



Health Benefits



Putting the pieces together to improve your health

Prescription Benefits State of Maryland

CVS Caremark[®] manages your prescription drug benefit under a contract with the State of Maryland.



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Introduction

This Prescription Benefit document describes how to get prescription medications, what medications are covered and not covered, and what portion of the prescription costs you will be required to pay.

CVS Caremark, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit under the State Employee and Retiree Health and Welfare Benefit Program (the Program). CVS Caremark maintains a preferred drug list (also known as a Formulary), manages a network of retail pharmacies and operates Mail Service and Specialty Drug pharmacies. CVS Caremark, in consultation with the Program, also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions and other safety measures.

Employees and eligible dependents covered by the Program's prescription drug benefit can use either retail pharmacies or the CVS Caremark Mail Service Pharmacy. Your benefit covers most prescription drugs, plus insulin and some over-the-counter (OTC) diabetic supplies and certain other OTC items considered preventative under the Affordable Care Act (ACA). Certain medications are subject to limitations and may require prior authorization for continued use.

Retail Pharmacies

Retail pharmacy service can be used for both acute (short-term) and maintenance (long-term) medications. You may receive up to a 90-day supply at a retail pharmacy. Refer to the plan grid for the appropriate copay.

All major chain pharmacies participate in the network as do most independent pharmacies. If you are using an independent drugstore, you should confirm whether it participates. To find out, visit www.info.caremark.com/stateofmaryland or call Customer Care at **1-844-460-8767** (TTY 711).

Member Identification Card (Member ID card)—Network Pharmacy

In order to utilize your Prescription Drug Benefit at a participating Retail Network Pharmacy, you should show your CVS Caremark ID Card at the time you obtain your prescription drug medication at a participating Retail Network Pharmacy.

If you do not show your Member ID Card at a Network Pharmacy, you will be required to pay the Full Retail Cost (Usual and Customary Charge) for the Prescription Drug Product at the pharmacy.

If you paid full Retail Cost at the pharmacy and wish to seek reimbursement, you may obtain a prescription drug claim form by calling CVS Caremark Customer Care at **1-844-460-8767** or online at <http://info.caremark.com/stateofmaryland>. Along with the prescription drug claim form, you will need the pharmacy receipt for your prescription.

When you submit a prescription drug claim on this basis, you will be responsible for the copay amount according to the Schedule of Benefits. The Program is charged the submitted amount less the applicable copay.



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CVS Caremark® Mail Service

Members that need medication on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills, if appropriate, to be filled via CVS Caremark Mail Service. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. You will pay two retail copayments for up to a 90-day supply.

Some of the benefits of mail service are the following:

- Medications are shipped standard delivery in a plain, weather-resistant package at no additional cost
- Flexible payments
- Refill orders placed at your convenience, by telephone or online
- Access to a registered pharmacist any time, day or night
- Ability to transfer prescriptions between mail order and CVS pharmacy

Getting started with mail service

You can begin using the CVS Caremark Mail Service Pharmacy for home delivery of your medications, using one of the following options:

Online: Register at <http://info.caremark.com/stateofmaryland> to begin managing your prescriptions online. Download the CVS Caremark app to begin using mail order

By mail: Ask your doctor to provide you with a written prescription for your medications. Sign in to **caremark.com** to download and print a mail service form. Mail the prescription(s) along with a completed order form to the address below:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094

Please note: To avoid delays in filling your prescription, be sure to include payment with your order. Please do not send correspondence to this address.

By fax or electronic submission from your doctor: Have your doctor's office fax the prescription for a 90-day supply, plus the appropriate number of refills (maximum one-year supply). Most prescriptions are sent electronically. Your doctor should be able to send your prescription to CVS Caremark Mail Services. We also accept faxes, and your doctor's office will have the appropriate fax number.

Important notes:

- Faxes must be sent from your doctor's office. Faxes from other locations, such as your home or workplace, cannot be accepted.
- For new prescriptions, please allow approximately one week from the day CVS Caremark Mail Service receives your request.
- You must use 75% of your medication before you can request a refill through mail service (80% of your medication for controlled substances).



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CVS Specialty®

CVS Specialty is a full-service pharmacy that provides your choice of home delivery service or delivery to your local CVS Pharmacy for specialty medications. These medications are used to treat a number of complex conditions, such as cancer and multiple sclerosis. CVS Specialty does more than provide your medication. We help you stay on track so you can stay healthier longer. We do this by providing the support you need to take them safely and effectively.

Getting started

To get started, call a CVS Specialty representative at **1-800-237-2767** or register online at **CVSspecialty.com**. You may also request that CVS Specialty contact your doctor for you, then call you to arrange for delivery of your medication on a day that is convenient for you. You may refill specialty medications one month at a time (maximum 30-day supply per copayment).

24/7 personalized care

CVS Specialty provides 24/7 support from an entire CareTeam of specially-trained pharmacists and nurses. Your CareTeam can help you manage your condition by: checking dosing and medication schedules; answering your medication questions; helping you manage side effects; helping you set up new medication regimens; and checking that you are taking your medication as prescribed.

Flexible, medication pick-up or delivery

CVS Specialty lets you stay in control and on track with flexible medication pick-up or delivery service. Just pick up your medication at any of the 9,700 CVS Pharmacy locations nationwide or have it delivered to your home or work—the choice is yours.†

Convenient online prescription management

Register for a secure, online specialty prescription profile and make managing your medication even easier with these online tools.

- **Fast refill requests:** Most specialty medications and supplies can be filled at the same time with the one-click “Refill All” tool.
- **Up-to-date prescription information:** View your prescription history, refills remaining, your costs, last fill date and more.
- **Medication pick-up or delivery options:** Request your refills be sent directly to the location of your choice or pick them up at your local CVS Pharmacy.
- **Secure prescription information storage:** Keep all your specialty prescription information in one, secure place. Save your favorite CVS Pharmacy location or address for faster ordering and checkout.



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Schedule of Benefits

Employees and Non-Medicare Retirees		
Local and Mail Service Pharmacies		
Type of Medication	Up to 45-Day Supply (1 copayment)	46- to 90-Day Supply (2 copayments)
Generics	\$10	\$20
Preferred Brands	\$25	\$50
Other Brands	\$40	\$80
Out-of-Pocket Maximum	Active Employees	Non-Medicare Retirees
Single only coverage	\$1,000	\$1,500
Family coverage	\$1,500	\$2,000

SLEOLA Plan Design – Employees Only		
Local and Mail Service Pharmacies		
Type of Medication	Up to 45-Day Supply (1 copayment)	46- to 90-Day Supply (2 copayments)
Generics	\$5	\$10
Preferred Brands	\$15	\$30
Other Brands	\$25	\$50
Out-of-Pocket Maximum		
All coverage tiers	\$700	

Notes for Non-SLEOLA and SLEOLA plan designs

1. If you receive a brand-name medication when a generic is available, you will pay the brand copayment plus the difference in cost between the generic and brand-name medication.
2. Some specialty drugs require limited distribution and must be filled through a specialty pharmacy.
3. Some drugs are limited to a 30-day supply. Starting in 2018, you will pay one-third of the 90-day copayment for every 30-days supply.



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Covered Prescription Drug Benefits

Prescription drugs, unless otherwise stated below, must be necessary and not experimental, in order to be Covered Services. Covered Services will be limited based on medical necessity, quantity and/or age limits established by the Plan, or utilization guidelines. Covered services are also subject to formulary management.

- Prescription legend drugs
- Certain OTC medications as indicated under the Affordable Care Act*
- Injectable insulin and needles and syringes used for administration of insulin
- Contraceptive drugs: oral, transdermal, vaginal and injectable
- Contraceptive devices
- Prenatal and Pediatric Prescription vitamins as well as those covered under the Affordable Care Act*
- Influenza immunizations and those immunizations covered under the Affordable Health Care Act*
- Diabetic supplies and equipment are covered such as diabetic test strips, lancets, swabs and glucose monitors. Contact CVS Caremark to determine approved covered supplies. If certain supplies, equipment or appliances are not available through the prescription benefit, they may be available through the medical benefit
- Injectables unless otherwise noted as benefit exclusions
- Prescription and some OTC smoking cessation drugs, such as nicotine replacement, bupropion/Zyban and Chantix* (with days supply limits)

Non-Covered Prescription Drug Benefits

- Anorectics (any drug used for the purpose of weight loss)
- DESI drugs (drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness)
- Pregnancy Termination Drugs (e.g., RU486, Mifeprex)
- Aerochamber, Aerochamber with Mask and Nebulizer Masks and all other medical supplies
- Over-the-counter vitamins except those covered under the Affordable Health Care Act*
- Bulk Compounding Ingredients, kits, high cost bases
- Medications used for cosmetic purposes only such as hair growth stimulants
- Experimental/Investigative Drugs
- Homeopathic Products
- Worker's Compensation Claims

*Certain prescription and OTC medications are considered preventative by the Affordable Care Act and are covered by the prescription drug benefit. A prescription is required to obtain these preventative medications through your prescription benefit plan. For more information, contact CVS Caremark Customer Care at 1-844-460-8767.



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Prior Authorization

Prior Authorization may be required for certain specialty and non-specialty prescription drugs). This may also be referred to as a coverage review. Prior Authorization helps to ensure the medication is clinically appropriate and cost-effective. This review uses formulary, clinical guidelines and other criteria to determine if the plan will pay for certain medications. At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system and your doctor will need to contact CVS Caremark's Prior Authorization department to provide justification for CVS Caremark's consideration of why you should be on the prescribed medication.

The following are examples that may require prior authorization for your prescription:

- Your doctor prescribes a medication not covered by the formulary
- The medication prescribed is subject to age limits
- The medication is only covered for certain conditions

If Prior Authorization is denied, written notification is sent to both you and your providers. You have the right to appeal through the appeals process. The written notification of denial you receive provides instructions for filing an appeal. Additional information regarding the appeals process is located at the end of this document.

To ask if a drug requires Prior Authorization, please contact CVS Caremark Customer Care at **1-844-460-8767**.

Formulary or Preferred Drug List

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage while maintaining the high quality of care.

The formulary for the Program will be updated on an annual basis, at the beginning of each calendar year. Plan Members for whom a prescription drug has been prescribed during the preceding twelve (12) month period will be notified at least forty-five (45) days before a drug is removed or changed on the formulary. **Note:** when a new generic becomes available it will be added to the formulary at the beginning of the next quarter. The corresponding brand name drug may be moved to tier 3 (non-preferred) at the same time.

You may request a copy of the Program's drug list or formulary by calling CVS Caremark Customer Care at **1-844-460-8767** or viewing the list online at www.info.caremark.com/stateofmaryland.



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Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate medication therapy and reducing prescription costs. Medications are grouped into two categories:

- 1. First-line medications:** These are the medications recommended for you to take first—usually generics, which have been proven safe and effective. You pay the lowest copayment for these.
- 2. Second-line medications:** These are brand-name medications. They are recommended for you only if a first-line medication does not work. You may pay more for brand-name medications.

These steps follow the most current and appropriate medication therapy recommendations. CVS Caremark will review your records for step therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a step therapy medication, the pharmacy will search your prescription records for use of a first-line alternative.

If prior use of a first-line medication is not found, the second-line medication will not be covered. You will need to obtain a new prescription from your doctor for one of the first-line alternatives, or have your doctor request a prior authorization for coverage of the second-line medication. For more information on step therapy, call Customer Care at **1-844-460-8767** or visit <http://info.caremark.com/stateofmaryland>.

Specialty Pharmacy Network

Specialty Drugs are prescription legend drugs which:

- Are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis
- May be injected, infused or require close monitoring by a physician or clinically trained individual; or
- Often have limited availability, special dispensing and delivery requirements, and/or require additional patient support

CVS Specialty, the mail order specialty pharmacy, and retail pharmacies (subject to availability), may fill specialty drug prescription orders. Select specialty drugs are limited to a 30-day supply. For your convenience, you may drop off and pick-up a specialty prescription, to be filled through CVS Specialty at any CVS pharmacy location.

To get started, call a CVS Specialty representative at **1-800-237-2767** or register online at **CVSspecialty.com**. You may also request that CVS Specialty contact your doctor for you, then call you to arrange for delivery of your medication on a day that is convenient for you.



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Out-of-Network Retail Pharmacy

If you visit an out-of-network retail pharmacy, you are responsible for payment of the entire amount charged by the non-network retail pharmacy and will then need to submit a prescription drug claim to CVS Caremark for reimbursement consideration.

These forms are available from CVS Caremark by calling Customer Care at **1-844-460-8767** or online at **<http://info.caremark.com/stateofmaryland>**. You must complete the form, attach an itemized receipt to the claim form, and submit to CVS Caremark.

The itemized receipt must show:

- Name and address of the non-network retail pharmacy
- Patient's name
- Prescription number
- Date the prescription was filled
- NDC number (drug number)
- Name of the drug and strength
- Cost of the prescription
- Quantity and days' supply of each covered drug or refill dispensed
- Doctor name or ID number
- DAW (dispense as written) code

You will be reimbursed for the submitted rate less member copay based on the Schedule of Benefits.

Website and Digital App

Access to important plan information is available online at **<http://info.caremark.com/stateofmaryland>**. Register to see member specific claims information and history. In addition, you can access plan information by downloading the CVS Caremark digital app.

Vacation Overrides

If you are going on vacation and need an additional supply of your medication, you should ask your pharmacist to call the Pharmacy Help Line to request a vacation override. This will allow you to obtain your next refill early. You may also contact Customer Care at **1-844-460-8767** for assistance.

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a processed claim, call CVS Caremark Customer Care at **1-844-460-8767**.



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Privacy

Your State of Maryland Benefit Plan meets the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to assure your health information is properly protected. CVS Health is committed to meeting both the HIPAA and State of Maryland guidelines related to protecting your privacy.

Definitions

Brand Name Drug: The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Generic Drugs: Prescription drugs that have been determined by the FDA to be equivalent to brand name drugs, but are not made or sold under a registered trade name or trademark. Generic drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the brand name drug.

Mail Service: Offers you a convenient means of obtaining maintenance medications by mail if you take prescription drugs on a regular basis. Covered prescription drugs are ordered directly from CVS Caremark's licensed Mail Service Pharmacy, and sent directly to your home.

Maintenance Medications: Maintenance drugs are those generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol. What is the difference between long-term and short-term drugs? Long-term drugs are those taken on an ongoing basis, such as those used to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time.

Network Specialty Pharmacy: A Pharmacy that has entered into a contractual agreement or is otherwise engaged by the plan and has the capabilities to provide Specialty Drug services and certain administrative functions to State of Maryland members.

Pharmacy and Therapeutics (P&T) Committee: The CVS Caremark P&T Committee consists of health care professionals whose primary purpose is to recommend policies in the evaluation, selection, and therapeutic use of drugs.

Prescription Order: A legal request, written by a provider, for a prescription drug or medication and any subsequent refills.



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Prescription Legend Drug, Prescription Drug, or Drug: A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under the Plan.

Prior Authorization: The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription drugs and their criteria for coverage are defined by the P&T Committee.

Step Therapy Protocol Exception: A determination by the prescription drug plan administrator that, based on a review of a request for the determination and any supporting documentation: (1) a step therapy protocol is not medically appropriate for treatment of a particular Plan member’s condition; and (2) the prescription drug plan will:

- Not require the Plan member’s use of a preceding prescription drug under the step therapy protocol; and
- Provide immediate coverage for another prescription drug that is prescribed for the covered Plan member

Step Therapy: A protocol that specifies that, as a condition of coverage, the order in which certain prescription drugs must be used to treat a Plan member’s condition.

Tiers: Your copayment/coinsurance amount may vary based on whether the prescription drug, including covered Specialty Drugs, has been classified by the Plan as a first, or second, or third “tier” drug.

- Tier 1 generally includes generic prescription drugs
- Tier 2 generally includes brand name or generic drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs
- Tier 3 generally includes brand name or certain generic drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other drugs in lower tiers

Urgent Care Situation: A Plan member’s injury or condition about which the following apply: (1) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, the injury or condition could seriously jeopardize the Plan member’s life, health or ability to regain maximum function; (2) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, the injury or condition could subject the Plan member to severe pain that cannot be adequately managed, based on the Plan member’s treating health care provider’s judgment.



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How to Reach CVS Caremark

On the Internet: To reach CVS Caremark online, go to <http://info.caremark.com/stateofmaryland>. Visit the CVS Caremark website anytime to:

- View plan highlights
- Locate participating local pharmacies
- Compare medication prices
- Find out if your medications are covered under your plan
- View the Formulary
- Refill your mail-order prescriptions, check the status of your Mail Service order, request more claim forms and order forms
- Download the CVS Caremark mobile app for your Smartphone

By Telephone: Call **1-844-460-8767** (TTY 711) to get answers to your questions about your prescription drug program.

By Mail: Ask your doctor to provide you with a written prescription for your medications. Sign in to **Caremark.com** to download and print a mail service form. Mail the prescription(s) along with a completed order form to the address below:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094

CVS Specialty: Call **1-800-237-2767** to enroll and get started with CVS Specialty. Your physician may initiate the process.

Appeal Procedures

CVS Caremark's Internal Review Appeal Process

There are two types of internal appeals that may be submitted through a first or second level appeal request:

- 1. Administrative:** These are benefit coverage decisions that are strictly based on the Plan's benefit design. These appeals do not require additional information to be obtained from the prescribing doctor, but may require additional information from you.
- 2. Clinical:** These are benefit coverage decisions that are based on the plan's prior authorization requirement and require additional information to be obtained from the prescribing doctor, such as clinical records or medical history information.



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Once you are notified that a claim is denied in whole or in part, you have the right to appeal. Requests appeals need to be received within 180 days of the initial denial. Appeals must be submitted in writing. Acceptable submission methods include fax or mail directly to CVS Caremark. All administrative and clinical appeals are reviewed according to the plan design provisions and a decision will be mailed within 15 business days of receipt of a written request by CVS Caremark for pre-service claims and within 30 days for post-service claims. Urgent pre-service claims will be processed within 72 hours from the receipt of the inquiry by CVS Caremark.

Independent (External) Review Appeal Process

You have the right to an Independent (External) Review Appeal of an “Adverse Benefit Determination”. An “Adverse Benefit Determination” is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a plan benefit, and may apply to both clinical and non-clinical determinations. To request an Independent (External) Review Appeal, you must have exhausted CVS Caremark’s Internal Review Appeal process described above.

The IRO process is handled by the Programs. The request may be made by you or your authorized representative by submitting supporting documentation, such as clinical records or medical history information. You must submit your request within four months after receiving the notice stating the results of your first and/or second level appeal request. The IRO will provide you and CVS Caremark (on behalf of the Program) with written notice of its final external review decision within 45 days after the IRO receives the request. You may also request an expedited Independent (External) Review and it will be conducted as quickly as possible.

A benefit determination made pursuant to the Independent (External) Review Appeal is binding on both the plan and you, except to the extent that other remedies may be available to you under either State or Federal law. For instance, if your claim is again denied following the Independent (External) Review Appeal, you may still be able to bring a claim in court to contest that decision.

To submit an appeal through the IRO process, contact the plan at:

Contact Name: Patricia Hawkins
phawkins@maryland.gov
Phone Number: 1-410-767-0656



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How to File an Appeal Request

You can submit all appeal requests by faxing to CVS Caremark at **1.866.689.3092**, or in writing to:

CVS Caremark
Attention: Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark's standard claims and appeals process complies with the Affordable Care Act (ACA) and their implementing regulations. Members will be accorded all rights granted to them under ERISA, ACA and any related laws and regulations. If indicated, CVS Caremark's review will also be conducted in compliance with any applicable state requirements or accreditation standards, including the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC).

Appeals of Adverse Benefit Determinations or Adverse Coverage Determinations

If an Adverse Coverage Determination is rendered on the member's Claim, the member may file an appeal of that determination. The member's appeal of the Adverse Coverage Determination must be made in writing and submitted to CVS Caremark within the time frame specified by applicable federal or state requirements after the member receives notice of the Adverse Benefit Determination or Adverse Coverage Determination.

If the Adverse Coverage Determination is rendered with respect to an Urgent Care Claim, the member and/or the member's authorized representative may submit an appeal by calling, faxing or mailing the request to CVS Caremark.

The member's appeal should include the following information:

- A clear statement that the communication is intended to appeal an Adverse Coverage Determination;
- Name of the person for whom the appeal is being filed. The member or prescriber may file an appeal. The member may also have a relative, friend, advocate, or anyone else (including an attorney) act on their behalf as their authorized representative;
- CVS Caremark identification number;
- Date of birth;
- A statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information or other information relating to the Claim



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CVS Caremark's Review

Review of Adverse Coverage Determinations: CVS Caremark provides a single-level appeal for Adverse Coverage Determinations. Upon receipt of an appeal of an Adverse Coverage Determination, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor in the PDD.

During its review of an appeal of an Adverse Coverage Determination, CVS Caremark shall:

- Provide for a full and fair review, allowing the member to review the Claim file and to present evidence and testimony. This includes providing the member (free of charge) with new or additional evidence or rationale relied upon in advance of a final internal Adverse Benefit Determination, and giving the member a reasonable opportunity to respond;
- 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 of 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;
- Provide a review that is designed to ensure the independence and impartiality of the person making the decision;
- Provide a review that does not give consideration to the initial Adverse Coverage Determination and is conducted by someone other than the individual who made the initial Adverse Coverage Determination (or a subordinate of such individual); and
- Provide for an expedited review process for Urgent Care Claims

For a claim requiring a Medical Necessity Review, CVS Caremark, in addition to the above, shall also:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Upon request, identify the health care professional, if any, whose advice was obtained in connection with the Adverse Coverage Determination