

## **Important Notice From Venezia Transport About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Venezia Transport and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:**

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. Venezia Transport has determined that the prescription drug coverage offered by the High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
- 3. You can keep your current coverage from High Deductible Health Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>TH</sup> to December 7<sup>th</sup>.

CMS Form 10182-NC

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**[INSERT IF EMPLOYER/UNION SPONSORED GROUP PLAN:** However, if you decide to drop your current coverage with [Insert Name of Entity], since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under [Insert Name of Plan.]

**[INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE:** Since you are losing creditable prescription drug coverage under the [Insert Name of Plan], you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

## **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

Since the coverage under [Insert Name of Plan], is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Venezia Transport coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Venezia Transport coverage, be aware that you and your dependents will not be able to get this coverage back outside of open enrollment.

## **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the Venezia HR Department for further information at 610-495-5200. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

## **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**VENEZIA TRANSPORTATION SERVICES, INC.**  
**PRESCRIPTION DRUG COVERAGE BENEFIT SUMMARY**

*(Effective 9/1/21)*

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## **Introduction**

The Prescription Drug Plan is a component benefit offered under the Venezia Transport Services, Inc. Plan (the “Plan”). This booklet is intended to supplement the Plan, which together comprise the official Plan document. An amendment to this booklet is considered an amendment to the official Plan document. We suggest that you read this booklet carefully to become familiar with the Prescription Drug coverage available to you and your family.

This booklet describes your Prescription Drug Plan, which is provided by Venezia Transport Services, Inc. and summarizes the benefits and essential details of the plan; as directed by the ERISA regulations of 1974.

## Definitions

This section defines certain important words used in this booklet. The meaning of each defined word, whenever it appears in this booklet, is governed by its definition as listed in this section. Please refer to the Venezia Transport Services, Inc. Plan document for additional defined terms.

**We, Us, and Our** – Venezia Transport Services, Inc.

**Affiliated Company** – A corporation or other business entity affiliated with Venezia Transport Services, Inc. through common ownership of stock or assets; or as otherwise defined Venezia Transport Services, Inc..

**Allowance** – Actual charges of a Provider or a dollar amount set by the Pharmacy Benefit Manager, unless otherwise required by law.

**Benefit Period** – The twelve month period starting on January 1<sup>st</sup> and ending on December 31<sup>st</sup>. The first and/or last benefit period may be less than a calendar year. The first benefit period begins on your coverage date. The last benefit period ends when you are no longer coverage.

**Brand Name Drugs** – A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer, and

- a. drugs as determined by the Food and Drug Administration and listed in the formulary of the State in which they are dispensed; and
- b. protected by the trademark registration of the pharmaceutical company which produces them.

**Clean Claim** – (1) the claim is an eligible claim for service rendered by an eligible Practitioner; (2) it has no material defect or impropriety (including, but not limited to, miscoding or missing documentation); (3) there is no dispute over the claim; (4) CVS Caremark has no reason to believe that the claim was submitted fraudulently; and (5) there is no need for special treatment such as might prevent timely payment.

**Copayment** – A specified dollar amount a Covered Person must pay for specific covered drugs for prescription drugs under this plan.

**Coinsurance** - A specified percentage amount a Covered Person must pay for specific covered drugs for prescription drugs under this plan.

**Covered Services and Supplies** – The types of services and supplies described in the covered services and supplies section of this booklet. The services and supplies must be furnished or ordered by a Provider.

**CVS Pharmacy** – An in network retail pharmacy wherein maintenance drugs can be obtained at a 90 day supply.

**Date of Service** – Date on which a prescription is filled or dispensed.

**Deductible** – A specified dollar amount a covered person must pay before drugs specific prescription drugs are covered under this plan

**Days Supply** – The number of days payable by the plan for the dispensed drug.

**Direct Claim** – A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement at contracted rate minus copay.

**Dispense as Written (DAW) 1** – A provision by where a physician requests a brand-name medication when a generic equivalent is available. When this provision applies the member will be responsible for the difference in cost between the generic and brand-name drug, as well as the brand-name copay.

**Dispense as Written (DAW) 2** – A provision by where a member requests a brand-name medication when a generic equivalent is available. When this provision applies the member will be responsible for the difference in cost between the generic and brand-name drug, as well as the brand-name copay.

**Enrollment Date** – The effective date of your coverage or, if earlier, the first day of any applicable waiting period.

**Federal Legend Drugs** – A drug that requires a prescription; these drugs can be identified by the presence of “Federal Legend” on the label.

**Formulary (Preferred) Drugs** – The plan includes a formulary. A formulary is a list of commonly prescribed medications that have been selected for their clinical effectiveness, safety and cost. By asking your doctor to prescribe formulary (plan-preferred) medications, you can help control health care costs while maintaining high-quality care. An independent Pharmacy and Therapeutics committee updates this list quarterly based on continuous evaluation of medications. You can contact CVS Caremark at **1-888-202-1654** to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at **www.caremark.com**. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist.

**FDA** – The Food and Drug Administration.

**Generic Prescription Drug** – A medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. Generic medications may differ in color, size, or shape, but the Food and Drug Administration requires that they have the same strength, purity, and quality as their brand-name counterparts. A generic medication can be produced once the manufacturer of the brand-name medication is required to allow other manufacturers the opportunity to produce the medication.

**Generic Step Therapy** – Generic step therapy requires that a cost effective generic alternative is tried first before targeted brands are covered. For Plan Members with a new prescription for a targeted single-source brand medication that has not been taken before and is presented, the adjudication system will check for previous generic use. If the history shows generic use, the targeted brand claim will pay. For targeted brands with no history of a generic trial, the retail pharmacist receives an electronic message with the generic-first criteria and a toll free number for the physician to call for more information. In the event the prescriber determines that a generic alternative is not right for the member, (s)he can call the Prior Authorization Department.

**In-Network Retail Claims** – Claims processed by pharmacies that are included in the member’s pharmacy network.



**Maintenance Medication** – Medications prescribed for long-term use, (i.e., the medication taken daily by high-blood pressure sufferers or diabetics).

**Mandatory Mail Order** – A provision by which all prescriptions for maintenance medications (medications taken on a regular basis) must be filled for 90-day supply using the mail-order service or Venezia Transport Services, Inc. Internal Pharmacy after the third (3<sup>rd</sup>) refill. If members continue to fill prescription at retail pharmacies after the third (3<sup>rd</sup>) fill, the plan will not cover any of the cost.

**Multi Source (Brand) Drug** – Medication that may have an FDA generic equivalent substitute available.

**Non-Formulary (Non-Preferred) Drugs** – A listing of brand name and generic prescription drugs that are covered, but are not on the preferred drug list.

**Non-Participating Pharmacy (Out-of-Network)** – A pharmacy not party to an agreement with the Claims Administrator, or a pharmacy who is party to such an agreement but who does not dispense prescription drugs in accordance with the terms of that Agreement. If you have a prescription filled at a pharmacy which is not participating, you must pay the pharmacy the full amount of its bill and submit a claim form with an itemized receipt for reimbursement. The Plan will pay benefits based on the amount it would have paid under the Plan at a Participating Pharmacy, less the applicable copayment.

**Out of Network Claims**– Claims processed by pharmacies that do not participate in the member's pharmacy network.

**Out of Pocket Maximum** – The maximum dollar amount that a Covered person must pay as Deductible, and/or Copayments and/or Coinsurance for Covered Services and Supplies during any Benefit Period. Once that dollar amount is reached, no further such payments are required for the remainder of that Benefit Period. **Note:** Any penalties imposed for not following plan guidelines will not apply to this maximum.

**Over the Counter (OTC Medication)** – Medication that does not require a prescription.

**Participating Pharmacy (In-Network)** – A local retail pharmacy, which is party to an agreement with the Claims Administrator to dispense drugs to persons covered under the Plan, but only:

- While the agreement remains in effect; and
- When such a pharmacy dispenses a prescription drug under the terms of its agreement with the Claims Administrator.

To find a Participating Pharmacy nearest you, call Member Services toll free **1-888-202-1654** or visit the website at [www.caremark.com](http://www.caremark.com) to use the online interactive pharmacy locator.

When you present your ID card at a Participating Pharmacy, you are charged according to the Pharmacy Co-payment Schedule. If you do not use your prescription card at the Participating Pharmacy, you will be responsible for 100% of the prescription retail price at the time of purchase. You will need to submit a completed claim form to CVS Caremark for reimbursement. These forms may be found online. The Plan will not cover any price difference between the amount charged by the pharmacy and the discounted amount that would have been charged if you had presented your ID Card. You will be responsible for this amount in addition to your co-payment amount.

**Pharmacy** – A facility that is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are dispensed by a pharmacist.

**Pharmacy Benefit Manager** – The organization that administers and provides the network of pharmacies utilized in the prescription plan; currently CVS Caremark.

**Preferred Drugs** – Generic Prescription Drugs or Brand Name Drugs (including single-source drugs), which are Determined by the Pharmacy Benefit Manager and identified on a list as such, which list shall be made available to Covered Persons and may be amended from time to time.

**Prescription Drug Maximum** – The total benefits that will be provided under this plan during the Covered Person's benefit period.

**Prescription Drug Network** – The network of pharmacies, as determined by the Pharmacy Benefit Manager, and identified as such, to provide benefits under this plan at negotiated rates.

**Prescription Drugs** – A prescription drug is any of the following:

- A drug, biological, or compounded prescription which, by Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription."
- Diabetic supplies when prescribed. This includes other diabetic equipment such as glucometers and insulin pumps, which may be covered under durable medical equipment.

**Prescription Order** – The request for drugs issued by a Practitioner licensed to make the request in the course of his professional practice.

**Prescription Mail Order** – A Covered Person's request that a Prescription Order for drugs be filled and mailed to him or her by a licensed mail order pharmacy.

**Prior Authorization** – Process by which some medications are covered by the Plan only for certain uses or in certain quantities. For example, a drug may not be covered when it is used for cosmetic purposes. Also, the quantity covered may be limited. In these cases, the pharmacy will let you know if additional information is required for your prescription to be covered.

**Specialty Pharmaceuticals** – Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs must be dispensed through a network Specialty Pharmaceutical Provider.

Examples of Prescription Drugs that qualify as Specialty Pharmaceuticals include those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; Gaucher's Disease.

**Specialty Pharmaceutical Provider** – A vendor that has contracted with the Venezia Transport Services, Inc. Pharmacy Benefit Manager (PBM) provide Specialty Pharmaceuticals on an In-Network basis.

**Step Therapy** – The process by which members may be required to try a lower cost therapeutic, equivalent medication, prior to filling a prescription. A list of medications that apply to this provision is available through the Pharmacy Benefit Manager and is subject to change.

## Schedule of Covered Services and Supplies

**BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PLAN ARE SUBJECT TO ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUMS) STATED IN THIS SCHEDULE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.**

**NOTE: OUR BENEFITS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS BOOKLET.**

**REFER TO THE SECTION OF THIS BOOKLET CALLED “EXCLUSIONS” TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.**

Venezia Transport Services, Inc.’s prescription drug benefits will provide the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations and exclusions stated within the Policy.

### **Prescription Drug Benefits**

Benefits, less the Copayment, are covered for Prescription Drugs dispensed under a Prescription Order and for insulin used outside of the Hospital.

1. From an in-network pharmacy:

The in-network pharmacy will supply prescription drugs and insulin and will not charge you an amount exceeding the copayment.

2. From a Mail Order Pharmacy:

The Mail Order Pharmacy will supply prescription drugs and insulin and will not charge you an amount exceeding the copayment.

3. From an Out of Network Pharmacy:

After submitting proof of payment acceptable to the Pharmacy Benefit Manager, you are entitled to receive up to 100% of the lesser of the in-network pharmacy price or charges less any applicable copayment.

The prescription drug copayments that will apply to prescription drugs obtained from an in-network pharmacy, CVS Mail Order Pharmacy, and CVS Specialty will be as follows:

### **PPO High Plan**

Out of Pocket Maximum (combined with Medical Benefits): \$7,500 Individual / \$15,000 Family (combined Retail/Mail)	30 DAY SUPPLY	90 DAY SUPPLY
	In Network Retail Pharmacy	CVS Pharmacy or Mail Order Pharmacy
Generic	\$10 copay	\$20 copay
(Preferred) Formulary Brand-Name	\$40 copay	\$80 copay
(Non-Preferred) Non-Formulary Brand-Name	\$70 copay	\$140 copay
Medications which cost \$1,000 or more	15% Coinsurance	15% Coinsurance

Out of Pocket Maximum (combined with Medical Benefits): \$7,500 Individual / \$15,000 Family (combined Retail/Mail)	30 DAY SUPPLY	90 DAY SUPPLY
	In Network Retail Pharmacy	CVS Pharmacy or Mail Order Pharmacy
Specialty	CVS Specialty Pharmacy	
Eligible Specialty Medications filled by CVS Specialty: <ul style="list-style-type: none"> <li>Members Opted into PrudentRx</li> <li>Members Opted out of PrudentRx</li> </ul>	\$0 Copay  30%	N/A

**High Deductible Health Plan (nonqualified)  
Deductible \$3,500 Individual/\$7,000 Family (embedded)**

Out of Pocket Maximum (combined with Medical Benefits): \$6,500 Individual / \$13,000 Family* (combined Retail/Mail)	30 DAY SUPPLY	90 DAY SUPPLY
	In Network Pharmacy	CVS Pharmacy or Mail Order Pharmacy
Generic (Preferred) Formulary Brand-Name (Non-Preferred) Non-Formulary Brand-Name Medications which cost \$1,000 or more	After Deductible*: 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance	After Deductible*: 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance
Specialty	CVS Specialty Pharmacy	
Eligible Specialty Medications filled by CVS Specialty: <ul style="list-style-type: none"> <li>Members Opted into PrudentRx</li> <li>Members Opted out of PrudentRx</li> </ul>	\$0 Copay  30%	N/A
*Deductible and Maximum Out-of-Pocket accumulators are on an embedded basis. No one member of a family will exceed the individual deductible or maximum out-of-pocket amount.		

Refills, as authorized under a prescription order, will be subject to the same requirements as in paragraph above of this section. Benefits for authorized refills will not be provided beyond 1 year from the original prescription date.

The **Mandatory Mail Order (and 90-day CVS Pharmacies)** provision applies by which all prescriptions for maintenance medications (medications taken on a regular basis) must be filled using the 90-day mail-order

service or through CVS Pharmacies after the third (3rd) refill. If members continue to fill prescription at other retail pharmacies after the third (3rd) fill, the prescription drug benefits will not cover any of the cost.

Specialty Pharmaceuticals - When Specialty Pharmaceuticals as prescribed by a physician are required, such Prescription Drugs must be purchased through a network Specialty Pharmaceutical Provider.

The prescription drug copayments that will apply to prescription drugs obtained from a CVS pharmacy or a mail-order pharmacy will be as follows:

For prescription mail orders, the quantity dispensed will be limited to a supply of up to 3 months. One copayment will be applied to each prescription mail order. Refills, as authorized under a prescription order, will be subject to the same limitations.

To maximize your savings under the mail order plan, ask your physician to prescribe a 90 day supply of medication and indicate the number of times the prescription may be refilled.

The prescription drug maximum that will apply to prescription drugs obtained from an in-network or out-of-network or mail-order pharmacy will be as follows:

<b>Prescription Drug Maximums</b>	\$ Unlimited Per Benefit Period
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## General Information

### How To Enroll

Eligible employees of the Employer (and eligible dependents) are eligible under the plan as more particularly described in *Appendix B* of the Venezia Transport Services, Inc. Plan Document, attached hereto and made a part thereof.

You may enroll in prescription drug benefits as described in the *Enrollment* section of the Venezia Transport Services, Inc. Plan. If you enroll your dependents, their coverage will become effective on the same date as your own.

### Your Identification Card

You will receive an identification card to show to the pharmacy when you receive prescription drugs or supplies. Your identification card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can start to use your benefits. All of your eligible dependents share your identification number as well. Should you need additional or replacement ID cards, please contact Member Services or visit [www.caremark.com](http://www.caremark.com) to either request a new card or print a temporary card.

Always carry this card and use your identification number when you receive covered services or supplies. If you lose your card, you can still use your coverage if you know your identification number. The inside back cover of this booklet has space to record your identification number along with other information you will need when making inquiries about your benefits. You should, however, contact your enrollment official immediately to replace the lost card.

You cannot let anyone not named in your coverage use your card or your coverage.

### When Your Coverage Begins

Your coverage begins on the effective date shown on your identification card as long as you have met the eligibility guidelines as described in *Appendix B* of the Venezia Transport Services, Inc. Plan document: attached hereto and made a part thereof.

### When Your Coverage Ends

Your coverage will end when you no longer meet the eligibility guidelines as described in the *When Coverage Ends* section of the Venezia Transport Services, Inc. Plan document attached hereto and made a part thereof.

### Special Enrollment Events

You can make permissible changes to your coverage once per year during annual enrollment. However, you have special enrollment rights under certain circumstances to make changes to your coverage mid plan year. Those special events and the election timeframes are outlined in the *Making Changes during the Year* section of the Venezia Transport Services, Inc. Plan document attached hereto and made a part thereof.

## **How The Prescription Drug Plan Works**

To maximize your prescription drug benefits, you should utilize the one of the more than 65,000 CVS Caremark participating pharmacies that have agreed to provide prescription drugs to Venezia Transport Services, Inc. subscribers at a discounted price. When you use a CVS Pharmacy you realize an added discount for up to a 90 day supply. When you use a network pharmacy, you only pay your applicable copayment or coinsurance for your prescriptions because you are being charged a discounted price rather than the actual retail price.

## **How To Claim Benefits**

### **If You Use CVS Pharmacy**

Present your prescription drug benefits identification card to the pharmacist along with your prescription order. At the time your prescription is dispensed, you pay the copayment, coinsurance or deductible, as applicable, to the pharmacist.

A CVS Pharmacy can dispense both 30 and 90 day supplies. The 90-day supply is designed for plan participants taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions.

The advantages of using the 90-day fill plan are:

- you may purchase up to a 90 day supply of medication **with only one 90-day supply copayment**; refer to schedule of covered services and supplies and
- the medication can be picked up right at the CVS Pharmacy.

### **If You Use another Retail Network Pharmacy**

The CVS Caremark Pharmacy Network is a national network that includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. Use one of these pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local pharmacy, visit [www.caremark.com](http://www.caremark.com) and click the “Register Now” button and follow the instructions or contact Member Services.

If you use a network pharmacy, present your prescription drug benefits identification card to the pharmacist along with your prescription order. At the time your prescription is dispensed, you pay the copayment, coinsurance or deductible, as applicable, to the pharmacist. Your pharmacist will forward the claim to us for reimbursement.

### **If You Use a Retail Non-Network Pharmacy**

You may be reimbursed by CVS Caremark should you visit a non-network pharmacy. However, it is to your advantage to visit a CVS Caremark network pharmacy. The non-network pharmacies will require you to pay for the full cost of the drug at the time of purchase, not just your co-payment amount. You must then complete a direct reimbursement claim form and forward it to CVS Caremark along with your drug receipt. Drug receipts are not cash register receipts and should include:

- amount charged;
- prescription number;
- name of the drug dispensed;

- manufacturer, dosage form, strength and quantity;
- date prescription was dispensed.

Direct reimbursement claim forms are available on the website or by calling Member Services. You will be reimbursed, for up to a 30-day supply for non-maintenance medications and up to a 90 day supply for maintenance medications, at the contracted rate of the prescription, less the co-payment. Reimbursement is based on generic or lower cost brand-name products, if either is available.

**As noted above, when you use a non-network pharmacy, we will reimburse you only the amount that we would have paid a network pharmacy, minus any applicable copayment, coinsurance, or deductible. Since this amount could be significantly lower than the retail price you may have paid, it is your advantage to use network pharmacies whenever possible.**

If a claim is wholly or partially denied for reasons other than plan limitations, the claimant will be notified of the decision within 30 days after CVS Caremark received the completed notice of claim.

CVS Caremark will provide to the claimant (or his agent or assignee) a notice that will set forth:

1. The reasons for the denial;
2. a statement as to what substantiating documentation or other documentation is needed to complete the claim;
3. a statement that the claim is disputed, if applicable; and
4. a statement of the special needs to which the claim is subject, if applicable.

All clean claims shall be paid not later than 30 calendar days of receipt of the completed claim of notice if the claim is submitted to CVS Caremark by electronic means, or within 40 calendar days of receipt of the completed notice of claim if the claim is submitted by other than electronic means. In addition, any portion of a claim that is complete and proper shall be paid according to the above time limits.

If you need help or have any questions concerning your prescription drug benefits, or any other inquiries, please call our Service Center at: **1-888-202-1654**.

### **CVS Caremark Mail Order Pharmacy**

CVS Caremark Mail Order Pharmacy is designed for plan participants taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The plan provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid.

The advantages of using the mail order plan are:

- you may purchase up to a 90 day supply of medication by mail **with only one mail order copayment**; refer to schedule of covered services and supplies and
- the medication is delivered directly to your home, eliminating the need to make repeated visits to your local pharmacy for these non-emergency prescriptions.

In order to fill your prescription through the CVS Caremark Pharmacy, mail your prescription, order form and payment in the envelope provided. You may also ask your doctor to fax your prescription by calling **1-888-202-1654** for further instruction. Your medication will usually be delivered within 10 days of CVS Caremark Pharmacy receiving your order.



To order refills, call the automated refill system at **1-888-202-1654**, or visit [www.caremark.com](http://www.caremark.com) Refills are normally delivered within 3 to 5 days.

If you are a first-time visitor to the site, please take a moment to register; have your member ID and a prescription number available.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Member Services.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions; one prescription should be written and filled at your local pharmacy and the second should be written for up to a 90-day supply and mailed to CVS Caremark Mail Order Pharmacy.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by highly qualified registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, CVS Caremark' pharmacists will contact either you or your doctor prior to dispensing the medication.

**A convenient, automatic refill program for your long-term medications is available.** When you refill certain mail-order prescriptions, you'll be asked whether you want to enroll. Once you enroll and are ready for a refill or renewal, your medications will automatically ship to you. Find out more about how this program works by logging in to [www.caremark.com](http://www.caremark.com) or by calling Member Services using the phone number on ID card. (To see which of your medications are eligible, log into [www.caremark.com](http://www.caremark.com).)

The **Mandatory Mail Order (and 90-day through CVS Pharmacy)** provision applies by which all prescriptions for maintenance medications (medications taken on a regular basis) must be filled using the 90-day mail-order service or through a CVS Pharmacy 90-day program after the third (3rd) refill. If members continue to fill prescription at retail pharmacies after the third (3rd) fill, the plan will not cover any of the cost.

### **Specialty Medications: Get personalized service through CVS Specialty Pharmacy**

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Our dedicated specialty pharmacy, CVS Specialty Pharmacy, is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

As part of your prescription drug benefit, you will have access to the enhanced services of CVS Specialty Pharmacy for your specialty medication needs. To get the most from your prescription drug benefit, start purchasing your specialty medications from CVS Specialty Pharmacy. **If you use a pharmacy other than CVS Specialty Pharmacy to purchase certain specialty medications, you will be responsible for the entire cost.**

Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through CVS Specialty Pharmacy, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of your medications at no additional charge

- Necessary supplies, such as needles and syringes, provided with your medications(doctor will need to write a prescription for each supply)
- Safety checks to help prevent potential drug interactions
- Refill reminders
- Health and safety monitoring
- Up to a 30-day supply of your specialty medication

For more information about CVS Specialty Pharmacy, or to order your specialty medications, please call Member Services toll-free at **1-866-295-2779**.

### **PrudentRx Copay Program for Specialty Medications**

The PrudentRx Copay Program will help plan members get copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby out-of-pocket (OOP) expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you currently take one or more medications included in your plan's exclusive Specialty Drug List, you will receive a welcome letter and phone call from PrudentRx that provides information about the program as it pertains to your medication. All eligible members will be automatically enrolled in The PrudentRx Copay Program, but you can choose to opt out of the program by calling **1-800-578-4403**.

Some manufacturers make you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at **1-800-578-4403** to provide any other information needed to enroll in the program. PrudentRx will also contact you if you need to enroll in the copay assistance for any medication that you take. If you choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full amount of the 30% copay responsibility on eligible specialty medications. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. If you or a covered family member are not currently taking, but will start a new medication covered under The PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the program.

Please note: your plan's exclusive Specialty Drug List may be updated periodically. Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible or coinsurance. Only amounts paid by the member apply to the deductible, coinsurance and OOP maximum under the plan. Because certain specialty medications do not qualify as "essential health benefits" (EHB) under the Affordable Care Act (ACA)<sup>4</sup>, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's maximum OOP (MOOP). A list of specialty medications that are not considered to be EHB is available. An exception process is available for deciding whether a medication that is not an EHB is medically necessary for a particular individual. There's an exception process to decide if a medication that's not an EHB is medically necessary for a particular member. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding The PrudentRx Copay Program.

**Prior authorization: When is a coverage review necessary?**

Some medications are not covered unless you first receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective.

## Summary of Covered Services and Supplies

This section lists the types of charges CVS Caremark will consider as covered services or supplies up to its allowance subject to all the terms of the Plan including, but not limited to, medical necessity and appropriateness, utilization review features, schedule of covered services and supplies, benefit limitations and exclusions.

### Prescription Drug Benefits

Prescription drugs purchased from a licensed pharmacy for use outside a hospital (or other facility) are eligible under your plan. You will receive a prescription drug identification card which you should use to obtain benefits. Prescription drugs are covered under the following circumstances:

1. when prescribed for an FDA-approved treatment;
2. when prescribed for a non FDA-approved treatment if the drug has been recognized as medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:
  - a. The American Medical Association Drug Evaluations;
  - b. The American Hospital Formulary Service Drug Information; or
  - c. The United States Pharmacopoeia Drug Information;

or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, coverage under this sub-paragraph shall not be required for any Experimental or Investigational drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Insulin is also covered. Please note that some prescriptions subject to medical review may not be eligible.

### Conditions Under Which Service Will Be Provided

Your identification card should be presented to the in-network pharmacy (other than a mail-order pharmacy) when you request benefits.

Venezia Transport Services, Inc. will not be responsible for any claim, injury or judgment based on tort or other grounds, including warranty of merchantability, arising out of or in connection with the sale, compounding, manufacturing or use of any prescription drug or insulin whether or not covered under the Plan.

### **(Preferred) Formulary and (Non-Preferred) Non-Formulary Medications**

The CVS Caremark Formulary List is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. CVS Caremark provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective.

If a drug you are taking is *not* on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and Venezia Transport Service, Inc.'s costs lower.

A current drug list is available online or upon request by calling Member Services. To avoid paying higher co-payments associated with non-preferred drugs, please take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your eligible family participants.

## **Limitations**

A pharmacy need not fill a prescription order which, in the pharmacist's professional judgment, should not be filled.

Prescription orders for prescription drugs determined to be medically necessary by CVS Caremark may be sold in supplies of up to no more than a 3 month supply.

Refills, as authorized under a prescription order, will be subject to the same requirements as in paragraph above of this section. Benefits for authorized refills will not be provided beyond 1 year from the original prescription date.

If applicable, no covered person shall be required to use a mail-order pharmacy. However, in the event a covered person chooses to use a mail-order pharmacy, the prescription drug copayment shall not differ between a mail order and retail pharmacy if a) the drugs are of the same strength, quality and days' supply; and b) the retail pharmacy agrees to the same terms, conditions, price and services applicable to the mail order pharmacy. No copayment, fee or other condition shall be imposed upon a covered person selecting a participating pharmacist that is not also equally imposed upon all covered persons selecting a participating pharmacist or pharmacy.

The plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the CVS Caremark Pharmacy, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. We will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

## Exclusions Under The Prescription Drug Plan

**The following are not covered services and supplies under the prescription drug benefits. Venezia Transport Services, Inc. will not pay for any charges incurred for, or on connection with:**

- Administration or injection of any drugs.
- Allergy Sera
- Any charges to the extent it exceeds the allowance.
- Any excluded medication as determined by the Plan Administrator in concert with the CVS Caremark formulary. You may contact CVS Caremark for the most current information regarding covered and excluded medications
- Any medication amounts over covered quantity limits or set plan maximums.
- Any Retin-A or pharmacologically similar topical drugs for participants age 35 and older, unless medically necessary.
- Any services or supplies not specifically defined as covered drugs herein.
- Any services provided or items furnished for which the pharmacy normally does not charges.
- Any special services provided by the Pharmacy, including but not limited to counseling and delivery.
- Balances for services and supplies after payment has been made under this plan.
- Blood or blood plasma products
- Completion of claim forms.
- Contraceptive drugs devices (except where indicated under Federal legislation). Emergency Contraceptives, Plan B, Diaphragms and Cervical Caps are excluded.
- Copayments, deductibles and the individual's part of any coinsurance; expenses incurred after any payment maximum is or would be reached.
- Court ordered treatment which is not medically necessary and appropriate.
- Covered drugs, devices, or other pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Covered drugs dispensed in quantities in excess of the Day Supply amounts stipulated under Limitations on Quantities Dispensed or refills of any prescriptions in excess of the number of refills specified by the physician or by law, or any drugs or medicines dispensed more than one year following the prescription order date
- Drugs connected with sex transformation and treatment for gender identity disorders.
- Drugs dispensed in unit-dose packaging when bulk packaging is available.
- Drugs dispensed in a physician's office or during confinement while a patient in a hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility beyond the 3 fill retail limit for maintenance medications.
- Drugs needed for an illness or Injury, including a condition which is the result of an Illness or Injury, which: (a) occurred on the job; and (b) is covered or could have been covered for benefits provided under a workers' compensation, employer's liability, occupational disease or similar law. However, this exclusion

does not apply to the following persons for whom coverage under workers' compensation is optional, unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

- Drugs provided by or in a government hospital, or provided by or in a facility run by the Department of Defense, for a service-related condition, unless coverage for the services is otherwise required by law. – Veterans Administration Claims are allowed.
- Drugs, obtained from a State or local public health agency, for the treatment of venereal disease or mental disease.
- Drugs dispensed by other than a pharmacist or a pharmacy or for services rendered by a pharmacist which are beyond the scope of his license. Benefits are not provided for drugs administered by a physician or other practitioner.
- Drugs prescribed for cosmetic purposes including but not limited to all hypopigmentation, Renova, and Vaniqa.
- Drugs that are needed due to condition to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the covered Person's engagement in an illegal occupation.
- Drugs and supplements that can be obtained over the counter that have an over the counter drug classification unless mandated by federal legislation. Any over the counter medication allowed under the plan requires a prescription from a medical provider. Some examples of covered drugs/supplements may include Aspirin 81 mg, iron supplements, folic acid and other vitamins. Note that age restrictions or diagnosis may be required for coverage.
- Drugs to replace those that may have been lost or stolen.
- Drugs to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.
- Drugs to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.
- Drugs to enhance normal functions, such as: steroids to improve athletic performance;
- Drugs to improve memory.
- Drugs and compounds not approved by the Pharmacy Benefit Manager.
- Drugs to treat sexual arousal dysfunction that are unauthorized.
- Drugs used or intended to be used in a manner which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the ID Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Plan or for which benefits have been exhausted.
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.
- Fertility agents.

- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (internal) infusion or by intravenous injection in the home setting.
- Herbal medicine.
- HSDD Agents – Mixed Serotonin Agonist/antagonist (ex. Addyi)
- Inhaler assisting devices.
- Injectibles not on covered drug list.
- Insulin pump supplies (does not include items such as testing strips, lancets, needles and syringes).
- Legend drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.
- Methadone maintenance unless approved by the Pharmacy Benefit Manager.
- Non-medical equipment which may be used primarily for personal hygiene or for comfort or convenience of a covered person rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, saunas, hot tubs, televisions, first aid kits, exercise equipment, heating pads and similar supplies which are useful to a person in the absence of illness or injury.
- Non-Federal Legend, Federal Legend Non-drugs, and Non-prescription (over the counter) drugs or supplies (except those as indicated under Federal legislation)
- Ostomy Supplies
- Personal comfort and convenience items.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Services or supplies:
  - eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the covered person asserts his rights to obtain this coverage or payment for these services;
  - for which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair;
  - for which the provider has not received a certificate of need or such other approvals as are required by law;
  - for which the covered person would not have been charged if he did not have health care coverage;
  - furnished by one of the following members of the covered person's family, unless otherwise stated in this booklet: spouse, child, parent, in-law, brother or sister;
  - in connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a bonafide diagnosis has been made because of existing symptoms;
  - needed because the covered person engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
  - not specifically covered under the Plan;
  - received as a result of: war, declared or undeclared; policy actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
  - rendered prior to the covered person's effective date or after his termination date of coverage under the plan, unless specified otherwise;
  - which are specifically limited or excluded elsewhere in this booklet;
  - which are not medically necessary and appropriate; or
  - which a covered person is not legally obligated to pay for;
  - Special medical reports not directly related to treatment of the covered person (e.g. employment physicals, reports prepared in connection with litigation);



- Telephone consultations;
  - Transportation; travel;
  - Weight reduction or control, special foods, food supplements, liquid diets, diet plans or any related products, except as specifically covered under this plan.
- Topical Fluoride products
  - Vitamins (except those vitamins which by law require a prescription order and for which there is no non-prescription alternative) or are mandated by federal legislation.

## **Reviews and Appeals Process**

Determinations on prescription drug benefits under the Venezia Transport Services, Inc. prescription drug benefit plan will be made by CVS Caremark in accordance with the following provisions. You may request coverage beyond your plan's standard benefit offering, or if you are dissatisfied with a benefit determination made by CVS Caremark, you may appeal the determination in writing.

### **Coverage review description**

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. CVS Caremark reviews both clinical and administrative coverage review requests:

**Clinical coverage review request:** A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

**Administrative coverage review request:** A request for coverage of a medication that is based on the Plan's benefit design.

### **How to request an initial coverage review**

To request an initial clinical coverage review, also called prior authorization, the prescriber can either submit the request electronically or by calling 1-800-294-5979. Information about electronic options can be found at [www.caremark.com](http://www.caremark.com).

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Prescription Claim Appeals Addendum, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to Caremark, Inc. Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172. For Specialty Appeals, the Prescription Claim Appeals Addendum, used to submit the request, can be completed and sent to CVS/Caremark, Inc. Attn: Specialty Guideline Management Appeals Department, 800 Biermann Court, Suite B, Mt. Prospect, IL 60056. Fax 1-855-230-5548 Attention: Appeals Department.

If the patient's situation meets the definition of urgent care under the law, an urgent care review may be requested and will be conducted as soon as possible, but no later than 24 hours from receipt of request. In general, an urgent care situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at 1-800-294-5979.

## How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to CVS Caremark for review. For an administrative coverage review request, the prescriber must submit information to CVS Caremark to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than: 72 business hours urgent requests 24 business hours	Notification of Decision	
		Approval	Denial
Urgent	24 hours**	Patient: letter  Prescriber: Fax (letter if fax not successful)	Patient: letter  Prescriber: Fax (letter if fax not successful)

\*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

\*\*Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

## How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Caremark, Inc. Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172. For Specialty Appeals: CVS/Caremark, Inc. Attn: Specialty Guideline Management Appeals Department, 800 Biermann Court, Suite B, Mt. Prospect, IL 60056. Fax 1-855-230-5548 Attention: Appeals Department.

Administrative review Requests: Caremark, Inc. Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172. For Specialty Appeals: CVS/Caremark, Inc. Attn:

Specialty Guideline Management Appeals Department, 800 Biermann Court, Suite B, Mt. Prospect, IL 60056. Fax 1-855-230-5548 Attention: Appeals Department.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone 1 866-443-1183 Option 1 or fax 1 866-443-1172. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

**How a level 1 appeal or urgent appeal is processed**

CVS Caremark completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or an independent third party utilization management company. Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than: 72 business hours urgent requests 24 business hours	Notification of Decision	
		Approval	Denial
Urgent*	24 hours	Patient: letter Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)

\*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

**How to request a level 2 appeal after a level 1 appeal has been denied**

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied

- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Caremark, Inc. Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172. For Specialty Appeals: CVS/Caremark, Inc. Attn: Specialty Guideline Management Appeals Department, 800 Biermann Court, Suite B, Mt. Prospect, IL 60056. Fax 1-855-230-5548 Attention: Appeals Department.

Administrative review Requests: Caremark, Inc. Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172. For Specialty Appeals: CVS/Caremark, Inc. Attn: Specialty Guideline Management Appeals Department, 800 Biermann Court, Suite B, Mt. Prospect, IL 60056. Fax 1-855-230-5548 Attention: Appeals Department.

An urgent level 2 appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone 1-866-443-1183 or fax 1 866-443-1172. Claims and appeals submitted by mail will not be considered for urgent processing unless a fax identifies the appeal as urgent.

**How a level 2 appeal is processed**

CVS Caremark completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist, Physician, panel of clinicians or an independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than: 72 business hours urgent requests 24 business hours	Notification of Decision	
		Approval	Denial
Urgent*	24 hours	Patient: letter Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)

\*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

## **When and How to request an External Review**

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to: CVS Caremark, Attn: Appeals Department MC 109, PO Box 52084 Phoenix, AZ 85072-2084. Fax 1-866-443-1172.

## **How an External Review is processed**

**Standard External Review:** CVS Caremark will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and CVS Caremark written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

**Urgent External Review:** Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

## **Member Services**

Visit CVS Caremark' website, [www.caremark.com](http://www.caremark.com), to view your plan design and co-payment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Member Services directly at **1-888-202-1654**. For future reference, this number is listed on the back of your CVS Caremark ID card.

This booklet is not a contract and contains only a general description of your prescription drug benefits. These benefits are subject to the terms, conditions, and limitations of the Venezia Transport Services, Inc. Wrap Plan

Document issued by your Employer and the provisions of the applicable Federal Law. If you need additional information, contact your Enrollment Official.

In the event there appears to be a contradiction between the benefits described in this booklet and those provided in the Wrap Plan Document, the Wrap Plan Document shall prevail.

## ERISA Plan Information

### TYPE OF ADMINISTRATION

The prescription drug benefits are self-funded and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The plan is not insured.

### PLAN NAME

The prescription drug benefits described in this booklet is a component benefit offered under the Venezia Transport Services, Inc. Plan (the "Plan"). The Plan document, along with the other related documents provided by the carrier and third party administrators (such as this Summary, certificates of insurance and descriptive booklets, which are incorporated into this Document), is designed to be your primary source of health and welfare benefits information. Refer to the Plan document for information about your benefits, and share it with your family members. This Summary is also intended to supplement the Plan document described above, which together comprise the official Plan document. An amendment to this Summary is considered an amendment to the official Plan document.

**PLAN NUMBER:** 502

**PLAN SPONSOR:** Venezia Transport Services, Inc.

**TAX ID NUMBER:** 23-2364297

**PLAN YEAR:** September 1 through August 31