Participating Employer in order to satisfactorily determine a Member's eligibility or compliance with any provision of this Pharmacy Benefit Plan.

SPECIALTY DRUG: The term Specialty Drug means an injectable or non-injectable biotech or biological drug prescribed by a Physician having one or more of several key characteristics, including:

1. Requirement for frequent dosing adjustments and intensive clinical monitoring;
2. Need for intensive patient training and compliance for effective treatment;
3. Limited or exclusive product distribution.

TOTALLY DISABLED: The term Totally Disabled means that due to an injury or disease the Covered Person is unable to perform the duties of any occupation for which he or she is suited by reason of education, training or experience. A Dependent shall be Totally Disabled if because of an injury or disease he or she is unable to engage in substantially all of the normal activities of persons of like age and sex in good health. CVS Caremark will determine if a Member is Totally Disabled and shall be entitled to request Proof of continued disability at least annually.

IV. ELIGIBILITY

The enrollment application and any other forms or statements as required by the Participating Employer must be received and accepted by CVS Caremark before the applicant shall be considered enrolled in Membership under the Pharmacy Benefit Plan. The Covered Person's and Dependent's right to coverage are subject to the condition that all information the Covered Person provides to the Participating Employer is true, correct and complete to the best of his or her knowledge and belief. The Covered Person is responsible for providing the Participating Employer with immediate notification of any changes that affect the eligibility of any Dependent as well as any change in the name, address or phone number of the Covered Person or his or her enrolled Dependent(s).

ELIGIBLE EMPLOYEES

Only current employees or, if applicable retired, employees of the Participating Employer who meet the Participating Employer's eligibility requirements for participation in its group health Plan, or former employees who choose to continue enrollment as allowed by the health insurance continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA provisions) may be enrolled in the Plan.

The following rules apply:

1. A newly hired employee must enroll in the group health Plan on or before the 31st day after he or she commences employment in order to be eligible to become a Covered Person.
2. The earliest date of Coverage for newly hired employees shall be the first day of the calendar month following the month in which the employee commences service.
3. Benefits under this Plan for Covered Persons are effective for all Covered Services except those for which the Plan is the Secondary Plan according to the Coordination of Benefits Section below.
4. If the employee/retiree is a Late Enrollee, he/she may only enroll at the next Open Enrollment.
5. Active and retired employees of the Participating Employer must be enrolled in the Participating Employer's group health Plan in order to become Covered Persons under the Plan.

ELIGIBLE DEPENDENTS

The following are eligible for Membership as Dependents under the Pharmacy Benefit Plan:

1. **Spouse or recognized Civil Union Partner**

The lawful spouse of the Covered Person under a legally valid, existing marriage or recognized Civil Union Partner as defined by the Plan Sponsor. Except as set forth in this section an individual from whom a Covered Person is divorced or legally separated is not eligible for coverage.

2. **Child of the Covered Person or Spouse**

A child of the Covered Person or spouse, including: a step-child of either, a child legally placed for adoption; a legally adopted child; or a child for whom the Covered Party has been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO), who is under the age of 26.

3. **Newborn Dependent Child**

Benefits for Covered Services under the Pharmacy Benefit Plan shall be provided for a newborn child of the Covered Person from the moment of birth,

To maintain coverage after 31 days following birth, a completed application for the newborn must be submitted within 31 days following the date of birth by the Covered Person, and accepted by the Participating Employer. Eligibility requirements must be met as specified in this Section.

Benefits for Covered Services for a newborn shall consist of Prescription Drugs and related products for treatment of injury or sickness, including Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, subject to the terms, conditions, exclusions and limitations of this Plan Document.

4. **A Newborn of an Enrolled Dependent Child**

A newborn child of an enrolled female Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 31 days immediately following birth, but is not eligible for enrollment beyond the 31-day period under the Pharmacy Benefit Plan.

5. **Totally Disabled Dependent Child**

A Totally Disabled Dependent child who is incapable of sustaining employment by reason of physical or mental handicap may continue as an enrolled Dependent or be eligible beyond the age limit set forth in the Pharmacy Benefit Plan, provided he or she:

- a. Is incapable of sustaining employment by reason of physical or mental handicap as certified by a Physician and for whom the Covered Person (or his or her spouse or Civil Union Partner) is chiefly responsible for support and maintenance; and

- b. Became disabled prior to the limiting age for a Dependent child and had comparable coverage as a Dependent at the time of enrollment; and
- c. If over the age of 26, is unmarried.

Proof of such incapacity and dependency must be received by the Participating Employer within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at that time or at the time of enrollment by a Physician and then no more than annually thereafter.

6. Qualified Medical Child Support Orders

A Dependent child may become eligible for benefits for Covered Services as a consequence of a domestic relations order issued by a state court to a divorced parent who is a Covered Person. Enrollment may be required even in circumstances in which the child was not previously enrolled in the Pharmacy Benefit Plan.

- 7. Dependents whose eligibility to participate has expired may elect to continue coverage in the Pharmacy Benefit Plan as required by applicable sections of the COBRA.

LATE ENROLLEE AND SPECIAL ENROLLMENT PERIODS

A Late Enrollee is an eligible employee, retiree, and/or Dependent who requests health insurance after the Participating Employer's Open Enrollment Period Effective Date, if applicable, or more than 31 days after the employee's and/or Dependent's earliest opportunity to enroll for coverage under any health benefit plan sponsored by Participating Employer. Late Enrollees will not be eligible for coverage except as provided herein. An eligible employee, retiree, and/or Dependent shall not be considered a Late Enrollee if a request for Membership is made and each of the following conditions is satisfied:

- 1. Coverage was not elected when the employee and/or Dependent was first eligible under the Pharmacy Benefit Plan solely because another group health benefit Plan provided coverage for the eligible employee, retiree, and/or Dependent; and
- 2. Coverage is lost under another group health plan due to exhaustion of continuation coverage under provisions of COBRA or state continuation coverage, employment termination, reduction in hours, death of a spouse, or divorce, or termination of the employer contribution toward the coverage being terminated or due to that Plan's involuntary termination or cancellation by its carrier or due to a substantial diminution of benefits or increase in the cost to the Covered Person, as determined solely by the Participating Employer; and
- 3. The Employee, retiree and/or Dependent enrolls under the Pharmacy Benefit Plan within 31 days after loss of coverage under the other Plan.

Special Enrollment Periods

A special enrollment period is allowed for newly acquired Dependents who have not been covered under other group coverage, following marriage, a birth, adoption or placement for adoption. Unless the Covered Person has coverage under the Pharmacy Benefit Plan that would cover the newly acquired Dependent *without* the payment of an additional premium on the date of the marriage, birth, adoption, Date of Placement, or other event that makes the new Dependent eligible for coverage, such new Dependents must be enrolled within thirty-one (31) days after the marriage, birth, adoption, Date of Placement, or other event that makes them eligible to enroll. Dependent children other than those described above are not eligible for the special enrollment period.

CHANGES AFFECTING ELIGIBILITY

It is the responsibility of the Covered Person to notify the Participating Employer of any change in the Dependent status of enrolled individuals within 31 days of the event or occurrence that renders such individual ineligible for continued coverage. Examples of such events include: a child's attainment of Age 26, or entry of a judgment of divorce or legal separation.

FAILURE TO PROVIDE NOTICE OF STATUS CHANGE

Any Covered Person who fails to provide notification of a change affecting the eligibility status of an enrolled Dependent will be subject to one or more of the following:

- An active Employee may be subject to disciplinary action if he or she enrolls or maintains an enrollment for a person who is not eligible for coverage as a Spouse or Dependent;
- The fair market value of health Benefit coverage provided to an ineligible individual will be reported to the Internal Revenue Service as income to the Covered Person; and
- The Participating Employer may seek to recover from the Covered Person the value of premiums advanced for coverage of an ineligible ex-spouse or Dependent.

Note: Family status changes are events that provide your former dependents with the right to continue medical coverage at their own expense for a limited period of time under a federal law known as COBRA. See Section XI below. Although the plan requires notification and termination of coverage for ineligible individuals within 31 days of the family status change, federal regulations give you and/or your dependent up to 60 days to notify the Participating Employer of the change in status in order to obtain COBRA continuation coverage. If notice of the change in family status is not provided within the 60-day period after the qualifying event, the Plan is not obligated to provide COBRA continuation coverage.

V. PRESCRIPTION DRUG BENEFITS

Subject to the Exclusions, Conditions and Limitations, and Schedules of Eligibility and Benefits in this Pharmacy Benefit Plan, a Member is entitled to benefits for Covered Drugs as described in this Section.

PARTICIPATING RETAIL PHARMACY BENEFITS

When a Covered Drug is dispensed by a Participating Retail or Participating Maintenance Drug Network Pharmacy, the Participating Pharmacy shall accept CVS Caremark's payment in full and shall make no charge to the Member except for any applicable Co-payment or other Cost-Share. Payment shall be made to the Participating Pharmacy by CVS Caremark. The Cost-Share is paid by the Member to the Pharmacy. Members may locate a Participating Pharmacy or Participating Maintenance Drug by calling the toll-free number listed on their Identification Card or visiting www.caremark.com. To obtain benefits, Members should show the Participating Pharmacy pharmacist their Identification Card.

NON-PARTICIPATING PHARMACY BENEFITS

When a Covered Drug is dispensed by a Non-Participating Pharmacy, the Member shall pay for the prescription out-of-pocket, and then will be reimbursed upon submitting a proper claim for reimbursement to CVS Caremark. Reimbursement is only available for Covered Services, and is subject to reduction for any applicable Cost-Share or Co-payment. Reimbursement is based on the Maximum Allowable Amount for Non-Participating Pharmacies. Claims must be filed with CVS Caremark within 2 years after the Covered Drug has been filled. The receipt must accompany the claim.

Members subject to mandatory Mail Order will only be reimbursed for the first 30-day supply of a Maintenance Prescription Drug that is dispensed by a Non-Participating Pharmacy or Non-Participating Maintenance Drug Network Pharmacy.

.MANDATORY PROGRAM FOR MAINTENANCE MEDICATIONS

For active employees and retirees under the age of 65 Mail Order is mandatory. All orders for a 31-90 day supply of a Maintenance Prescription Drug must be filled by one of the methods set forth below. Members will pay a reduced Cost Share, shown on the Schedule of Benefits, when they obtain Maintenance Prescription Drugs by:

- 1) Using the CVS Caremark Mail Order program (refer to the Mail Order program brochure included with Member materials or call the Dedicated Member Services Unit at 1-800-318-2572); or
- 2) Using any retail pharmacy participating in the State of Connecticut Maintenance Drug Pharmacy Network. This network includes all CVS Pharmacies, independent pharmacies, other pharmacy chains including those located in grocery store chains and large retailers. Members may locate a Participating Pharmacy by calling the toll-free number listed on

their Identification Card or by visiting www.caremark.com.

OPTIONAL MAIL ORDER PROGRAM FOR MEDICARE RETIREES

Members who are Medicare enrollees age 65 or older may—but are not required to—obtain a 31 to 90-day supply of a Maintenance Prescription Drug from the CVS Caremark Mail Order Program or from a CVS Caremark retail store or other retail pharmacy participating in the State of Connecticut Maintenance Drug Network. If they do so, co-pays for their medications will be waived, as shown on the Schedule of Prescription Drug Benefits. Details about the Mail Order program can be found in the brochure included with their Member materials, or by calling the Dedicated Member Services Unit at 1-800-318-2572.

COVERED SERVICES

Coverage is provided for Medically Necessary Prescription Drugs, Maintenance Prescription Drugs, and Certain Preventive Medications that (a) qualify as Covered Drugs, (b) are dispensed by a Pharmacy, and (c) are prescribed by a licensed practitioner of the healing arts operating within the scope of his or her particular license, subject to the Exclusions and Limitations set forth in Section VI of this Plan Document.

This Plan Covers:

1. Federal legend drugs;
2. Compounded medications when all of the following criteria are satisfied:
 - a. All active ingredients are federal legend drugs;
 - b. The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation unless medically necessary;
 - c. The compounded medication is specifically produced for use by a covered person to treat a covered condition;
 - d. The compounded medication, including all sterile compounded products, are made in compliance with Connecticut Statutes; and
 - e. Prior Authorization for such medication has been approved.

Note:

- Over-the-counter (OTC) products are not covered;
- Bulk powders, bulk chemicals, and propriety bases used in compounded medications are generally not covered subject to medical necessity review and appeal;
- Reconstitution of oral powders is not considered compounding; and
- The compounding pharmacist must bill the NDC of the product used in the quantity of final reconstituted volume.

Maximum Supply. Unless one of the **Special Exceptions** described below applies, the maximum supply of a Prescription Drug (other than a Maintenance Prescription Drug) for which benefits shall be provided when dispensed under any one prescription by retail establishment is a 30-day supply.¹ Thereafter, the maximum supply of a Maintenance Prescription Drug that can

¹ Certain Covered Drugs have specific quantity limits, as set forth on Exhibit A or as determined by state and federal statutes, FDA approved labeling for use and/or drug

be dispensed by Mail Order or by a pharmacy participating in the State of Connecticut Maintenance Drug Network is a 90-day supply.

Special Exceptions. There are certain circumstances when a Special Exception to the maximum supply limit may be appropriate. A Member may qualify for a Special Exception if the Member can demonstrate that it will be difficult or impossible for that Member to obtain Covered Drugs in a regular, timely and appropriate manner.

The Member should contact the Member Services/Customer Service Department at the number located on his or her Identification Card to determine the applicable specific quantity for Covered Drugs or whether, and to what extent, a Special Exception may be applicable under the circumstances. Such Special Exception may be approved for a maximum period of six (6) calendar months at one time.

Coverage for Contraceptive Medications. The Plan Covers provision of contraceptive medications for females for \$0.00 cost share. The 30-day supply of a new Contraceptive Medication may be filled at a Retail Pharmacy. Thereafter, refills of Contraceptive Medications must be filled as Maintenance Medications.

Coverage for Certain Preventive Medications: The following medications will be Covered Services when prescribed by a licensed provider for a Member within the designated age/gender for the indicated circumstances or conditions for \$0 Cost Share.

1. **Aspirin to Prevent Cardiovascular Disease (CVD): Men.** For men age 45 to 79 years, generic aspirin with dosages between 81 and 325 mg will be covered when prescribed by a licensed provider; **Women.** For women age 55 to 79 years generic aspirin with dosage between 81 and 325 mg will be covered when prescribed by a licensed provider.
2. **Iron Supplementation in Children:** Over the counter iron supplementation for asymptomatic children to the age of 1 will be covered when prescribed by a licensed provider.
3. **Supplementation with Folic Acid:** For women to age 55, a daily supplement containing 0.4 to 0.8 mg (400 to 800 MCG) of folic acid will be covered when prescribed by a licensed provider.
4. **Smoking Cessation—Adults:** Over-the-counter generic nicotine replacement products, will be covered when prescribed by a licensed provider.
5. **Chemoprevention of Dental Caries (Cavities):** For preschool children (between the ages of 6 months and up to 6 years of age) whose primary water source is deficient in

utilization review. Drug utilization review may include but is not limited to: drug-to-drug interaction screening, dosage-range screening, drug-of-preference screening, therapy protocol screening, gender and age-benefit screening, duration of use and monitoring of refills.

fluoride, oral forms of brand and generic fluoride will be covered when prescribed by a licensed provider in the following dosages: Sodium fluoride tab 0.5 mg; Sodium fluoride chew tab 0.25 - 0.5 mg, Sodium fluoride soln 0.125 ~ 0.25 mg/Drop, • Sodium fluoride soln 0.25 mg/0.6 ml; • Sodium fluoride soln 0.5 mg/ml.

6. Contraceptives and Emergency Contraception: Over-the-counter contraceptives and emergency contraception will be covered for females when prescribed by a licensed provider.

Covered Drugs Requiring Prior Authorization

A list of Covered Drugs that require Prior Authorization is attached as Exhibit A. The list of Covered Drugs for which Prior Authorization is required is subject to change, based upon (a) the existence of new FDA Approved Drug Products or Technologies; or (b) for FDA Approved Drug Products or Technologies, determinations after review by the CVS Caremark Prescription Pharmacy and Therapeutics Committee. The CVS Caremark Pharmacy and Therapeutics Committee will review these medications based on FDA approved indications and nationally recognized treatment guidelines.

As changes are made to this list in response to the availability of New FDA Approved Drug Products or Technologies, and/or review by the CVS Caremark Pharmacy and Therapeutics Committee, the Plan Sponsor will update the Plan Document. A Member may contact the Member Services/Customer Service Department at the number located on his or her Identification Card or CVS Caremark's website with any questions about Prescription Drugs that require Prior Authorization. The inclusion of a New FDA Approved Drug Product or Technology on the list of drugs requiring Prior Authorization is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in this Plan Document for information on coverage, limitations, and exclusions.

To Obtain Covered Drugs Requiring Prior Authorization

The Member or Member's representative must obtain Prior Authorization in order to receive benefits for certain Covered Drugs. When a Covered Drug that requires Prior Authorization is prescribed for a Member, the Member or the Member's representative must call CVS Caremark at 1-800-294-5979 or fax a written request for prior authorization to CVS Caremark, at 1-888-836-0730.

Upon receipt of the request for Prior Authorization, CVS Caremark will either:

- deny Prior Authorization for the Prescription Drug or
- Approve benefits for that Prescription Drug up to any specified quantity limit.

Duration of Prior Authorization

Once benefits for a drug requiring Prior Authorization have been approved (including coverage that results from an internal review or external appeal) the authorization will be effective for one calendar year from the date of coverage, after which point a new request for Prior Authorization of that drug must be submitted.

OTHER PRESCRIPTION DRUG BENEFIT PROVISIONS

1. The Plan may require a Member to furnish CVS Caremark with any information about the diagnosis of any injury or illness and about the nature, quality, and quantity of the Prescription Drug or Maintenance Prescription Drug prescribed, and may deny coverage if adequate information is not furnished.
2. The Plan Sponsor shall not be liable for any claims, injury, demand or judgment based on tort, product liability, or other grounds (including warranty of merchantability), arising out of the coverage, compounding, dispensing, manufacturing, or use of any Prescription Drug or Maintenance Prescription Drug dispensed under the provisions of this Pharmacy Benefit Plan.
3. When a Non-Maintenance Prescription Drug order or a Maintenance Prescription Drug order does not specify “No Substitution,” and the order is filled with a Brand Name drug at the request of the Member or Prescriber, even though a federally approved generic equivalent drug is available, the Member will be responsible for both the Generic Prescription Drug Co-payment amount, as shown on the Schedule of Prescription Drug Benefits, and the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug.
4. When a Brand Name Prescription Drug (for which a Generic Prescription Drug is available) is Medically Necessary to treat a Member’s specific injury or illness, the Prescriber must submit a completed Medical Necessity form to CVS Caremark by facsimile. If Medical Necessity is established, the Brand Name Drug will be dispensed without the Member being responsible for paying the difference in cost between the Generic and the Brand Name Prescription Drug.
5. In the event that no Generic Prescription Drug is available for the dispensing of a Non-Maintenance Prescription Drug, a Member is required to pay the Brand Drug Co-payment amount as shown on the Schedule of Prescription Drug Benefits.
6. The Co-payment for a Non-Formulary Brand Drug may be reduced to the Co-payment applicable to a Formulary Brand Name Drug if the Prescriber submits a completed Medical Necessity form to CVS Caremark by facsimile and Medical Necessity is found.
7. If a Member purchases a Prescription Drug at a Non-Participating Pharmacy, the Member will be reimbursed based on the Maximum Allowable Amount for the Covered Drug less any applicable Cost-Share, after review and approval of the claim. Claims must be filed with CVS Caremark within 2 years after the prescription has been filled. The receipt must accompany the claim. Members will not be reimbursed for the cost of filling anything other

than the first 30-day fill of a Maintenance Prescription Drug at a Non-participating Retail or Mail-Order Pharmacy. Members are subject to the following claims submission process when a Covered Drug is dispensed by a Non-Participating Retail or Mail Order Pharmacy:

- a. Members must pay for Covered Drugs at the time of purchase, and submit the original receipt to CVS Caremark.
- b. The claim must indicate the name and quantity of Covered Drugs dispensed.
- c. Claims, receipts and other supporting material must be filed with CVS Caremark within two years after the Covered Drug was dispensed.
- d. Claims and supporting material should be sent to

CVS Caremark, DMR,
PO BOX 52136
Phoenix, AZ 85072-2136.

8. Benefits for up to 6 pill(s)/unit(s)/dose(s) per month are available for a Covered Drug related to the treatment of male or female sexual dysfunctions or inadequacies. See Exhibit A.
9. Members in HEP may qualify for reduced Cost Shares for Maintenance Medications prescribed for the treatment of the following conditions: Diabetes, Asthma/COPD, High Blood Pressure, Hyperlipidemia, or Heart Disease/Heart Failure.

VI. EXCLUSIONS AND LIMITATIONS

MEDICATIONS/PRODUCTS EXCLUDED FROM COVERAGE UNDER PLAN

This Pharmacy Benefit Plan provides no coverage for any Prescription Drug or Maintenance Prescription Drug that is or has been:

1. Dispensed before the Member's Effective Date or after his or her termination date.
2. The subject of a request for further information by CVS Caremark (for example, for utilization review purposes) where CVS Caremark is not provided with the information requested.
3. Filled in excess of that specified by the prescribing Physician or dispensed/refilled after one year from the original date of the prescription.
4. Taken while in or administered by a hospital or any other health care facility or office.
5. Paid for by the Medicare Program.
6. Covered under Worker's Compensation, Medicaid or other (non-Medicare) Governmental program, even if the Member chooses not to claim such benefits.
7. Furnished by the U.S. Veterans' Administration, except that if this Plan is the secondary plan, any co-pay amount a Member is required to pay may be submitted for reimbursement under the Coordination of Benefits provisions.
8. Compounded Medications for which Prior Authorization has not been approved.
9. Dispensed or prescribed in a manner contrary to normal medical practice. However, coverage shall not be excluded for any drug prescribed for the treatment of cancer on the grounds that the drug is prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, provided that the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).
- 10.. Considered Experimental or Investigational in nature, which includes any drug that requires federal or other governmental agency approval not granted at the time the drug was prescribed, or any drug that is approved by the FDA for controlled studies only.
11. All over-the-counter products and medications unless designated as Preventive Medications under the Covered Services section. This includes, but is not limited to, electrolyte replacement, non-specialized infant formula for which no prescription is

required, miscellaneous nutritional supplements and all other over-the-counter products and medication

12. Anorexiant.
13. Any cosmetic drugs including, but not limited to, Renova, skin pigmentation preparations, any drugs or products used for the treatment of baldness, or topical dental fluorides.
14. Growth Hormones for the treatment of Idiopathic Short Stature (ISS).
15. Any antibacterial soap.
16. Any detergents, shampoos, toothpaste/gels, or mouthwash/rinses.
17. An appliance, device, or other medical supplies and durable medical equipment unless shown under the definition of Prescription Drug.
18. A hypodermic needle, syringe, or similar device, except for the administration of Covered Drugs when prescribed in accordance with the terms and conditions of the Pharmacy Benefit Plan.
19. An allergenic extract or vaccine.
20. A contraceptive or contraceptive device, that:
 - a. has not been approved by the FDA, and
 - b. is not prescribed by a licensed Physician.
21. Condoms, contraceptive sponges, spermicides, and over-the-counter Emergency Contraceptives, unless prescribed by a licensed Physician.
22. Any other services or items not listed in this Policy.
23. Drugs or medicines covered under any other Plan sponsored by the Participating Employer.
24. Blood glucose meters or insulin injecting devices.
25. Vitamins that are used as a dietary supplement rather than as treatment, including liquid nutritional supplements; pediatric Prescription Drug vitamins, and prescribed versions of Vitamins A, D, K, B12, Niacin and Folic Acid, except as listed as Preventive Medications under Covered Services.
26. Any drug labeled "Caution - limited by Federal Law for Investigational Use" or experimental drugs.

27. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
28. Drugs or medicines needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
29. Drugs or medicines needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war, or drugs dispensed to a Member while on active duty in any armed force.
30. Any expenses related to the administration of any drug.
31. Drugs, medicines or products that are not Medically Necessary.
32. Erectile dysfunction Prescription Drugs, except as described under "Other Prescription Drug Benefit Provisions".
33. Infertility Prescription Drugs.
34. Over-the-counter smoking deterrents, except as listed as Preventive Medications under "Covered Services".
35. Dispensed in excess of amounts provided under "Covered Services" regarding Special Exceptions to the Maximum Supply Limit, vacation supplies and replacement of lost, stolen, spilled, broken or dropped Prescription Drugs up to two times per year.

EXCLUSION OF WORKERS' COMPENSATION

To the extent permitted by law no benefits shall be provided for Covered Services that are paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Non-Participating Pharmacy services or which, by law, were rendered without expense to the Member.

The Plan shall be entitled to the following:

1. To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
2. To charge the Member for such dollar value, to the extent that the Member has been paid for the Covered Services.
3. To reduce any sum owing to the Member by the amount that the Member has received payment.

4. To place a lien on any sum owing to the Member for the amount the Plan has paid for Covered Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Plan and the designated Workers' Compensation carrier as to whether or not the Member is entitled to receive Workers' Compensation benefit payments.
5. To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
6. If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines for coverage under such program in order for this Pharmacy Benefit Plan to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

EXCLUSION OF AUTOMOBILE INSURANCE
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To the extent permissible by law, benefits shall not be provided by this Pharmacy Benefit Plan for Covered Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

The Plan shall be entitled:

1. To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled;
2. To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.
3. To reduce any sum owing to the Member by the amount the Member has received from any and all sources, including but not limited to, first party payment.
4. Benefits shall be subject to Coordination of Benefits, as described in the Coordination of Benefits in Section VII of this Plan Document, for Covered Services a Member receives under an automobile insurance policy, which provides benefits without regard to fault.
5. If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines for coverage under that policy. It is necessary to follow all the guidelines under that policy in order for the Plan to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

VII. COORDINATION OF BENEFITS (COB)

All benefits provided under this Pharmacy Benefit Plan are subject to the Coordination of Benefits process described in this Section.

APPLICABILITY

1. The Coordination of Benefits (COB) provision applies to this Pharmacy Benefit Plan when a Member has health care coverage under more than one Plan. As explained more fully below, when this Pharmacy Benefit Plan is a "Primary Plan" its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When this Pharmacy Benefit Plan is a "Secondary Plan," its benefits are determined after those of the other Plan, and may be reduced by the other Plan's benefits. If a coverage arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
2. If the Member is covered by this Pharmacy Benefit Plan and another Plan, the Order of Benefit Determination Rules in this Section shall determine which Plan is the Primary Plan. The benefits of this Pharmacy Benefit Plan:
 - a. Shall not be reduced when under the Order of Benefit Determination Rules this Pharmacy Benefit Plan is the Primary Plan; but
 - b. May be reduced (or the reasonable cash value of any Covered Service provided under this Pharmacy Benefit Plan may be recovered from the Primary Plan) when, under the Order of Benefit Determination Rules, another Plan is the Primary Plan;
 - c. Penalties imposed on a Member by the Primary Plan are not subject to COB;
 - d. The Member must submit the explanation of benefits from the Primary Plan to CVS Caremark within two years of the date of service in order to be eligible for payment under this Coordination of Benefits Section.

DEFINITIONS

In addition to the defined terms listed in the Definitions section of this Pharmacy Benefit Plan, the following also apply to this Coordination of Benefits Section.

ALLOWABLE EXPENSE: The term Allowable Expense means a Medically Necessary Allowable Expense, for an item of expense for health care, when the item of expense, including any Co-payment amount, is covered at least in part by one or more Plans covering the Member for whom the claim is made. When this Pharmacy Benefit Plan provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

CLAIM DETERMINATION PERIOD: The term Claim Determination Period means a Calendar Year. However, it does not include any part of a Calendar Year during which a person has no coverage under this Pharmacy Benefit Plan, or any part of a Calendar Year before the date this COB provision or a similar provision takes effect.

PRIMARY PLAN: The term Primary Plan means a Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either of the following is true:

- The Plan either has no Order of Benefit Determination rules or it has rules which differ from those stated in this Section; or
- All Plans which cover the person use the Order of Benefit Determination rules as stated in this Section, and under those rules the Plan determines its benefits first. There may be more than one Primary Plan (for example, two Plans which have no Order of Benefit Determination rules).

When this Pharmacy Benefit Plan is the Primary Plan, Covered Services are provided or covered without considering the other Plan's benefits.

SECONDARY PLAN: The term Secondary Plan means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section decide the order in which his or her benefits are determined in relation to each other. The benefits of the Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this Section, has its benefits determined before those of the Secondary Plan.

When this Pharmacy Benefit Plan is the Secondary Plan, benefits for Covered Services under the Pharmacy Benefit Plan may be reduced and the Plan may recover from the Primary Plan, the Provider of Covered Services, or the Member, the reasonable cash value of the Covered Services provided by this Pharmacy Benefit Plan.

ORDER OF BENEFIT DETERMINATION RULES

General Rule

When a Member receives Covered Services by or through this Pharmacy Benefit Plan (or is otherwise entitled to claim benefits under Pharmacy Benefit Plan) and has followed all the guidelines and procedures, as specified in this Plan Document, and the Covered Services are a basis for a claim under another Plan, this Pharmacy Benefit Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those described in this Plan Document; and
2. Both the other Plan's rules and this Pharmacy Benefit Plan's coordination rules, as described below, require that this Pharmacy Benefit Plan's benefits be determined before those of the other Plan.

Coordination Rules

The Plan determines its order of benefits using the following rules:

1. Other than a Dependent

The benefits of the Plan which covers the person as a Covered Person, (that is, other than as a Dependent), are primary to those of the Plan which covers the person as a Dependent;

2. Dependent Child/Parents Not Separated or Divorced

When this Pharmacy Benefit Plan and another Plan cover the same child as a Dependent of different persons, called “parents,” the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year, but if both parents have the same birthday, the Plan which covered a parent longer is primary. Only the month and day of the birthday are considered.

3. Dependent Child/Separated or Divorced Parents

In the case of a Member who is a Dependent child:

- a. When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody;
- b. When the parents are divorced and the parent with legal custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the step-parent; and
- c. The benefit of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

However, if the specific terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the Plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other Plan that covers the child as a Dependent. The provisions of this Subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payor has actual knowledge of the terms of the court order

4. Active/Inactive Employee

A Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) is primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. Longer/Shorter/Length of Coverage

If none of the above rules determines the order of benefits, the Plan which covered a Covered Person longer is primary to the Plan which covered that person for the shorter time.

6. Medicare

If a Member is eligible for Medicare and still covered under this Pharmacy Benefit Plan, the Plan will provide benefits of this Pharmacy Benefit Plan, to the extent that coverage for such services is not provided by Medicare Parts B or D.

EFFECT OF THIS PHARMACY BENEFIT PLAN ON OTHER BENEFITS

1. This Subsection applies when, in accordance with the Order of Benefit Determination Rules, this Pharmacy Benefit Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Pharmacy Benefit Plan may be reduced under this Subsection. Such other Plan or Plans are referred to as "the other Plans."
2. Reduction in this Pharmacy Benefit Plan's benefits. When the Pharmacy Benefit Plan is the Secondary Plan, the Plan will provide benefits at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. The Plan Sponsor shall never pay more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are "excess" or "always secondary" and if this Pharmacy Benefit Plan is determined to be secondary under this Pharmacy Benefit Plan's COB provisions, the amount of benefits payable under this Pharmacy Benefit Plan shall be determined on the basis of this Pharmacy Benefit Plan being secondary.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain information is needed to apply these COB rules. The Plan Sponsor has the right to decide which information it needs. By enrolling in the Pharmacy Benefit Plan the Member consents to the release of information necessary to apply the COB rules. Any Member claiming benefits under this Pharmacy Benefit Plan must furnish information which the Plan Sponsor and/or CVS Caremark determine is necessary for the coordination of benefits.

FACILITY OF PAYMENT

A payment made or a service provided under another Plan may include an amount which should have been paid or provided under this Pharmacy Benefit Plan. If it does, the Plan may pay that amount to the organization that made the payment. Such amount shall then be considered as though it were a benefit paid under this Pharmacy Benefit Plan.

RIGHT OF RECOVERY UNDER COB

If the amount of benefits provided under the Pharmacy Benefit Plan is more than should have been paid under this COB provision, or if this Pharmacy Benefit Plan has provided services which should have been paid by the Primary Plan the Plan Sponsor may recover the excess or the reasonable cash value of the Covered Services, as applicable, from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

The right of the Plan Sponsor to recover from a Member shall be limited to the Allowable Expense that the Member has received from another Plan. Acceptance of Covered Services will constitute consent by the Member to the Plan Sponsor's right of recovery. The Member agrees to take such further action to execute and deliver such documents as may be required and do whatever else is necessary to secure the Plan Sponsor's rights to recover excess payments. The Covered Person's failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

VIII. TERMINATION

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

TERMINATION OF A MEMBER'S COVERAGE

The Member's enrollment in the Pharmacy Benefit Plan shall terminate:

1. The last day of the month in which required premium equivalents for your coverage are not paid when due;
2. At the Member's option, during the Participating Employer's Open Enrollment Period, to be effective as of the renewal date of the Pharmacy Benefit Plan;
3. The day following a Covered Person's death. When a Covered Person dies, his or her Dependents' coverage shall be terminated on the first day of the month following the Covered Person's death unless they are eligible and elect to continue coverage pursuant to COBRA or are otherwise eligible for continued coverage under some other benefit Plan maintained by the Participating Employer;
4. When you cease to meet the Participating Employer's Eligibility requirements as defined in the Addendum of this Plan Document, coverage will end on the first day of the month following the loss of eligibility. When a Dependent's eligibility for coverage is lost due to misrepresentation of status, divorce or legal separation, termination of coverage will occur on the first day of the month following the effective date of the divorce or legal separation or discovery of the misrepresentation.
5. If and when a Member permits any other person to use his or her Identification Card to obtain services.
6. If and when it is determined that a Covered Person has enrolled an ineligible person as a Dependent under the Plan or has failed to provide the Participating Employer with required notification of the occurrence of an event that causes an individual enrolled as a dependent to no longer be eligible for coverage as such. Such events or occurrences include by way of example, divorce, legal separation, or attainment of maximum age.

Notwithstanding anything else above, coverage for an enrolled Dependent will terminate on the day after the death of that enrolled Dependent.

MEMBER NOTIFICATION

Pursuant to Connecticut General Statutes, if the Participating Employer cancels or discontinues its participation in the Partnership Plan with respect to its entire group or a class of employees, the Participating Employer must send the Covered Person written notification of cancellation or discontinuation of this Pharmacy Benefit Plan at least 15 days before the effective date of

cancellation or discontinuation. Coverage will be terminated regardless of whether the notice was given.

CONTINUATION OPTIONS

In the event you lose eligibility under this Pharmacy Benefit Plan, you may be entitled to continue coverage under certain circumstances. Continuation options will be provided under each of the following circumstances for the period indicated or until the Member becomes eligible for other group coverage, except as otherwise stated in this Section.

Note: Notwithstanding anything else in this Plan Document to the contrary, continuation coverage under this Pharmacy Benefit Plan will terminate upon the expiration of the contract between the State of Connecticut and CVS Caremark or if required premium equivalents are not paid when due.

COBRA CONTINUATION COVERAGE

1. Members in groups subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), may continue membership in this Prescription Drug Benefit Plan to the extent required by law. The Participating Employer or its representative shall administer COBRA continuation benefits. Coverage shall also be available to a child born to or placed for adoption with the Member while the Member is receiving continuation coverage under COBRA. The right to continuation coverage in this Prescription Benefit Plan will terminate, however, upon termination of the Agreement between the State of Connecticut and CVS Caremark.

Continuation of coverage for up to 36 months shall be available for an enrolled Dependent following:

- a. The death of the Member;
- b. The legal separation or divorce from the Member;
- c. The Member’s entitlement for Medicare; or
- d. The attainment of the limiting age for an enrolled Dependent child.

Continuation of coverage for up to 30 months shall be available to a Member and his or her enrolled Dependents following:

- a. The Member’s reduction in work hours;
- b. The Member’s voluntary resignation;

- c. Lay-off or termination of the Member for any reason other than gross misconduct.
- d. An additional 11 months shall be available to a Member or an enrolled Dependent who is determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under COBRA or becomes disabled at any time during the first 60 days of COBRA continuation coverage. The Member or enrolled Dependent must provide notice of the disability determination to the Participating Employer not later than 60 days after the date of the Social Security Administration's determination and before the end of the initial 18 months of COBRA continuation coverage.

If it is determined that the Member is no longer disabled, the extended continuation of coverage period can be terminated on the first of the month following 30 days after the final determination notice.

The continuation of coverage must be equal to the benefits under this Pharmacy Benefit Plan that are available to currently employed Members. A Member who is eligible for continuation of coverage must be provided with at least 60 days in which to elect such coverage.

A Member's eligibility for such continuation of coverage ends earlier than the above periods if:

- a. The Member becomes eligible for benefits under another group health plan as a result of employment, re-employment, or marriage, except when the new plan contains any exclusion or limitation relating to any pre-existing condition of the Member that would affect coverage under this Prescription Benefit Plan; or
- b. The premium for continuation of coverage is not paid on time; or
- c. The Member becomes entitled to Medicare benefits.

IX. PAYMENT PROVISIONS

PAYMENT FOR COVERED SERVICES

Payment for Covered Services from a Participating Pharmacy shall be made to the Participating Pharmacy. Payment for Covered Services provided by a Non-Participating Pharmacy shall be made directly to the Member, who shall be responsible for payment to the Non-Participating Pharmacy. Where a Dependent child receives Covered Services from a Non-Participating Pharmacy, CVS Caremark will send payment directly to the custodial parent when the CVS Caremark is notified in writing, even if that parent is not a Member.

In order to be considered for payment, claims for payment for Covered Services provided by Non-Participating Retail or Mail Order Pharmacies must be received by CVS Caremark within 2 years from the date the Covered Services were performed. Submit such Claims to:

CVS Caremark, DMR
PO BOX 52136
Phoenix, AZ 85072-2136

CVS Caremark will not routinely issue a benefit payment of less than \$1.00 except upon written request from the Member. Claims for Covered Services submitted more than 2 years after the date the services were performed shall not be covered or paid.

Claims for benefits for Covered Services provided to a Member will be processed within thirty (30) days of the date the claim is received by CVS Caremark. If a claim decision cannot be made within the 30-day period, an extension of up to fifteen (15) days may be requested. Before the end of the initial thirty (30)-day period, CVS Caremark will send the Member written notice of the reason(s) for the delay.

If the time to process a claim is extended because the Member has not submitted requested information, the time period required for the claim processing will be tolled from the date the notice of requested information is sent to the Member until the date CVS Caremark receives the Member's response. CVS Caremark will make a claim decision within fifteen (15) days after receipt of the requested information. Members should submit the requested information within forty-five (45) days of receipt of the request.

NON-PAYMENT FOR MAINTENANCE DRUGS FILLED OUTSIDE OF MAIL ORDER OR MAINTENANCE DRUG NETWORK

Members who are subject to mandatory Mail Order will not be reimbursed for the cost of filling anything other than the first 30-day fill of a Maintenance Prescription Drug at a Non-participating Retail or Mail-Order Pharmacy.

CLAIM OVERPAYMENTS

When CVS Caremark has made payments for Covered Services (either in error in excess of the

maximum amount of payment necessary to satisfy the provisions of this Pharmacy Benefit Plan) irrespective of to whom paid, CVS Caremark on behalf of the Plan has the right to recover these payments from one or more of the following: (a) Any person to or for whom such payments were made; (b) Any insurance companies; or (c) Any other organization receiving said payment.

The Plan's right to recover may include deducting the amount CVS Caremark has paid in error or in excess from future benefits payments. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure the Plan's right to recover any erroneous or excess payments.

RIGHT OF RECOVERY

The purpose of the Plan is to provide Coverage for qualified pharmacy expenses that are not covered by a third party. If the Plan pays benefits for any claim a Covered Person incurs as the result of negligence, willful misconduct or other action or omission of a third party, the Plan has a right of subrogation. To the extent permitted by law, where the Covered Person has a right of recovery against third parties for the cost of Covered Services the Plan shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Program.

Acceptance of Covered Services will constitute consent by the Covered Person to the Plan's right of recovery. The Covered Person agrees to execute and deliver such additional instruments, and to take such other action as CVS Caremark or Plan may require, to implement this provision. To the extent permitted by law, the Plan, or CVS Caremark acting on its behalf, will have the right to bring suit against such third party in the name of the Covered Person and in its own name as subrogee. The Covered Person shall do nothing to prejudice the Plan's rights under this provision without its consent.

If a Covered Person receives payment from a third party by suit or by way of settlement for the cost of Covered Services, such Covered Person is obligated to reimburse the Plan for benefits paid on his or her behalf out of the recovery from the third party or insurer. To the extent permitted by law, the Plan has a lien on any amount recovered by the Covered Person from the responsible third party or insurer whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full, less a pro rata share of the reasonable attorney's fees and costs the Covered Person sustained in obtaining the recovery.

You must notify the Plan immediately if you begin settlement negotiations with or obtain a judgment against a third party or insurer in connection with an accident or injury for which benefits have been paid by the Plan.

X. GRIEVANCE AND APPEAL RIGHTS

CLAIM DENIALS

If benefits are denied, in whole or in part, CVS Caremark will send the Member a written notice within the established time periods described in the section entitled “Payment for Covered Services.” The Member or the Member's duly authorized representative may appeal the denial as described in the Member Appeal Process section below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why such information is needed, the claim appeal procedures and applicable time limits.

If the denial involves a utilization review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge; and
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

MEMBER APPEAL PROCESS

A Member's questions about the Pharmacy Benefit Plan often can be handled informally and may be addressed by contacting Member Service/Customer Service, using the telephone number provided on the back of the Member's Identification Card. In addition, information about the following Appeal process may be obtained by contacting Member Service/Customer Service.

The Appeal process is available to the Member, the Member's duly authorized representative, the Provider of record, or the Provider of record's duly authorized representative.

This Appeal process is divided into two types of appeals: adverse utilization review determinations and adverse non-utilization review determinations. Utilization review determinations, such as prior authorizations, are determinations based on Medical Necessity or other criteria related to the nature of the drug or the Member's condition being treated. Non-utilization review determinations concern issues relating to the Member's Pharmacy Benefit Plan that do not involve the exercise of clinical judgment, such as eligibility for benefits, coverage of claims, or claims processing.

APPEAL PROCESS FOR ADVERSE MEDICAL NECESSITY DETERMINATIONS

DEFINITIONS

The following terms are used to describe the claims and appeals review services:

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 medication or product based on the application of the Plan's benefits, review requirements, 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 the Plan's established procedures.

Final External Adverse Benefit Determination – An external review of an adverse benefit determination. This review is available only after CVS Caremark's internal appeals process has been exhausted unless the appeal involves an Urgent Care Claim for which Expedited Review is sought.

Independent Review Organization (IRO) – An independent company that consists of a network of practicing physicians and board certified specialists in all fields of medicine. IRO medical experts provide an impartial evaluation of benefit determinations for Medical Necessity appeals and for the External Review process.

Medically Necessary (Medical Necessity) – Medications or products are considered Medically Necessary if:

- Use of the medication 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 or product is based on recognized standards for the health care specialty involved;
- Use of the medication 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 or product is not solely for the convenience of the Member, Member's family, or provider.

Non-Utilization Review Determination—A review relating to the Member's Pharmacy Benefit Plan, such as an individual's eligibility for benefits, coverage of claims or claims processing that do not involve Medical Necessity or the exercise of clinical judgment.

Plan – The prescription drug component of the State of Connecticut Partnership Plan as administered by CVS Caremark.

Prior Authorization Claim Review – CVS Caremark’s pre-service review of a Member’s initial request for a particular medication or product. CVS Caremark will apply a set of pre-defined criteria to determine whether the requested medication or product is appropriate.

Pre-Service Appeals Review – Review of a Claim for a medication 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 Review includes Member requests for prior authorization.

Post-Service Appeals Review –Review of a Claim for a medication or product that the Plan denied, reduced, or failed to provide or make a benefit for.

Urgent Care Claim – A Claim for a medication, 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 or product.

CVS Caremark will provide the *First Internal Review* for appeals for Pre-Service and Post-Service Claims. CVS Caremark will provide an additional *Second Level Internal Appeal* of Pre-Service and Post-Service Claims. The Medical Necessity review for a *Second Level Internal Appeal* will be conducted by an independent medical expert, who specializes in the condition involved.

A plan Member who receives an adverse Second Level Appeal Determination may further appeal by pursuing an *External Appeal* with the Connecticut Department of Insurance within the time periods set forth below.

INTERNAL REVIEWS (FIRST AND SECOND LEVEL APPEALS)
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Prior Authorization Review:

CVS Caremark will administer the prescription drug benefit program by comparing Member requests for certain medications and/or other prescription benefits against coverage rules, pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that the Member’s request for prior authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

First Level Appeal 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.

The Member’s appeal should include the following information:

- Name of the Member 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:

Prescription Claim Appeals MC 109
 CVS Caremark
 P.O. Box 52084
 Phoenix, AZ 85072-2084
 Fax: 1-866-443-1172.

For Urgent Care Claims, the Member or the Member's Provider or authorized representative may request an expedited appeal by calling toll-free 1-866-443-1183, faxing a written appeal to 1-866-443-1172, or mailing a written appeal to the address above.

Appeals of prior authorization determinations for compound medications are reviewed by an independent specialist and constitute a second level internal review.

Second Level Internal Review.

If an Adverse Benefit Determination is rendered on the Member's First Level Appeal, the Member may file an appeal of that determination. The Member's Second Level Appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the Member receives notice the decision on the First Level Appeal. The appeal must in writing and must be sent by mail or facsimile to:

Prescription Claim Appeals MC 109
 CVS Caremark
 P.O. Box 52084
 Phoenix, AZ 85072-2084
 Fax: 1-866-443-1172

For Urgent Care Claims, a Member or the Member's authorized representative may request an expedited appeal by calling toll-free 1-866-443-1183, faxing a written appeal to 1-866-443-1172 or mailing a written appeal with a copy of the letter providing notice of the denial of the First Level Appeal to the address above.

EXTERNAL REVIEW—CONNECTICUT DEPARTMENT OF INSURANCE

A Plan Member whose Claim for prescription drug benefits has been denied after a Second Level Appeal may request, in writing, an External Review of his or her Claim within 120 days after receiving notice of the Final Internal Adverse Benefit Determination. The Member's request should include their 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 to:

State of Connecticut Insurance Department
Attn: External Appeals
P.O. Box 816
Hartford, CT 06142-0816.
860-297-3910

For overnight delivery services only, send applications for External Review to the following street address:

State of Connecticut Insurance Department
Attn: External Appeals
153 Market Street, 7th Floor
Hartford, CT 06143
860-297-3910.

Any request for an external appeal of an adverse utilization review determination must be received by the Connecticut Insurance Department within one hundred twenty (120) days from the date of the receipt of the final Appeal determination.

Contents of External Appeal

The following items must be included in the Appeal.

- A completed "request for External Appeal" form.
- An authorization form allowing the CVS Caremark and your health care professional to release medical information to the independent review organization.
- Evidence of being enrolled in the Plan (photocopy of the identification card issued by the Plan).
- Copies of all correspondence from CVS Caremark.
- A copy of the Final Determination letter indicating that all internal Appeal mechanisms have been exhausted.
- A copy of the summary plan description or explanation of benefits.
- **The filing fee of \$25**

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

Urgent/Expedited Care Claims: In an emergency or life threatening situation, a Member or a Provider acting on a Member's behalf can file an expedited external appeal without exhausting all of the Plan's internal appeals procedures. The Member or Provider can also apply for an expedited internal appeal of a claim at the same time.

An independent review organization will determine whether the Member's appeal will be handled on an expedited basis. If the appeal is not accepted for expedited review, the

Member will be required to exhaust all internal appeals before seeking external review.

TIMETABLE FOR DECISION BY CVS CAREMARK

Pre-Authorization Review – CVS Caremark will make a decision on a prior authorization request for a Plan benefit within 48 hours after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 24 hours, unless extended by law.

Pre-Service Claim First Level Appeal. CVS Caremark will make a decision on a First-Level Appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the Member’s appeal.

Pre-Service Claim Second Level 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. A decision on the Member’s Second-Level Appeal of the Adverse Benefit Determination will be made by independent medical experts within 15 days after the Second Level Appeal is received.

Pre-Service Claim Urgent/ Expedited Care Appeal 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 Second Level Appeal(s) is received.

Post-Service Claim Appeal – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 30 days after it receives the appeal. If CVS Caremark renders an Adverse Benefit Determination, Member may appeal through the External Review process.

External Review – If a Member appeals an Adverse Benefit Determination by requesting an External Review with the Connecticut Insurance Department, CVS Caremark will complete a preliminary review of the Member’s eligibility within 5 days of receiving the request from the Commissioner of Insurance for a standard External Review, and within one day of receiving the request from the Commissioner of Insurance in the case of an expedited External Review.

CVS Caremark’s preliminary review will determine whether (a) the individual is a Covered Person; (b) the service requested is a Covered Service under the Plan (c) the Covered Person has exhausted all internal grievance procedures; and (d) the Covered Person has provided all the information and forms required to process an external review or an expedited external review. Within one day of completing the preliminary review CVS Caremark shall notify the Commissioner, the Covered Person and, if applicable, the Covered Person's authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The Independent Review Organization (“IRO”) appointed by the Department of Insurance to review the case, shall rend its decision within 45 days after receipt of the assignment from the Commissioner to conduct the review.

Type of Review	Time* for Caremark to Respond
Pre-Service (Prior Authorization) or Concurrent	48 hours
Pre-Service —Urgent	24 hours
First Level Appeal	
Urgent Pre Service Utilization Review	72 hours*
Pre-Service Utilization Review	15 days
Post Service Utilization Review	30 days
Second Level Appeal	
Urgent Pre Service Utilization Review	72 hours*
Pre-Service Utilization Review	15 days
Post Service Utilization Review	30 days
External Review—Standard	CVS Caremark will complete preliminary review within 5 days of receipt of request from Insurance Dept.
External Review—Expedited	CVS Caremark will complete preliminary review within 24 hours of receipt of request from Insurance Dept.

*Calculated from time carrier receives all information required to evaluate claim or resolve appeal.

SCOPE OF REVIEW

CVS Caremark Internal Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS Caremark is required to:

- 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 benefit 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 Claim, and requests an additional Second-Level review by an Independent Review Organization (IRO), the IRO shall:

- Review the claim in accordance with the Plan's benefit and coverage rules and Medical Necessity;
- 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 be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the Member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- 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, or a statement that such 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 Medical Necessity, either the independent medical expert's explanation of the scientific or clinical judgment for the 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

External Review—Department of Insurance:

The External Review of a Member's appeal will be conducted by an assigned Independent Review Organization ("IRO") selected by the Commissioner of the Connecticut Insurance Department.

The IRO will notify the Member of its acceptance of the assignment. The Member will then have 10 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 or the Plan Sponsor. 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 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.

Binding Effect of External Review Decision

An external review decision, whether a standard external review or an expedited external review, shall be binding on the Plan Sponsor and the Covered Person, except to the extent the Plan Sponsor or Covered Person has other remedies available under federal or state law. A Covered Person or a Covered Person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same Adverse Determination or final adverse determination for which the Covered Person or the Covered Person's authorized representative already received an external review decision or an expedited external review decision.

APPEAL PROCESS FOR ADVERSE DETERMINATIONS NOT INVOLVING MEDICAL NECESSITY OR CLINICAL JUDGMENT

If a Non-utilization Review determination results in a denial of coverage, a review may be requested by the Member or the Member's authorized representative. The review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date of the adverse determination. Review requests should be sent by facsimile or mailed to:

CVS Caremark
Prescription Claim Appeals MC 109

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 866-554-1172

The review request should include copies of any additional supporting documentation.

A review determination will be issued in writing within thirty (30) days of receipt of a request for review. The written determination will be issued within five (5) business days from the date the review decision is made. If the services are denied because they are not a Covered Benefit under the Plan or that the Member is not eligible for coverage under the Plan, no External Appeal is available.

MEMBER RIGHTS TO INFORMATION

The Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records and other information relevant to the Member's claim for benefits. If an internal rule, guideline, protocol, or other similar criterion is relied upon, the specific rule, guideline, protocol or other similar criterion will be provided to the Member free of charge upon request.

If an Adverse Benefit Determination is based on a Medical Necessity, or Experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the health benefit plan to the Member's medical circumstances will be provided free of charge upon request.

XI. MISCELLANEOUS PROVISIONS

PLAN INFORMATION PRACTICES NOTICE

The purpose of this Information Practices Notice is to provide notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member's information to persons or entities outside of the Plan without the Member's authorization in certain circumstances including for purposes of treatment, payment or healthcare operations.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

NOTICE TO PLAN SPONSOR

Notice given to the Plan Sponsor must be sent to the Office of the State Comptroller, in care of the Healthcare Policy and Benefit Services Division, 55 Elm Street, Hartford, CT 06106. Notice given to a Member will be sent to the Member's address as it appears on the records of the Participating Employer.

MEMBER'S OBLIGATIONS REGARDING INFORMATION

A Member shall complete and submit to the Participating Employer such applications or other forms or statements as the Participating Employer or Plan Sponsor may reasonably request in connection with enrollment, continuation of membership or claims for benefits.

Member warrants that all information contained therein shall be true, correct, and complete to the best of the Member's knowledge and belief and the Member accepts that all rights to benefits under this Pharmacy Benefit Plan are conditional upon those warranties. The submission of false or incomplete information by a Covered Person or Member or failure to provide notice within 31 days of a change in status that affects eligibility for Coverage of any enrolled individual shall subject the Covered Person and/or the improperly enrolled individual to one or more of the following:

- An active Employee may be subject to disciplinary action by the Participating Employer, if he or she enrolls or maintains an enrollment for a person who is not eligible for coverage as a Spouse or Dependent;
- The fair market value of Health Benefit coverage provided to an ineligible individual will be reported by the Participating Employer to the Internal Revenue Service as income to

the Covered Person or to the ineligible individual and, as such, will be subject to taxation; and

- The Plan may seek to recover from the Covered Person or the improperly enrolled individual the value of Covered Benefits provided to said individual.

CLERICAL ERRORS

Clerical errors made in connection with the Pharmacy Benefit Plan, whether by CVS Caremark, SilverScript, the Member, the Participating Employer, or Plan Sponsor, will not terminate coverage that would otherwise have been effective or continue coverage that would otherwise have ceased or should not have been in effect.

FILING A CLAIM

The Plan Sponsor will not be liable under the Pharmacy Benefit Plan unless proper notice is furnished by CVS Caremark that Covered Services have been rendered to a Member. In no event will the Plan Sponsor be required to accept notice more than two years after Covered Services are received.

IDENTIFICATION CARDS

Upon approval by the Participating Employer and provision of address files, CVS Caremark or SilverScript, where applicable, will mail Identification Cards directly to Covered Persons and their enrolled Dependents.

CHANGES TO PLAN BENEFITS OR ELIGIBILITY REQUIREMENTS

This Pharmacy Benefit Plan shall remain in effect unless amended, terminated, rescinded, suspended or cancelled as described herein. The Plan Sponsor has the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The effective date of any changes shall be designated in writing by the Plan Sponsor.

Except with respect to rules on administration of eligibility requirements as set forth in Section IV and incorporated in the Addendum hereto, no agent or representative of the Participating Employer is authorized to change this Pharmacy Benefit Plan or to waive any provisions of the Plan Document.

Any change to a Participating Employer's eligibility rules so as to modify the size and composition of the covered population approved at the time of Participating Employer's admission to the Partnership Plan is prohibited. Any eligibility change by a Participating Employer that would have the effect of permitting enrollment of individuals that are neither active nor retired employees of the Participating Employer or eligible Dependents is null and void.

GENERAL PROVISIONS

- A. This Plan Document supersedes all other agreements or descriptions of the benefits provided under this program.
- B. Identification Cards. Cards issued to Participants pursuant to this Plan are for identification purposes only. Possession of an identification card confers no right to Covered Services or other benefits under this Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable benefit cost contributions under this Plan have been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Plan will be liable for the actual cost of such services or benefits. In addition, any Covered Employee who fails to notify the Participating Employer of a change in circumstances that affects an individual's eligibility status (including without limitation, divorce, legal separation, a child's attainment of age 26, etc.) may have the fair market value of coverage reported as income and, if actively employed, may be subject to disciplinary action, including termination.
- C. Notice. Any notice required under this Plan Document to be given to the Participating Employer may be sent by U.S. Mail, first class, postage prepaid to the address listed on the Addendum to this Plan Document. Any notice to be given to the Plan Sponsor may be sent by U.S. Mail, first class, postage prepaid to the address listed in the front of the document. Notice to a Participant will be sent to the last address the Plan has for that Participant. Participant agrees to provide the Participating Employer with notice, within 31 days, of any change of address.
- D. Interpretation of Plan. The laws of the State of Connecticut shall be applied to the interpretation of this Plan.
- E. Gender. The use of any gender in this Plan Document is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).
- F. Modifications. This Plan Document is subject to amendment, modification, and termination in accordance with this provision and applicable collective bargaining agreements affecting health care coverage, benefits and services under the State of Connecticut Employee Health Plan.
- G. Clerical Error. Clerical error, whether by the Plan Sponsor or the Carrier with respect to Plan Document or any other documentation issued by the Carrier in connection with the Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
- H. Policies and Procedures. The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which Participants shall comply.
- I. Waiver. The waiver by any party of any breach of any provision of the agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

XII. PROTECTED HEALTH INFORMATION

A. PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

1. Unless otherwise permitted by law and subject to obtaining written certification pursuant to paragraph 5 of this section, the Plan may disclose Protected Health Information to the Plan Sponsor provided the Plan Sponsor uses or discloses such Protected Health Information only for the following purposes.

- a. Performing Plan Administration Functions which the Plan Sponsor performs.
- b. Obtaining premium bids from carriers for providing coverage
- c. Modifying, amending or terminating the group health plan.

Notwithstanding the provisions of the Plan to the contrary in no event will the Plan Sponsor use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

2. **Information regarding Participation:** Notwithstanding paragraph 1 of this Section, the Plan may disclose to the Plan Sponsor information regarding participation or enrollment.

3. **Conditions of disclosure:** With respect to any disclosure Plan Sponsor shall

- a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
- b. Shall ensure that any agents, contractors or subcontractors to whom it provides Protected Health Information shall agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information.
- c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other employee benefit plan of the Plan Sponsor.
- d. Report any use or disclosure of the information that is inconsistent with the use or disclosures provided for of which it becomes aware;
- e. Make available Protected Health Information in accordance with 45 CFR §164.524
- f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.
- g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR 164.
- i. If feasible, return or destroy all Protected Health Information received that the Plan Sponsor still maintains in any forma and retain no copies of such information

when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

- j. Ensure that adequate separation between Plan and the Plan Sponsor, required by 45 CFR §504(f)(2)(iii) is satisfied.
- k. Reasonably and appropriately safeguard electronic PHI that is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

4. **Certification by Plan Sponsor.** CVS Caremark and SilverScript shall disclose Protected Health Information to the Plan Sponsor only upon receipt of certification that the Plan Sponsor that the Plan Document incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 4 of this Section. The Plan shall not disclose and may not permit CVS Caremark or SilverScript to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR §164.504(b)(1)(iii)(C) is included in the appropriate notice.

5. **Adequate Separation between the Plan and the Plan Sponsor.** The Plan Sponsor shall only allow employees of the Office of the State Comptroller, Healthcare Policy & Benefit Services Division, access to the Protected Health Information, to perform the Plan Administration Functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees does not comply with the provisions of the Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

6. **Permitted Uses and Disclosures of Summary Health Information.** Notwithstanding paragraph 1 of this Section the Plan Sponsor may authorize the state's data warehouse vendor to disclose summary Health Information to a Participating Employer, provided the Participating Employer requests the Summary Health Information for the purpose of :

- a. Performing Plan Administration Functions that the Participating Employer provides with respect to its own enrolled population
- b. Obtaining premium bids for providing benefit coverage for its own members; or
- c. Modifying, amending or terminating its participation in the Plan.

Provided that any designee, agent, contractors or subcontractors of the Participating Employer to whom Plan Sponsor provides Protected Health Information shall agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information.

B. DEFINITIONS

Plan Administration Functions means administration functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor. In the normal course, such functions may include such functions as include monitoring the compliance of Participating Employer's Members with the requirements of the Health Enhancement Program or assisting Members in resolving complaints regarding the handling or processing of claims or denial of coverage.

Protected Health Information means individually identifiable health information that is (1) received or created by a health care provider, Carrier or health plan and (2) that relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual and identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information" excludes health information or medical information supplied to the Plan Sponsor in its role as an employer. For example, medical information submitted in support of an application for Family Medical Leave or Disability.

Summary Medical Information means: Information that (1) summarizes the claims history, claims expenses or types of claims experience by individuals for whom a plan sponsor provided health benefits under a Health Plan and from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated o the level of a five-digit zip code

**OFFICE OF THE STATE COMPTROLLER OF
THE STATE OF CONNECTICUT, ON BEHALF
OF THE STATE OF CONNECTICUT**

By: /s/ Kevin Lembo

Title: STATE COMPTROLLER

EXHIBIT A

PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION

When a Covered Drug which requires Prior Authorization is prescribed for a Member, the Member or the Member's representative must call CVS Caremark at 1-800-294-5979, or fax a written request for prior authorization to CVS Caremark, at 1-888-836-0730.

Drug Class/ Name	Criteria
Compound Medications	Prior Authorization required
Abstral	Prior Authorization required
Actemra	Prior Authorization required
Actiq	Prior Authorization required
Alsuma	Quantity limit: 8 injectors per 30 days
Amerge	Quantity limit: 9 tablets per 30 days
Amevive	Prior Authorization required
Axert	Quantity limit: 12 tablets per 30 days
Caverject	Quantity Limit: 6 units per 30 days
Cialis	Quantity limit: 6 tablets per 30 days
Cialis, 5 mg	Prior Authorization required, limited to those diagnosed with BPH
Cimzia	Prior Authorization required
Edex	Quantity Limit: 6 units per 30 days
Enbrel	Prior authorization required
Fentora	Prior Authorization required
Frova	Quantity limit: 9 tablets per 30 days
Genotropin	Prior authorization required (no coverage for ISS)
Growth Hormones	Prior authorization required (no coverage for ISS)
Humatrope	Prior authorization required (no coverage for ISS)
Humira	Prior authorization required
Imitrex Injection Kits	Quantity limit: 4 kits per 30 days
Imitrex Nasal inhaler	Quantity limit: 12units per 30 days
Imitrex tablets	Quantity limit: 9 tablets per 30 days
Imitrex Vials	Quantity limit: 10 vials (5ml) per 30 days
Incivek	Prior Authorization required
Increlex	Prior Authorization required (no coverage for ISS)
Infergen	Prior Authorization required
Intron A	Prior Authorization required
Kineret	Prior authorization required
Lazanda	Prior Authorization required
Levitra	Quantity limit: 6 tablets per 30 days
Maxalt tablet	Quantity limit: 12 tablets per 30 days
Maxalt-MLT tablets	Quantity limit: 12 tablets per 30 days

Drug Class/ Name	Criteria
Migranal nasal inhaler	Quantity limit: 1 kit (8 units) per 30 days
Muse	Quantity Limit: 6 units per 30 days
Norditropin	Prior authorization required (no coverage for ISS)
Nutropin/AQ	Prior authorization required (no coverage for ISS)
Nuvigil	Prior authorization required
Omnitrope	Prior authorization required (no coverage for ISS)
Onsolis	Prior Authorization required
Orencia	Prior Authorization required
Pegasys	Prior authorization required
Peg-Intron	Prior authorization required
Provigil	Prior authorization required
Relpax	Quantity limit: 12 tablets/ 30 days
Remicade	Prior Authorization required
Ribavirin	Prior Authorization required
Rituxan	Prior Authorization required
Saizen	Prior authorization required (no coverage for ISS)
Serostim	Prior authorization required
Simponi	Prior Authorization required
Stadol Nasal Spray (available as generic, butorphanol nasal spray, only)	Quantity limit: 2 bottle per 30 days; available as generic only
Staxyn	Quantity Limit: 6 tablets per 30 days
Stelara	Prior Authorization required
Subsys	Prior Authorization required
Sumavel DosePro	Quantity limit: 12 DosePros per 30 days
Tev-Tropin	Prior authorization required (no coverage for ISS)
Treximet	Quantity limit: 9 tablets per 30 days
Viagra	Quantity limit: 6 tablets per 30 days
Vitrelis	Prior Authorization required
Xeljanz	Prior Authorization required
Xyrem	Prior authorization required
Zomig Nasal Spray	Quantity limit: 12 inhalers per 30 days
Zomig/Zomig ZMT tablets	Quantity limit: 12 tablets per 30 days
Zorbtive	Prior authorization required (no coverage for ISS)

**ADDENDUM TO PARTNERSHIP PHARMACY PLAN DOCUMENT
To be completed by Participating Employer**

Contact Information

All notices to the Participating Employer covered by this Plan should be directed as follows:

[INSERT NAME/CONTACT INFORMATION]

Eligibility Requirements

Describe Group Covered:

Entire Population

Active Employees:

Retired Employees

Sub-Group Covered:

Active Employees:

Retired Employees

Notice: Participating Employer is prohibited from offering enrollment in this Plan (except as a Dependent) to any individual who is not an Active or Retired Employee of the Participating Employer.

Dependents:

[Complete only if group offers coverage as a Dependent to individuals other than as described in Plan Document Section IV. A.3]

Notice: All additional Dependent eligibility provisions must be disclosed in advance of enrollment and are subject to review and approval by Comptroller.

Compliance with Internal Revenue Provisions

Participating Employer is responsible for maintaining its own Internal Revenue Code Section 125 Plan and for compliance with IRS requirements for reporting on the fair market value of health benefit coverage provided to any individual who does not qualify as the employee's dependent under Section 152 of the Internal Revenue Code.