ATTACHMENT - OUTPATIENT PRESCRIPTION DRUG PLAN – CVS/CAREMARK

The following Outpatient Prescription Drug Plan is administered by CaremarkPCS Health, L.L.C. (CVS/caremark). CVS/caremark is a prescription drug benefit claims administrator for the pharmacy benefits described in this Attachment *Outpatient Prescription Drug Plan – CVS/caremark*.

This Attachment to the VMware Medical Summary Plan Description (SPD) describes the Employer-sponsored Outpatient Prescription Drug Plan ("Pharmacy Plan"). The Pharmacy Plan is a Benefit Program incorporated under the VMware Inc. Health and Welfare Plan and this is the Component Document describing the Pharmacy Plan Benefit Program.

CVS/caremark is a private prescription drug benefit claims administrator for the pharmacy benefits described in this Attachment *Outpatient Prescription Drug Plan – CVS/caremark*. VMware Inc. has entered into an agreement with CVS/caremark, under which CVS/caremark will process eligible pharmacy expenses and provide certain other administrative services pertaining to the Pharmacy Plan.

Please read this Attachment thoroughly to learn how the Pharmacy Plan works. If you have questions call CVS/caremark at the number on the back of your ID card. Capitalized terms not otherwise defined in this Attachment have the meaning set forth in the medical plan portion of the SPD, Section 10, *Defined Terms*.

INTRODUCTION – Pharmacy Benefits

Eligibility

You must be covered under a medical plan sponsored by VMware Inc. and administered by United Healthcare in order to participate in the Pharmacy Plan administered by CVS/caremark. You are enrolled in the Pharmacy Plan at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in the medical portion of this SPD, Section 3, *When Coverage Begins*. Contact the HR Source Team if you have questions about eligibility and enrollment.

If you are hired during the plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in the UnitedHealth Care (UHC) Summary Plan Description (SPD), Section 3, When Coverage Begins.

Each year during the annual Open Enrollment Period, you have the opportunity to review plan options and make changes. Any changes you make during the Open Enrollment Period will become effective as described in the medical plan portion of the SPD, Section 3, *When Coverage Begins*.

Cost of Coverage

You and VMware Inc. share in the cost of the medical plan, there is no charge to you for participation in the Pharmacy Plan. Your contribution amount, (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Covered Prescription Drug Benefits

Prescription drugs must be medically necessary and not experimental or investigational, in order to be Covered Services. For certain prescription drugs, the prescribing physician may be asked to provide additional information before CVS/caremark can determine medical necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific prescription drugs. Covered Services will be limited based on medical necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Preventive Care Medications

Benefits under the Pharmacy Plan include those for Preventive Care Medications as defined under *Glossary - Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication at **www.caremark.com** or by calling CVS/caremark at the number on your ID card.

Pharmacy Types

How you obtain your benefits depends upon the type of pharmacy you go to.

Network Retail Pharmacy

The Pharmacy Plan has a National Network of over 68,000 participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting CVS/caremark at the number on your ID card or by logging onto **www.caremark.com.**

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the applicable Deductible and Coinsurance. The Pharmacy Plan pays Benefits for certain covered Prescription Drugs:

- As written by a Physician
- Up to a consecutive 31 day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed

- Up to a 90 day supply of maintenance medications can also be obtained at network retail pharmacies per the plan design

CVS/caremark Mail Service

The mail order service may allow you to fill up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, diabetes, high blood pressure, and arthritis.

To use the mail order service, complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. The patient profile form can be obtained by contacting CVS/caremark at the number on your ID card or going to www.caremark.com.

The Pharmacy Plan pays mail order Benefits for certain covered Prescription Drugs:

- As written by a Physician.
- Up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Network Specialty Pharmacy for specialty medications

You must use **CVS Specialty Pharmacy** to fill prescriptions for specialty medications. Specialty Pharmacies outside of the Network are not covered.

The **CVS Specialty Pharmacy** is a full-service mail order pharmacy that provides home delivery service for specialty medications. These medications are used to treat a number of complex conditions, such as cancer and arthritis.

To get started, call a **CVS Specialty Pharmacy** representative at 1-800-237-2767 or register online at www.CVSspecialty.com.

You may request that CVS Specialty contact your doctor for you, then call you to arrange for delivery of your medication. Alternatively, you may also drop off your specialty prescription at a local CVS/Pharmacy location of your choice. The pharmacist at your local CVS/Pharmacy location will transmit the specialty prescription to CVS Specialty. You may then elect to pick up your specialty medication at CVS/Pharmacy or have it shipped to your home or location of your

choice.

Specialty medications may be refilled one month at a time (maximum 30-day supply).

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

Register for a secure, online specialty prescription profile:

- Fill all your specialty medications and supplies at the same time
- View your prescription history, refills remaining, your costs, last fill date and more.
- Request your refills be sent directly to the location of your choice or pick them up at your local CVS Pharmacy.
- Keep all your specialty prescription information in one, secure place.

Specialty Copay Card Programs

Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Non-Network Retail Pharmacy

If you visit a non-network retail pharmacy, you are responsible for payment of the entire amount charged by the non-network pharmacy and will then need to submit a prescription drug claim to CVS/caremark for reimbursement. These forms are available from CVS/caremark by calling the phone number on the back of your ID or by visiting www.caremark.com.

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

SCHEDULE OF BENEFITS

The table below provides an overview of the Pharmacy Plan's Prescription Drug Product coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network Pharmacy.

Deductible and Coinsurance

Each prescription order may be subject to a deductible and coinsurance. If the prescription order includes more than one covered drug, separate coinsurance will apply to each covered drug.

Benefit Levels - Tiers

The Pharmacy Plan pays Benefits at different levels for Tier-1, Tier-2 and Tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Pharmacy Plan are categorized into these three tiers on the Standard Control Formulary (Formulary). The tier status of a Prescription Drug Product can change periodically, generally quarterly, based on the CVS/caremark National Pharmacy and Therapeutics Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the Formulary may change periodically, you can visit www.caremark.com or call CVS/caremark at the number on your ID card for the most current information.

Each tier is assigned Coinsurance, which is the amount you pay after meeting your Deductible when you visit the pharmacy or order your medications through mail order.

- Tier-1 (generic) is your lowest Coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 (preferred brand) is your middle Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 (non-preferred brand) is your highest Coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

United HealthCare HSA Choice Plus Plan

	Network Retail Pharmacy up to a 90-day supply	**Out-of-Network Retail Pharmacy up to a 90-day supply**	**Mail Order up to a 90-day supply**
Plan Deductible	Combined Medical and Pharmacy Deductible $1,500 Individual $3,000 Family	Combined Medical and Pharmacy Deductible $1,500 Individual $3,000 Family	Combined Medical and Pharmacy Deductible $1,500 Individual $3,000 Family
Plan Maximum Out-of Pocket (MOOP)	Combined Medical and Pharmacy MOOP $2,500 Individual $5,000 Family	Combined Medical and Pharmacy MOOP $2,500 Individual $5,000 Family	Combined Medical and Pharmacy MOOP $2,500 Individual $5,000 Family
Tier-1	10% after plan deductible	50% after plan deductible	10% after plan deductible
Tier-2	15% after plan deductible	50% after plan deductible	15% after plan deductible
Tier-3	20% after plan deductible	50% after plan deductible	20% after plan deductible
Specialty	Limited to 30 day supply Coverage based on Tiers above at CVS Specialty Pharmacies Only	Not covered	Not covered

United HealthCare Traditional PPO Choice Plus Plan

	Network Retail Pharmacy up to a 90-day supply	**Out-of-Network Retail Pharmacy up to a 90-day supply**	**Mail Order up to a 90-day supply**
Plan Deductible	Combined Medical & Pharmacy Deductible $500 Individual $1,500 Family	Combined Medical & Pharmacy Deductible $500 Individual $1,500 Family	Combined Medical & Pharmacy Deductible $500 Individual $1,500 Family
Plan Maximum Out-of-Pocket (MOOP)	Combined Medical & Pharmacy MOOP $2,350 Individual $7,050 Family	Combined Medical & Pharmacy MOOP $2,350 Individual $7,050 Family	Combined Medical & Pharmacy MOOP $2,350 Individual $7,050 Family
Tier-1	10% after plan deductible	50% after plan deductible	10% after plan deductible
Tier-2	25% after plan deductible	50% after plan deductible	25% after plan deductible
Tier-3	40% after plan deductible	50% after plan deductible	40% after plan deductible
Specialty	Limited to 30 day supply Coverage based on Tiers above at CVS Specialty Pharmacies Only	Not covered	Not covered

You are not responsible for paying a deductible for Preventive Care Medications.

Days' Supply

The number of days' supply of a drug that you may receive is limited. The days' supply limit applicable to prescription drug coverage is shown in the Schedule of Benefits.

If you are going on vacation and you need more than the days' supply allowed for a retail prescription under this Plan, you should ask your pharmacist to call the Pharmacy Help Line to request a vacation override. If your prescription is through CVS/caremark Mail Service or CVS Specialty, call CVS/caremark and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your ID card.

Days' supply may be less than the amount shown in the Schedule of Benefits due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Coordination of Benefits

Note: The Coordination of Benefits provision described in Section 8, *Coordination of Benefits* applies to covered Prescription Drug Products as described in this Attachment. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by CVS/caremark during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the full price for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Pharmacy Plan. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

Prior Authorization

Prior Authorization may be required for certain prescription drugs or the prescribed quantity of a particular Drug. In most cases, Network providers are responsible for obtaining prior authorization from CVS/caremark before they provide these services to you.

Prior Authorization helps promote appropriate utilization and enforcement of clinical guidelines for prescription drug benefit coverage. At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system.

CVS/caremark uses criteria developed by the National Pharmacy and Therapeutics Committee which have been reviewed and adopted by the Plan. CVS/caremark may contact your provider if additional information is required to determine whether Prior Authorization should be granted.

The following situations may require prior authorization for your prescription:

- Your doctor prescribes a drug not covered by the formulary
- The medication prescribed is subject to age limits
- You need additional quantities of certain medications

- The medication is only covered for certain conditions
- The medication is a specialty medication

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.

To determine if a drug requires Prior Authorization, please contact CVS/caremark Customer Care at the phone number on your ID Card or go to www.caremark.com.

You, your provider, or pharmacist may check with CVS/caremark Customer Care to verify covered prescription drugs, any quantity and/or age limits, prior authorization or other requirements of the Plan.

You may request a copy of the Standard Control Formulary by calling CVS/caremark Customer Care at the number on your ID card or view the list online at www.caremark.com.

CVS/CAREMARK STANDARD CLAIM AND APPEAL PROCEDURES

CVS/caremark, acting on behalf of the VMware, will provide the following claims and appeals review services:

- Pre-Authorization Claim Review
- Coverage Determination Claim Review
- Post-Service Claim Review
- Pre-Service Appeal Review
- Coverage Determination Appeal Review
- Post-Service Appeal Review

CVS/caremark's standard claims and appeals process complies with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), 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.

To request a claim review or appeal, contact CVS/caremark at the phone number on your ID Card.

Pre-Authorization Claim Review:

CVS/caremark will evaluate member requests for certain medications and/or other prescription benefits against pre-defined medical criteria adopted by the Plan specifically related to use of those medications or prescription benefits before the prescription is filled or the medical care is provided.

If CVS/caremark determines that the member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Coverage Determination Review:

A member's request for a particular drug or benefit will be compared against the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor to determine if the requested drug is a covered benefit.

If CVS/caremark determines that the member's request for a drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies selected by the Plan Sponsor, that determination will constitute an Adverse Coverage Determination.

Post-Service Claims Review:

A member's request for payment of a post-service claim for a particular drug or benefit will be compared against the preferred drug lists, formularies, or other defined plan benefits selected by the Plan Sponsor to determine if the requested item qualifies as a covered benefit.

If CVS/caremark determines that the member's request for the drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies selected by the Plan Sponsor, that determination will constitute an Adverse Coverage Determination.

Timing of Review:

Pre-Authorization Review – CVS/caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS/caremark will make a decision on the Claim as soon as possible, but not later than 72 hours.

Coverage Determination Review – CVS/caremark will make a decision on a Coverage Determination within 15 days after it receives such a request. If the member is requesting the Coverage Determination of an Urgent Care Claim, a decision on such request will be made as soon as possible, but not later than 72 hours.

Post-Service Review – CVS/caremark will make a decision on a Post-Service Claim within 30 days after it receives such a request.

Appeals of Adverse Benefit Determinations or Adverse Coverage Determinations:

If an Adverse Benefit Determination or Adverse Coverage Determination is rendered on the member's Claim, the member or authorized representative may file an appeal of that determination. The appeal of the Adverse Benefit Determination or 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.

The member or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. CVS/caremark will provide the member or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

If the Adverse Benefit Determination or 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 Benefit Determination or 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.

Review of Adverse Benefit Determinations of Pre-Service Claims

CVS/caremark will provide the review of appeals of Pre-Service Claims. Such appeals will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested and a determination will be made by an appropriately-qualified reviewer. If the member's appeal does not meet these criteria, a Medical Necessity review will be conducted by an appropriately-qualified reviewer or sub-delegated or subcontracted medical necessity review organization.

Review of 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.

Appeal Review Procedure

During its review of an appeal of an Adverse Benefit Determination or 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 Benefit Determination or Adverse Coverage Determination and is conducted by someone other than the individual who made the initial Adverse Benefit Determination or 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;
- Ensure that the health care professional was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual); and
- Upon request, identify the health care professional, if any, whose advice was obtained in connection with the Adverse Benefit Determination.

Timing of Review:

Pre-Service Claim Appeal – CVS/caremark will make a decision on the appeal of an Adverse Benefit Determination or Adverse Coverage Determination rendered on a Pre-Service Claim within 30 days after it receives the member's appeal.

If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made as soon as possible, but not later than 72 hours after the request for appeal is received.

Post-Service Claim Appeal – CVS/caremark will make a decision on an appeal of a Post-Service Claim within 60 days after it receives such an appeal.

Notice of Adverse Benefit Determination, Adverse Coverage Determination, Appeal of Adverse Benefit Determination or Appeal of Adverse Coverage Determination:

Following the review of a member's Claim, CVS/caremark will notify the member of any Adverse Benefit Determination, Adverse Coverage Determination, Appeal of Adverse Benefit Determination or Appeal of Adverse Coverage Determination, in writing, in a culturally and linguistically appropriate manner. Decisions on Urgent Care Appeals will also be communicated by telephone. When required by state laws or regulations, decisions on other Adverse Benefit Determinations and Adverse Coverage Determinations will be communicated by telephone as well. This notice will include:

- The specific reason or reasons for the determination in easily-understood language;
- Reference to specific Plan provision on which the determination was based;
- If not a final determination, a description of any additional material or information necessary for the member to perfect the claim, and an explanation of why such material or information is necessary;
- If not a final determination, a description of the Plan's review procedures and the time limits applicable to such procedures;
- If not a final determination and a claim involving urgent care, a description of the expedited review process applicable to such claims;
- If a final determination, a statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request;
- If the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity, either the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request;

- A statement of the member's right to bring action under ERISA Section 502(a), if applicable;
- A description of the available internal appeals process and external review process, including information on how to file an appeal; and
- Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review.

Authority as Claims Fiduciary:

CVS/caremark shall serve as the claims fiduciary with respect to prescription drug benefit Claims arising under the Plan and review of appeals of Adverse Benefit Determinations and Adverse Coverage Determinations. CVS/caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS/caremark is not responsible for the conduct of any Medical Necessity review performed by a sub-delegated medical necessity review organization.

Assigning Prescription Drugs to the Standard Control Formulary

CVS/caremark's National Pharmacy and Therapeutics Committee is authorized to make tier placement changes on CVS/caremark's behalf. The CVS/caremark National Pharmacy and Therapeutics Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The CVS/caremark National Pharmacy and Therapeutics Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the CVS/caremark National Pharmacy and Therapeutics Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.caremark.com** or call the number on your ID card for the most up-to-date tier status.

Subrogation and Reimbursement

The Pharmacy Plan has a right to subrogation and reimbursement, as described in the SPD Section 9, *General Legal Provisions*.

When the Pharmacy Plan Ends

Your coverage under the Pharmacy Plan ends as described in the SPD, Section 4, *When Coverage Ends*.

Rebates and Other Discounts

CVS/caremark and VMware Inc. may, at times, receive rebates for certain drugs on the Formulary. Rebates are not applied at point-of-sale, nor are they taken into account in determining your Coinsurance.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 2, *Exclusions & Limitations* also apply to this Attachment. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access additional information at **www.caremark.com** or by calling the number on your ID card.

Medications that are:

- For any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Pharmaceutical Products for which Benefits are provided in the medical plan (not in this Attachment)
- Available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, with exceptions. Exceptions include prescription products with an OTC equivalent of equal strength.

- Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3).
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered).
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the CVS/caremark National Pharmacy and Therapeutics Committee.
- Prescribed, dispensed or intended for use during an Inpatient Stay.
- Prescribed for appetite suppression, and other weight loss products.
- Prescribed to treat infertility. Infertility benefits are provided by Progyny as described in the Infertility Rider.
- Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that CVS/caremark and VMware Inc. determines do not meet the definition of a Covered Health Care Service.
- Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
- Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.
- Typically administered by a qualified provider or licensed health professional in an outpatient setting.
- In a particular Therapeutic Class (visit **www.caremark.com** or call the number on the back of your ID card for information on which Therapeutic Classes are excluded).
- Unit dose packaging of Prescription Drug Products.
- Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless CVS/caremark and VMware Inc. have agreed to cover an Experimental or Investigational treatment, as defined in Section 10, *Defined Terms*.
- Used for cosmetic purposes
- General vitamins, except for the following which require a prescription:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

GLOSSARY - PRESCRIPTION DRUGS

Adverse Benefit Determination (Does Not Include Adverse Coverage Determinations as defined below) – The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Coverage Determination – An Adverse Coverage Determination is based solely on the terms of the Plan, the preferred drug lists, formulary or other plan benefits selected by the Plan Sponsor and does not involve a determination that the requested drug is experimental or investigational or not medically necessary.

Brand-name - a Prescription Drug Product that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer.
- Identified by CVS/caremark as a Brand-name product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.
- You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by CVS/caremark.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

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

Formulary - see **Standard Control Formulary (Formulary)**.

Generic - a Prescription Drug Product that is either:

- Chemically Equivalent to a Brand-name drug.
- Identified by CVS/caremark as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.
- You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by CVS/caremark.

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 the licensed Mail Service Pharmacy that has entered into a reimbursement agreement

with the Plan, 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. Examples of maintenance medications are atorvastatin and simvastatin to control high blood pressure, or Novolog and metformin to manage diabetes.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service or product 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;
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of the member, member's family or provider.

National Pharmacy and Therapeutics Committee - the committee that CVS/caremark designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with CVS/caremark or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products
- Been designated by CVS/caremark as a Network Pharmacy

Network Specialty Pharmacy – A Pharmacy that has entered into a contractual agreement or is otherwise engaged by the plan to render Specialty Prescription Drug Services and certain administrative functions to you for the Specialty Pharmacy Network.

Pharmacy - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order. A pharmacy may be a network provider or a non-network provider.

Post-Service Claim – A claim which is not a Pre-Service Claim, as defined below; essentially, a Claim for a Plan benefit for which the medical care has already been provided.

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

Pre-Service Claim – A Claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care. Pre-Service Claims include member requests for pre-authorization.

Prescription Drug Charge - the rate CVS/caremark has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, only be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and *are included on the CVS Preventive Therapy Drug List. Some Preventive Care Medications are payable at 100% of the Prescription Drug Charge (without application of any Coinsurance or Deductible) as required by applicable law under any of the following:*

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication at www.caremark.com or by calling CVS/caremark at the number on your ID card.

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 National

Pharmacy and Therapeutics Committee.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain rare or complex illnesses. You may access a complete list of Specialty Prescription Drug Products at www.caremark.com or by calling the number on your ID card.

Standard Control Formulary (Formulary) - a list that categorizes by Tier, medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to CVS/caremark's periodic review and modification (generally quarterly). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting CVS/caremark at the number on your ID card or www.caremark.com.

Therapeutic Class - a group or category of Prescription Drug Product with similar uses and/or actions.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile

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

HOW TO REACH CVS/CAREMARK:

Online

- To reach CVS/caremark online, go to www.caremark.com
- Visit the CVS/caremark website anytime to refill your mail-order prescriptions, check the status of your Mail Service order, request more claim forms and order forms, view the formulary or find a participating retail pharmacy near you.
- You can download the CVS/caremark mobile app for your Smartphone

Telephone

- Call the phone number on your ID Card to get answers to your questions about your prescription drug program.

Paper Claims

- Please send prescriptions to:

  CVS/Health
  Attn: Commercial Claims
  PO box 52136
  Phoenix, AZ 85072-2136

Special Services

- You may call a registered pharmacist at any time for emergency consultations at 1-866-234-6869
- Our hearing-impaired members may use our TDD number at 1-800-231-4403, 24 hours a day, 7 days a week.
- Visually impaired members may request that their mail-order prescriptions include labels in large print or BRAILLE by calling 1-866-234-6869.
- For information on specialty medications through CVS Specialty, call toll-free at 1-800-237-2767