Prescription Drug Plan

Prince George's County Public Schools

2025 Summary of Coverage

Active Employees

Pre-Medicare Retirees

CVS Caremark® manages your prescription drug plan under a contract with Prince George's County Public Schools.

Introduction

CVS Caremark manages your Prescription Drug Plan (the Plan) under a contract with Prince George's County Public Schools. You are covered by the Prescription Drug Plan only if you elect to be covered during Open Enrollment (or other allowed times) and you pay your required contribution. Coverage by a health insurance plan offered by Prince George's County Public Schools does not automatically provide you with coverage by the Prescription Drug Plan.

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 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.

Here is a brief outline of your prescription drug benefits under the Plan. More detail is provided later in this Summary of Coverage.

	Short-Term Drugs CVS Caremark Retail Pharmacy Network **(Up to a 34-day supply)**	**Long-Term Drugs** CVS Caremark Mail Service or CVS Pharmacy Locations **(Up to a 90-day supply)**
Generic Drugs Always ask your doctor if there's a generic drug available. It could save you money.	**$10** copay for a generic drug	**$20** copay for a generic drug
Preferred Brand-Name Drugs If a generic is not available or appropriate, ask your doctor to prescribe from the preferred drug list.	**$40** copay for a preferred brand-name drug	**$80** copay for a preferred brand-name drug
Non-Preferred Brand-Name Drugs Drugs that aren't on the preferred drug list will cost more.	**$70** copay for a non-preferred brand-name drug	**$140** copay for a non-preferred brand-name drug
Maximum Out-of-Pocket	$1,500 per individual / $3,000 per family per calendar year	

Preferred Drug List

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

The Plan's preferred drug list is updated on an annual basis, usually at the beginning of each calendar year. Changes may also be made during the year. If you are taking a prescription drug that is on the preferred drug list, you will be notified if the drug is removed or changed on the list.

You may request a copy of the Plan's preferred drug list by calling CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564) or view the list online at *www.caremark.com*.

Covered Prescription Drug Types

Prescription drugs must be medically necessary, not experimental/investigative, and prescribed by a licensed health care provider, in order to be a covered by the Plan.

A prescription drug (and related services and products) is considered Medically Necessary and not experimental/investigative only if:

- its use meets clinically appropriate criteria in accordance with U.S. Food and Drug Administration (FDA)-approved labeling or nationally recognized compendia (such as American Hospital Formulary Service [AHFS] or Micromedex) or evidence-based practice guidelines;
- its use represents the most appropriate level of care for the patient, based on the seriousness of the condition being treated, the frequency and duration of services and the place where services are performed; and
- its use is not solely for the convenience of the patient, the patient's family or the provider.

Covered Prescription Drugs may be subject to Utilization Management programs as explained later in this Summary. The following are some types of Covered Prescription Drugs:

- Prescription drugs, which say "Caution: Federal law prohibits dispensing without a prescription" on the packing label, or which are compounded medications that contain at least one prescription drug
- Certain over the counter (OTC) drugs for which coverage is required by federal law*
- Injectable insulin, needles and syringes used for administration of insulin, and disposable insulin pumps; glucose monitors and standard insulin pumps are not covered
- Diabetes supplies such as diabetes test strips, lancets and swabs
- Contraceptive drugs: oral, transdermal, vaginal and injectable
- Contraceptive devices
- Prenatal and pediatric prescription vitamins for which coverage is required by federal law*
- Injectable drugs that you administer yourself, unless otherwise noted as non-covered
- Prescription and some OTC smoking cessation drugs, such as nicotine replacement, bupropion/Zyban and Chantix* (with supply limits)

Non-Covered Prescription Drugs

The following drugs (and related services and products) are not covered by the Plan:

- Anorectics (any drug used for the purpose of weight loss)
    - This exclusion does not apply to certain anorexigenic drugs (Wegovy, Zepbound) that have a Supplemental Indication for treatment beyond weight loss, and that satisfy criteria established by CVS Caremark.
- Pregnancy Termination Drugs (e.g., RU486, Mifeprex)
- Aerochamber, Aerochamber with Mask and Nebulizer Masks and all other medical supplies

- Over-the-counter (OTC) products with the exception of insulin, diabetes monitoring products and those for which coverage is required by federal law*
- Bulk Compounding Ingredients, kits, high-cost bases
- Drugs used for cosmetic purposes only such as hair growth stimulants
- Experimental/investigative drugs
- Homeopathic products
- Worker's Compensation Claims
- Drugs that have not been approved for marketing by the U.S. Food and Drug Administration

*Affordable Care Act

Federal law under the Affordable Care Act requires coverage of certain preventive care drugs at no cost to you, which means you don't have to pay a copay. These no-cost preventive care drugs must have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Certain prescribed OTC drugs that are considered preventive by the Affordable Care Act are covered by this Plan. A prescription is required for OTC preventive care drugs to be covered by this Plan. For more information, contact CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564).

For additional details, refer to "ACA Preventive Services List" link on *https://www.caremark.com*..

In-Network Retail Pharmacies to Fill Your Short-Term Prescriptions

You can fill short-term prescriptions (less than 90 days) at a CVS Caremark Network retail pharmacy.

Long-term prescriptions for maintenance drugs (90 days or more) are only covered when filled through the Maintenance Choice program described below.

Most major chain pharmacies participate in the CVS Caremark Network, as do many independent pharmacies. If you use an independent pharmacy, you should check whether it participates in the Network by calling CVS Customer Care at the number on your ID card (or 1-888-865-6564**)** or visit *www.caremark.com*.

Be sure to show your CVS Caremark ID card when you fill your prescription. If you do not show your ID card, you will be required to pay the full retail cost for the prescription and then apply for reimbursement from the Plan.

To apply for reimbursement, you can obtain a prescription drug claim form online at *www.caremark.com* or by calling CVS Caremark Customer Care. Send the claim form to the address shown on the form. You will need to include the itemized receipt that shows what you paid for the prescription. You will only be reimbursed for the "maximum allowable amount" as determined by CVS Caremark based on its contracted rate with Network pharmacies, less the required copay and any other processing charges.

Out-of-Network Retail Pharmacy

If you use an Out-of-Network retail pharmacy, you must pay the entire amount charged by the pharmacy and then apply for reimbursement as explained above.

The itemized receipt must show:

- Name and address of the Out-of-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 drug or refill dispensed
- Doctor name or ID number
- DAW (dispense as written) code

Maintenance Choice to Fill Your Long-Term Prescriptions

Maintenance Choice offers you choice and savings when it comes to filling long-term prescriptions (90 days or more) for maintenance drugs. If you need a long term maintenance drug you can ask your provider to prescribe up to a 90-day supply to be filled through the CVS Caremark Maintenance Choice program. You only pay two 34-day copays for up to a 90-day supply when you use Maintenance Choice. You have two ways to use Maintenance Choice:

CVS Caremark Mail Service:

- No-cost standard shipping in a plain, weather-resistant, tamper-resistant and (when needed) temperature-controlled package
- Flexible payment options and (if you elect) automatic refills
- Refill orders placed at your convenience, by telephone or online
- Access to a registered pharmacist any time, day or night

CVS Retail Pharmacy:

- Pick up your maintenance drugs from your local CVS retail pharmacy at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at *www.caremark.com*.

Maintenance Choice is Mandatory

You must use Maintenance Choice to fill your long-term prescriptions for maintenance drugs. After two 34-day fills, the Plan does not cover maintenance drugs that are not obtained through Maintenance Choice.

Getting started with Maintenance Choice

You can begin using Maintenance Choice for your maintenance drug prescription using one of the following options:

Online: Register at *www.caremark.com* to begin managing your prescription online. You can also download the CVS Caremark app to get started with Mail Service.

By mail: Ask your provider to give you a written prescription for your maintenance drug. Sign in to *www.caremark.com* to download and print a Mail Service form. Mail the prescription along with the completed form to the address shown on the form.

Please note: To avoid delays in filling your prescription, be sure to include payment with your order.

By fax or electronic submission from your provider: Your provider's office may be able to fax or electronically submit the prescription for your maintenance drug. Ask your provider's office if they can do this.

Important notes:

- Faxes must be sent from your provider's office. Faxes from other locations, such as your home orworkplace, 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 prescription before you can request a refill through Maintenance Choice.
- Special rules may apply to Maintenance Choice fills of prescriptions for controlled substances.

Call CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564) for more information.

Specialty Drugs

The Prescription Drug Plan covers certain Specialty Drugs that are not administered by your doctor or while an inpatient. Specialty Drugs must be obtained through the CVS Specialty pharmacy (described below), or they are not covered by the Plan.

Specialty Drugs administered by your provider or while an inpatient are not covered by the Prescription Drug Plan, but may be covered by your medical plan.

Specialty Drugs are prescription 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®

CVS Specialty is a full-service pharmacy that provides your choice of home delivery service or delivery to your local CVS Pharmacy for specialty drugs. CVS Specialty does more than fill your specialty drug prescription. It helps you stay on track by providing the support you need to help ensure you take your specialty drug 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 provider for you, then call you to arrange for delivery of your specialty drug on a day that is convenient for you. You may only refill specialty drug prescriptions one month at a time (maximum 30-day supply per refill).

24/7 personalized care

CVS Specialty provides 24/7 support from an entire care team of specially trained pharmacists and nurses.Your care team can help you manage your condition by: checking dosing and medication schedules; answering your

questions; helping you manage side effects; helping you set up new medication regimens; and checking that you are taking your specialty drug as prescribed.

Flexible prescription pick-up or delivery

CVS Specialty lets you stay in control and on track with flexible prescription pick-up or delivery service. You can pick up your specialty drug prescription at any of the 9,900 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 specialty drug even easier with these online tools.

- **Fast refill requests**: Most specialty drugs 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.
- **Prescription 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.

+Where allowed by law. Based on the availability of CVS Pharmacy locations and subject to applicable laws and regulations. Services are also available at Long's Drugs locations. Products are dispensed by CVS Specialty pharmacy and certain services are only accessed by calling CVS Specialty pharmacy directly. Certain specialty drugs may not qualify.

Utilization Management Programs

To promote safety along with appropriate and cost-effective use of prescription drugs, the Prescription Drug Plan includes several Utilization Management programs as summarized below. For a complete explanation of the programs, visit: *www.caremark.com*.

Prior Authorization

Prior Authorization may be required for certain specialty and non-specialty prescription drugs. Prior Authorization helps to ensure the drug is clinically appropriate and cost-effective. CVS Caremark determines if Prior Authorization is required based on clinical guidelines and other criteria. At the time you fill a prescription, the pharmacist is informed through the pharmacy's computer system if Prior Authorization is required before the prescription can be filled. If so, your provider must contact CVS Caremark's Prior Authorization department to provide justification for CVS Caremark's consideration of why you should be on the prescribed drug. The following are examples of drugs that may require Prior Authorization for your prescription:

- The drug is not on the preferred drug list
- The drug prescribed is subject to age limits
- The drug prescribed is only covered for certain conditions

If Prior Authorization is denied, written notice will be sent to you and your provider. You have the right to appeal the denial through the appeals process described below. The written notice of denial will provide instructions for filing an appeal.

Quantity Limits

For some drugs, the Plan covers a limited quantity within a specific time period. These limits are based on FDA-approved prescribing information, approved medical guidelines and/or the average utilization quantity for the drugs. If medically necessary, some drugs with quantity limits can have the limits increased with Prior Authorization.

Step Therapy

Certain drugs require that you first try a preferred drug to treat your medical condition before the Plan covers the drug your provider may have initially prescribed. This is called Step Therapy.

When medically necessary, your provider may request an exception to the Step Therapy requirement and ask for Prior Authorization by completing the electronic Prior Authorization form or faxing the paper form with the required clinical information to CVS Caremark.

To find out if a drug requires Prior Authorization, or for more information on Quantity Limits or Step Therapy, please contact CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564).

Website and Digital App

Access to important plan information is available online at *www.caremark.com*.

Register to see member specific claims information and history. In addition, you can access plan information by downloading the CVS Caremark digital app.

Out of Country Overrides

If you are going out of the United States and need more than a 90-day supply of a prescription, you must fill out an Out of Country Request Form and then fax it to the number listed on the form to receive approval. The Form will specify the required supporting documentation related to your trip. The form will not be reviewed without supporting documentation. If you have questions, please contact CVS Customer Care at the number on your ID card (or 1-888-865-6564).

Privacy

Your Prescription Drug Plan meets the provisions of the Health Insurance Portability and Accountability Act (HIPAA) to assure your health information is properly protected. CVS Health is committed to meeting both the HIPAA and the Prince George's County Public Schools guidelines related to protecting your privacy.

Claims and Appeals

If you believe your claim for prescription drug benefits was incorrectly denied or you have questions about a processed claim, call CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564).

The CVS Caremark Internal Appeals Process

If your request for a prescription drug, including a request for Prior Authorization (a “Claim”), is denied in whole or in part, you have the right to appeal the denial to CVS Caremark. Requests for appeals must be in writing and received within 180 days of the date of the Claim denial. **If you do not file your appeal within 180 days, you lose all rights to appeal.** Acceptable submission methods include fax or mail directly to CVS Caremark. All appeals are reviewed according to the rules of the CVS Caremark internal appeals process. For a copy of the internal appeals process rules, call CVS Caremark Customer Care at the number on your ID card (or 1-888-865-6564).

A decision on your appeal will be rendered within 72 hours of receipt by CVS Caremark of an Urgent Care Claim appeal, within15 days of receipt by CVS Caremark of a Prior Authorization Claim appeal, and within 30 days of receipt for all other Claim appeals.

Requests for Prior Authorization of a prescription drug needed for Urgent Care will be processed within 72 hours after receipt by CVS Caremark. A Claim is for Urgent Care if following the time limits set forth above:

- could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or
- in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the service or supply.

In general, whether a prescription drug is for Urgent Care is determined by CVS Caremark based on the standards of a prudent layperson with average knowledge of health and medicine. However, if a physician with knowledge of the patient's medical condition determines that the prescription drug is for Urgent Care, it will be treated as such.

How to file an appeal

You can submit all appeals by faxing to CVS Caremark at 1-866-443-1172, or in writing to the address for appeals shown on the Claim denial notice.

Appeal of Claim Denials

If your Claim for a prescription drug is denied in whole or in part, you or your authorized representative may file an appeal of that denial with CVS Caremark. Your health care provider who prescribed the drug in question may act as your authorized representative. You may also have a relative, friend, advocate, or anyone else (including an attorney) act as your authorized representative

Your appeal must be made in writing and submitted to CVS Caremark within the time frame specified in the notice of Claim denial.

If an Urgent Care Claim is denied, you or your authorized representative may also submit an appeal by calling or faxing the request to CVS Caremark.

Your appeal should include the following information:

- A clear statement that the communication is intended to appeal a Claim denial;
- Name of the person for whom the appeal is being filed.
- CVS Caremark identification number;
- Date of birth;
- A statement of why you think the denial of your Claim was wrong;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information or other information relating to the Claim.

If your appeal is denied

If your appeal is denied in whole or in part, you will be notified in writing. The notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your appeal, and how to request a free copy of the rule or guideline. The notice will tell you if

your appeal was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon.

Discretionary Authority

In deciding your appeal, CVS Caremark has the discretionary authority to interpret the terms of the Prescription Drug Plan, to determine eligibility for and entitlement to benefits under the Plan, and to decide any questions of fact which relate to entitlement to benefits under the Plan.

External Review

If CVS Caremark denies your appeal of a Claim denial after you have properly completed the CVS Caremark internal appeals process as explained above, you may further appeal that denial using the federal External Review process. **You are only eligible for External Review if your Claim for prescription drug benefits, including a request for Prior Authorization, was denied based on medical judgment (meaning whether the drug was medically necessary or experimental).**

CVS Caremark will administer the federal External Review process in accordance with federal regulations and as summarized below.

External Review Process (Non-Expedited) Request for Review:
You may request in writing an External Review within 123 days after receiving notice that your internal appeal to CVS Caremark has been denied. Your request should include your name, contact information, including mailing address and daytime phone number, member ID number, and a copy of the CVS Caremark appeal denial letter. External Review requests must be clearly identified as an "External Review" when submitted. Your request for External Review and supporting documentation may be mailed or faxed to the attention of the CVS Caremark External Review Appeals Department, as indicated in the appeal denial letter.

Preliminary Review:

Within five days of receiving your request for External Review, CVS Caremark will conduct a preliminary review to ensure that the request qualifies for External Review. In this preliminary review, CVS Caremark will determine whether:

- You were covered under the Plan at the time the prescription drug at issue was requested or provided.
- The denial of coverage was not because you were not covered by the Plan (such denials are not eligible for External Review);
- The denial involves medical judgment;
- You have exhausted the CVS Caremark internal appeals process; and
- You have provided all the information and forms necessary to process the External Review.

Within one day after completing its preliminary review, CVS Caremark will notify you in writing that: (i) your request for External Review is complete and has been submitted to the Independent Review Organization (IRO); (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to Independent Review Organization (IRO):

If your request for External Review is complete and eligible for External Review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted, and will provide the IRO with all necessary

documents and information considered in denying your claim. The IRO will review the case to determine if it contains an element of medical judgment. If the case does not contain medical judgment, the IRO will notify CVS Caremark that the case does not meet the requirements for External Review, in which case CVS Caremark will notify you that the IRO has determined that the case is not eligible. If the case does contain medical judgment, the IRO will accept the case and notify you in writing of its acceptance of the assignment. You will then have 10 days to provide the IRO with any additional information you want the IRO to consider.

The IRO will conduct its External Review without giving any consideration to any earlier determinations made by CVS Caremark. The IRO may consider information beyond the record for your denied Claim, such as:

- Your medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your health care provider;
- The terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used on behalf of the Plan; and
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to your request for External Review.

Timing of IRO's Determination:

The IRO will provide you and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review.

The IRO's notice will contain:

- The date the IRO received the External Review assignment from CVS Caremark, and the date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to you;
- A statement that you may still be eligible to seek judicial review of any adverse External Review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist you.

Reversal of the Plan's Prior Decision:

If CVS Caremark, acting on the Plan's behalf, receives notice from the IRO that it has reversed the denial of your Claim, CVS Caremark will provide coverage or payment for the Claim, subject to the right of the Plan and

the Plan sponsor to seek judicial review of the decision and other remedies available under state or federal law.

Federal External Review Process (Expedited)

You may request an expedited External Review if your Claim denial involves a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

Request for Expedited Review:

You or your provider may request an expedited External Review by calling CVS Caremark Customer Care at the number on your benefit ID card (or 1-888-865-6564), or by contacting your benefits office. The request should include your name, contact information, including mailing address and daytime phone number, member ID number, and a description of the Claim denial.

Alternatively, a request for expedited External Review and supporting documentation may be faxed to the attention of the CVS Caremark External Review Appeals Department at the fax number indicated in the appeal denial letter. External Review requests must be clearly identified as an “External Review” when submitted. All requests for expedited review must be clearly identified as “urgent” at submission.

Preliminary Review:

Immediately upon receipt of your request for expedited External Review, CVS Caremark will determine whether the request meets the requirements described above for non-expedited External Review. Immediately upon completing this review, CVS Caremark will notify you that: (i) your request for External Review is complete and has been submitted to the IRO; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO:

Upon determining that your request is eligible for expedited External Review, CVS Caremark will assign an IRO to review your Claim. CVS Caremark will provide all necessary documents and information considered in making the Claim and appeal denial to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

Timing of the IRO’s Determination:

The IRO will provide you and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for External Review. If this notice is provided orally, within 48 hours after providing the oral notice, the IRO will provide written confirmation of its decision.

Authority for Review:

CVS Caremark will be responsible only for conducting the preliminary review of your request for External Review, ensuring that you are timely notified of the decision as to eligibility for External Review, and for

assigning the request for External Review to an IRO. The actual External Review of your appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the External Review performed by an IRO.