

CalPERS Outpatient Prescription Drug Benefit Plan for selected CalPERS Health Maintenance Organization (HMO) Basic Plans

Evidence of Coverage

Effective January 1, 2014

Table of Contents

IN I RODUCTION	2
SUMMARY OF BENEFITS	3
OUTPATIENT PRESCRIPTION DRUG BENEFIT PLAN	
Outpatient Prescription Drug Benefit Plan	
Copayment Structure	
Maintenance Choice®	
Coinsurance, "Member Pays the Difference"*** and "Partial Copay Waiver**"	
Retail Pharmacy Program	8
How To Use The Retail Pharmacy Program Nationwide	8
Compound Medications	10
Mail Service Program	
PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS	13
OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS	14
PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS	
ADVERSE BENEFIT DETERMINATION (ABD) CHART	21
DEFINITIONS	25

INTRODUCTION

CalPERS Health Maintenance Organization (HMO) Outpatient Prescription Drug Benefit Plan administered by CVS Caremark

CVS Caremark administers the outpatient Prescription Drug benefit for the following CalPERS HMO Basic Plans:

- Anthem Blue Cross: Traditional and Select HMO
- Health Net of California: SmartCare and Salud y Mas
- Sharp Performance Plus
- UnitedHealthcare Alliance HMO

CVS Caremark services include administration of the Retail Pharmacy Program and the Mail Service Program; delivery of specialty pharmacy products, including injectable Medications; clinical pharmacist consultation; and clinical collaboration with your physician to ensure you receive optimal total healthcare.

Please take the time to familiarize yourself with this Evidence of Coverage (EOC) booklet. As Plan Member, you are responsible for meeting the requirements of the Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance.

Welcome to CalPERS HMO Outpatient Prescription Drug Benefit Plan!

SUMMARY OF BENEFITS

Benefits	Covered Services	Member Pays
Prescription Drugs p. 4	Retail Pharmacy Program for short-term use up to a 30-day supply	\$5 generic \$20 Preferred (On CVS Caremark's Preferred Drug List) Brand-Name Medications \$50 Non-Preferred (Not on CVS Caremark's Preferred Drug List) Brand-Name Medications**** \$40 for Partial Copay Waiver of Non-Preferred Brand copayment *** 50% Erectile or Sexual Dysfunction Drugs
	Maintenance Medications*, if refilled at a retail pharmacy** after 2nd fill up to a 30 day supply	\$10 generic \$40 Preferred (On CVS Caremark's Preferred Drug List) Brand-Name Medications \$100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) Brand-Name Medications**** \$70 for Partial Copay Waiver of Non-Preferred Brand copayment *** 50% Erectile or Sexual Dysfunction Drugs
	Mail Service/Maintenance Choice®**Program for maintenance Medications* up to a 90-day supply Out-of-Pocket Maximum, per person each Calendar Year: \$1,000 (only includes Generic and Preferred Brands)	\$10 generic \$40 Preferred (On CVS Caremark's Preferred Drug List) Brand-Name Medications \$100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) Brand-Name Medications**** \$70 for Partial Copay Waiver of Non-Preferred Brand copayment *** 50% Erectile or Sexual Dysfunction Drugs *** In order to obtain a Partial Copay Waiver of the
	* Maintenance Medications are drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, such as diabetes or high blood pressure. These drugs are usually taken longer than sixty (60) days. Specialty Medications do not apply. Refer to the Outpatient Prescription Drug Plan section beginning on page 4 for more information. ** Maintenance Medications may be filled or refilled at CVS/pharmacy or Longs Drugs locations even after the 2 nd refill through the Maintenance Choice® program. See page 7 for details regarding Maintenance Choice®.	Non-Preferred Brand copayment, your physician must document the Medical Necessity for the Non-Preferred product vs. the Preferred product(s) and the available generic alternative(s) through CVS Caremark's formal appeals process outlined on pages 16-17. ****Member Pays the Difference. For brand name Medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent is available, the Member will pay the difference in cost between the brand Medication and its generic equivalent, plus the applicable generic copayment.

MEDICAL NECESSITY

The benefits of this Plan are provided only for those Prescription Drugs that are determined to be Medically Necessary; however, even Medically Necessary Prescription Drugs are subject to the Outpatient Prescription Drug Exclusions section starting on page 14.

"Medically Necessary" Prescription Drugs are those that a Prescriber, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice (i.e., standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors); and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
- not primarily for the convenience of the covered individual, physician or other health care provider; and
- not more costly than an alternative Prescription Drug at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

The fact that a Prescriber may prescribe a Prescription Drug does not in itself make it Medically Necessary. The Plan reviews Prescription Drugs to assure that they meet the Medical Necessity criteria above. The Plan's review processes are consistent with processes found in other managed care environments and are consistent with the Plan's pharmacy policies. A Prescription Drug may be determined not to be Medically Necessary even though it may be considered beneficial to the Member.

Claims Review

The Plan reserves the right to review all claims and medical records to determine whether Prescription Drugs are Medically Necessary and efficiently delivered, and whether any exclusions or limitations apply.

OUTPATIENT PRESCRIPTION DRUG BENEFIT PLAN

Outpatient Prescription Drug Benefit Plan

The Outpatient Prescription Drug Benefit Plan is administered by CVS Caremark. This Plan will pay for Prescription Medications which are: (a) prescribed by a Prescriber (defined on page 27) in connection with a covered illness, condition, or accidental injury; (b) dispensed by a registered pharmacist; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs section on page 13. All Prescription Medications are subject to clinical drug utilization review when dispensed and to the exclusions listed in the Outpatient Prescription Drug Exclusions on pages 14-15.

Covered outpatient Prescription drugs prescribed by a Prescriber in connection with a covered illness or accidental injury and dispensed by a registered pharmacist may be obtained either through the CVS Caremark Retail Pharmacy Program or the CVS Caremark Mail Service Program.

The Plan's Outpatient Prescription Drug Benefit is designed to save you and the Plan money without compromising safety and effectiveness standards by encouraging you to ask your physician to prescribe Generic Drugs whenever possible and to also prescribe Medications on CVS Caremark's Preferred Drug List which can be found at www.caremark.com/calpers. You can still receive any covered Medication, and your physician still maintains the choice of Medication prescribed but this may increase your financial responsibility.

Copayment Structure

The Plan's Incentive Copayment Structure includes generic, Preferred and Non-Preferred Brand-Name Medications. The Member has an incentive to use generic and Preferred brand-name drugs, and Mail Service or CVS/pharmacy for maintenance Medications. Your copayment will vary depending on whether you use retail or Mail Service/ CVS/pharmacy, and whether you select generic, Preferred or Non-Preferred Brand-Name Medications, or whether you refill maintenance Medications at a non-CVS/pharmacy after the second fill.

The following table shows the copayment structure for the retail pharmacy and mail service programs:

	Up to 30 – day supply	Up to 90 – day supply
	Participating Retail Pharmacy (short- term use Medications) CVS Caremark Specialty Pharmacy	CVS Caremark Mail Service/ CVS/pharmacy (long term use – maintenance Medications*)
Generic	\$5	\$10
Preferred Brand	\$20	\$40
Non-Preferred Brand	\$50	\$100
Partial Copay Waiver of Non- Preferred Brands**	\$40**	\$70**
Non-Preferred Brands *** (with generic equivalents)	Member Pays the Difference*** (pg. 7)	Member Pays the Difference*** (pg. 7)
Erectile or Sexual Dysfunction Drugs	50% coinsurance	50% coinsurance

	Out-of-Pocket Maximum, per person each	Out-of-Pocket Maximum, per person each				
	Calendar Year: not applicable	Calendar Year: \$1,000 (only includes Generic and Preferred Brands)				
		Maintenance Medications* filled at anon-CVS/pharmacy after 2 nd fill are limited to a 30-day supply and are charged the higher copayment.				
* A maintanance Madigation abould not require frequent decade adjustments and is prescribed for a long term or						

* A maintenance Medication should not require frequent dosage adjustments and is prescribed for a long-term or chronic condition, such as diabetes, and high blood pressure or is otherwise prescribed for long-term use (as an example, birth control). Ask your physician if you will be taking a prescribed Medication longer than 60 days. If you continue to refill a maintenance Prescription at a non-CVS/pharmacy after the second fill, you will be charged a higher copayment, which is the applicable Mail Service copayment described above. Please note that while Medications can be filled at a retail pharmacy, long-term Medications (Medications taken for 60 days or more) will cost more if refilled at a retail pharmacy after the second fill. Members can refill the same Medications by Mail Service or at a CVS/pharmacy at a cost savings. Certain Specialty Medications are available only through the CVS Caremark Specialty Pharmacy and are limited up to a 30-day supply.

NOTE: The list of Medications subject to a higher copayment after the second fill at a retail pharmacy and the list of Specialty Medications available only through CVS Caremark Specialty Pharmacy are subject to change. To find out which Medications are impacted, Members can visit CVS Caremark on-line at www.caremark.com/calpers or call CVS Caremark Customer Care at 1-800-237-2767, 7:30 AM – 7:30 PM Pacific.

Examples of common long-term or chronic conditions:

Birth control High blood pressure High cholesterol Diabetes

Examples of common short-term acute illnesses or conditions:

Influenza (the "Flu") Pneumonia Urinary tract infection

**To obtain a partial copay waiver exception, your physician must document the Medical Necessity for the nonpreferred product vs. the preferred product(s) and the available generic alternative(s). Members can call CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to request an exception form. The partial copay waiver is only available for Non-Preferred Brands and excludes Erectile or Sexual Dysfunction Drugs.

The copayment applies to each Prescription order and to each refill. The copayment is not reimbursable. (Under some circumstances your Prescription may cost less than the actual copayments, and you will be charged the lesser amount.)

All Prescriptions filled by Mail Service will be filled with a FDA-approved bioequivalent generic, if one exists, unless your physician specifies otherwise. A one thousand-dollar (\$1,000) maximum (only includes Generic and Preferred Brands) Calendar Year copayment (per person) applies to Mail Service/ Maintenance Choice® Prescriptions.

Although Generic Medications (defined on page 26) are not mandatory, the Plan encourages you to purchase Generic Medications whenever possible. Generic equivalent Medications may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that they have the same quality, strength, purity and stability as the Brand-Name Medications (defined on page 25). Prescriptions filled with Generic equivalent Medications have lower copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Maintenance Choice®

Maintenance Medications for long-term or chronic conditions may be obtained at CVS/pharmacy and Longs Drugs retail pharmacy locations, for up to a ninety (90) day supply, through the Maintenance Choice®. Maintenance Choice® offers the face-to-face experience and quick service of retail, with the lower Mail Service copayment structure. Prescriptions for eighty-four (84) to ninety (90) day supplies of maintenance Medications can be filled under the Maintenance Choice® and your copayment will be the same as it would be for a Mail Service order. To utilize Maintenance Choice®, visit a CVS/pharmacy or Longs Drug retail pharmacy location and follow the procedure described on page 7 under "Participating Pharmacy."

Coinsurance, "Member Pays the Difference"*** and "Partial Copay Waiver**"

- Erectile or Sexual Dysfunction Drugs (as defined on page 26) are subject to a 50% coinsurance.
- "Member Pays the Difference" program: If a Non-Preferred brand name drug is selected when a generic equivalent is available, you will pay the difference in cost between the brand name drug and the generic equivalent, plus the generic copayment.
- Member Pays the Difference Exceptions will only be considered for physician requested brand name drugs with a generic equivalent for Medical Necessity.
- You may apply for a Partial Copay Waiver Exception of a Non-Preferred Brand copayment or Member Pays the Difference Exception by contacting CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to request an Exception form. Your physician must document the Medical Necessity for the Non-Preferred product(s) vs. the Preferred product(s) and the available generic alternative(s).
- Partial Copay Waiver Exception and Member Pays the Difference Exception authorizations will be entered from the date of the approval. Retroactive reimbursement requests will not be granted.

Examples of Member Pays the Difference Claims for Non-Preferred Brand-Name Medications*

Drug	Brand plan cost	l	Generic pla cost	n	Differenc	e	Generic copay	Member pays*
Zocor®	\$100	-	\$15	=	\$85	+	\$5	\$90
Valium®	\$79.64	-	\$7.50	=	\$72.14	+	\$5	\$77.14

^{*}Dollar amounts listed are for illustration only and will vary depending on your particular Prescription.

Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a Participating Pharmacy by using your (plan name) ID card.

At Participating Pharmacies, simply show your ID card and pay either a five dollar (\$5.00) copayment for Generic Medications, a twenty dollar (\$20.00) copayment for Preferred Brand-Name Medications, or a fifty dollar (\$50.00) copayment for Non-Preferred Brand-Name Medications. Preventive immunizations at provided at no cost to you. Non-Preferred Brand-Name Medications can be purchased for a forty dollar (\$40.00) copayment with an approved partial copay waiver. If the pharmacy does not accept your ID card and is a Non-Participating Pharmacy (defined on page 27), there is additional cost to you.

If you refill a maintenance Medication at a retail pharmacy after the second fill, you will be charged a higher copayment, which is the applicable Mail Service copayment described above under Copayment Structure.

To find a Participating Pharmacy close to you, simply visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described below. For covered Medications you take on a long-term basis (60 days or more), use CVS Caremark Mail Service, or a CVS/pharmacy for a lower copayment. For more information on CVS Caremark Mail Service, see How To Use CVS Caremark Mail Service on pages 10-11, visit the CVS Caremark Web site at www.caremark.com/calpers, or call CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

 Take your Prescription to any Participating Pharmacy*. To locate a Participating Pharmacy near you, visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

*Limitations may apply.

- Present your HMO's ID card to the pharmacist. The pharmacist will fill the Prescription for up to a 30-day supply of Medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.
- 3. You will be required to pay the pharmacist your appropriate copayment for each Prescription order or refill. You may be required to sign a receipt for your Prescription at the pharmacy.

4. In the event you do not have your ID card prior to going to the pharmacy, contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) for assistance with processing your Prescription at a Participating Pharmacy. In order to obtain an ID card, you may contact your HMO's customer service department. If you pay the Participating Pharmacy the full cost of your Medication at the time of purchase without presenting your ID card, your reimbursement will be the same as if you had used a Non-Participating Pharmacy. (See example below.)

Non-Participating Pharmacy/Out-of-Network/Foreign Prescription Claims

If you fill Medications at a Non-Participating Pharmacy, either inside or outside California, you will be required to pay the full cost of the Medication at the time of purchase. To receive reimbursement, complete a CVS Caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. Claims must be submitted within twelve (12) months from the date of purchase to be covered. Any claim submitted outside the twelve (12) month time period will be denied.

Payment will be made directly to you. It will be based on the amount that the Plan would reimburse a Participating Pharmacy minus the applicable copayment.

Example of Direct Reimbursement Claim for a Preferred Brand-Name Medication*

1.	Pharmacy charge to you (Retail Charge)	\$	48.00
2.	Minus CVS Caremark's Negotiated Network Amount on a Preferred Brand-		
	Name Medication	(\$	30.00)
3.	Amount you pay in excess of allowable amount due to using a Non-		
	Participating Pharmacy or not using your ID Card at a Participating Pharmacy	\$	18.00
4.	Plus your copayment for a Preferred Brand-Name Medication	\$	20.00
5.	Your total out-of-pocket cost would be	\$	38.00

If you had used your ID Card at a Participating Pharmacy, the Pharmacy would only charge the Plan \$30.00 for the drug, and your out-of-pocket cost would only have been the \$20.00 copayment. Please note that if you paid a higher copayment after your second fill at retail for a maintenance Medication, you will not be reimbursed for the higher amount.

As you can see, using a Non-Participating Pharmacy or not using your ID card at a Participating Pharmacy results in substantially more cost to you than using your ID card at a Participating Pharmacy. Under certain circumstances your copayment amount may be higher than the cost of the Medication, and no reimbursement would be allowed.

*Dollar amounts listed are for illustration only and will vary depending on your particular prescription.

Note: Covered Medications purchased from your physician will be reimbursed under the Non-Participating Pharmacy benefit through CVS Caremark.

Foreign Prescription Drug Claims: There are no participating pharmacies outside of the United States. To receive reimbursement for outpatient Prescription Medications purchased outside the United States, complete a CVS Caremark Prescription Reimbursement Claim Form and mail the form along with your pharmacy receipt to CVS Caremark. The Non-Participating Pharmacy must still have a valid pharmacy ID (NPI) in order for CalPERS to approve the paper claim. This can be obtained from the pharmacy that you filled the Prescription at. To obtain a claim form, visit the CVS Caremark web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

Reimbursement for drugs will be limited to those obtained while living or traveling outside of the United States and will be subject to the same restrictions and coverage limitations as set forth in this Evidence of Coverage document. Excluded from coverage are foreign drugs for which there is no approved U.S. equivalent, Experimental or Investigational drugs, or drugs not covered by the Plan (e.g., drugs used for cosmetic purposes, drugs for weight loss, etc.). Please refer to the list of covered drugs outlined in the Outpatient Prescription Drug Benefit Plan section starting on page 3 and Outpatient Prescription Drug Exclusions section on pages 14-15.

50% coinsurance applies for Medications used to treat erectile or sexual dysfunction. Claims must be submitted within twelve (12) months from the date of purchase.

Direct Reimbursement Claim Forms

To obtain a CVS Caremark Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). You must sign any Prescription Reimbursement Claim Forms prior to submitting the form (and Prescription Reimbursement Claim Forms for Plan Members under age 18 must be signed by the Plan Member's parent or guardian).

Compound Medications

Compound Medications, in which two or more ingredients are combined by the pharmacist, are covered by the Plan if at least one of the active ingredients requires: (a) a Prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copay. The copayment for a compound Medication is based off the pricing of each individual drug used in the compound. The copayment is determined by the ingredient used in the compound that is on the highest tier of the Prescription Drug Benefit Copayment Structure (see pages 5-6 for chart). Compounds that include a brand name drug with a generic equivalent will be subjected to the Member Pays the Difference rule. Compound powders will have non-preferred brand copayment. There are three ways to obtain compounded Medications through the Plan: (1) through CVS Caremark Mail Service; (2) through a Participating Retail Pharmacy; or (3) from a non-participating compounding pharmacy. The CVS Caremark Mail Service provides compounding services for many Medications; however, CVS Caremark does not compound some Medications. These compounds must be obtained through a Participating Retail Pharmacy or another compounding pharmacy. If a Participating Pharmacy or a Non-Participating Pharmacy is not able to bill on-line, you will be required to pay the full cost of the compound Medications at the time of purchase and then submit a direct claim for reimbursement. You will be required to pay the full cost of the Medications at the time of purchase and then submit a direct claim for reimbursement. To receive reimbursement, complete a CVS Caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. Certain fees charged by compounding pharmacies may not be covered by your insurance. Please call CVS Caremark Customer Service at 1-877-542-0284 (1-800-863-5488 [TDD]) for details.

Mail Service Program

Maintenance Medications for long-term or chronic conditions may be obtained by mail, for up to a ninety (90) day supply, through CVS Caremark's Mail Service Program. Mail Service offers additional savings, specialized clinical care and convenience if you need Prescription Medication on an ongoing basis. For example:

- Additional Savings: You can receive up to a ninety (90) day supply of Medication for only ten dollars (\$10.00) for each Generic Medication, forty dollars (\$40.00) for each Preferred Brand-Name Medication, one hundred dollars (\$100.00) for each Non-Preferred Brand-Name Medication, or seventy dollars (\$70.00) for each Partial Copay Waiver of Non-Preferred Brand Copayment. In addition to out-of-pocket cost savings, you save additional trips to the pharmacy.
- Convenience: Your Medication is delivered to your home by mail.
- Security: You can receive up to a 90-day supply of Medication at one time.
- A toll-free customer service number: Your questions can be answered by contacting a CVS Caremark Customer Care Representative at 1-877-542-0284 (1-800-863-5488 [TDD]).
- Out-of-pocket maximum: Your maximum Calendar Year copayment (per person) through the Mail Service Program is one thousand dollars (\$1,000). This only applies to copayments for Generic and Preferred Brands.

How To Use CVS Caremark Mail Service

If you must take Medication on an ongoing basis, CVS Caremark Mail Service is ideal for you. To use this program, just follow these steps:

- 1. Ask your physician to prescribe maintenance Medications for up to a ninety (90) day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.
- Send the following to CVS Caremark in the pre-addressed Mail Service envelope:
 - a. The original Prescription order(s) Photocopies are not accepted.
 - b. A completed CVS Caremark Mail Service Order Form. The CVS Caremark Mail Service Order Form can be obtained by visiting the CVS Caremark Web site at www.caremark.com/calpers, or by contacting CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) and using the automated phone system or requesting to speak with a customer service representative.
 - c. A check or money order for an amount that covers your copayment for each Prescription: \$10 generic, \$40 Preferred brand-name, \$100 Non-Preferred brand-name or \$70 Partial Copay Waiver of Non-Preferred brand-name. Checks or money orders should be made payable to CVS Caremark. CVS Caremark also has a safe, convenient way for you to pay for your orders called Electronic Check Processing. Electronic Check Processing is an electronic funds transfer system that automatically deducts your copayment from your checking account. For more information or to enroll on-line, visit www.caremark.com/calpers or call Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). If you prefer to pay for all of your orders by credit card, you may want to join CVS Caremark's automatic payment program. You can enroll by visiting the CVS Caremark Web site at www.caremark.com/calpers or by calling toll-free 1-877-542-0284 (1-800-863-5488 [TDD]).

- 3. You may also have your physician fax your Prescriptions or send them electronically (often called e-prescribing) to CVS Caremark.
 - a. Physicians may fax new Prescription(s) using "Fast Start" to CVS Caremark at 1-800-378-0323. (CVS Caremark can only accept faxes from your physician.)
 - b. To send Prescriptions electronically, your physician may enter the Prescription on an electronic handheld device or computer.
- 4. To order your Mail Service refill:

a. Use CVS Caremark's Web site

Visit www.caremark.com/calpers, your on-line Prescription service, to order Prescription refills or inquire about the status of your order. You will need to register on the site and log in. When you register you will need the cardholder's ID number which is located on HMO Plan ID card.

b. Call CVS Caremark's Automated Refill Phone System

CVS Caremark's automated telephone service gives you a convenient way to refill your Prescriptions at any time of the day or night. Call 1-877-542-0284 (1-800-863-5488 [TDD]) for CVS Caremark's fully automated refill phone service. When you call, be ready to provide the cardholder's ID number, Member's year of birth, and your credit card number along with the expiration date.

c. Refill by Mail

Order your refill three weeks in advance of your current Prescription running out. Refill dates will be included on the Prescription label you receive from CVS Caremark and the refill order forms that will be included with all Prescriptions for which refills remain. Mark the appropriate box on the CVS Caremark Mail Service Order Form and mail it, along with your payment to CVS Caremark in the pre-addressed envelope included with your previous shipment.

Medications will not be released by CVS Caremark Mail Service without a form of payment on file.

How to submit a payment to CVS Caremark

You should always submit a payment to CVS Caremark when you order Prescriptions through CVS Caremark Mail Service, just as if you were ordering a Prescription from a retail pharmacy. CVS Caremark accepts the following as types of payment methods:

- Electronic Check
- Check/Money Order
- Credit Card/Debit Card Visa®, MasterCard®, Discover®/NOVUS, American Express®
- BillMeLater® (Visit <u>www.caremark.com/calpers</u> or call CVS Caremark Customer Care to
 find out if this option is available to you.) BillMeLater® is an easy way to pay in full or over
 time without using your credit card. BillMeLater® is subject to credit approval as determined
 by the lender, CIT Bank, Salt Lake City, Utah and is available to U.S. customers who are of
 legal age in their state of residence.

CVS Caremark recommends placing a credit card on file if you will be ordering ongoing Prescriptions through CVS Caremark Mail Service. A credit card can be placed on your account by logging in to your account at www.caremark.com/calpers, calling Customer Care or filling out the credit card information on CVS Caremark Mail Service Order Form when you mail in your Prescription order. If "Default Payment Method" is selected during order, your chosen payment method will automatically be charged every time that a new Prescription or refill is ordered.

If you have questions regarding CVS Caremark Mail Service or to find out if your Medication is on CVS Caremark's Preferred Drug List, visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). All Prescriptions received through Mail Service will be filled with an FDA-approved bioequivalent generic substitute if one exists.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include a Prior Authorization Program/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan. The Plan reserves the right to exclude, discontinue or limit coverage of drugs or a class of drugs, at any time following a review.

The Plan may implement additional new programs designed to ensure that Medications dispensed to its Members are covered under this Plan. As new drugs are developed, including generic versions of brand-name drugs, or when drugs receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those drugs or class of drugs under the Plan. Any benefit payments made for a Prescription Medication will not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that Medication at a later date.

The purpose of Prescription Drug Coverage Management Programs, which are administered by CVS Caremark in accordance with the Plan, is to ensure that certain Medications are covered in accordance with specific Plan coverage rules.

Prior Authorization/Point of Sale Utilization Review Program

If your Prescription requires a prior authorization, the dispensing pharmacist is notified by an automated message before the drug is dispensed. The dispensing pharmacist may receive a message such as "Plan Limits Exceeded" or "Prior Authorization Required" depending on the drug category. Your physician should contact CVS Caremark to determine if the prescribed Medication meets the Plan's approved coverage rules. Approvals for prior authorizations are typically granted for one year; however, the time frame may be greater or less than one year depending on the drug. This process is usually completed within forty-eight (48) hours. You and your Prescriber will receive notification from CVS Caremark of the prior authorization outcome. Some drugs that require prior authorization may be subject to a quantity limitation that may differ from the 30-day supply.

Please visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to determine if your drug requires prior authorization.

CVS Caremark's Specialty Pharmacy Services

CVS Caremark's Specialty Pharmacy offers convenient access and delivery of Specialty Medications (as defined in this EOC), many of which are injectable, as well as personalized service and educational support. A CVS Caremark patient care representative will be your primary contact for ongoing delivery needs, questions, and support.

To obtain specialty Medications, you or your physician should call 1-800-237-2767. CVS Caremark's Specialty Pharmacy hours of operation are 7:30 AM to 7:30 PM PST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact CVS Caremark's Specialty Pharmacy at 1-800-237-2767 for specific coverage information.

Specialty Medications will be limited to a maximum thirty (30) day supply.

Specialty Preferred Drug Plan - Specialty Preferred Drug Strategies control costs and maintain quality of care by encouraging prescribing toward a clinically effective therapy. This program requires a Member to try the preferred Specialty Medication(s) within the drug class prior to receiving coverage for the non-preferred drug. If you don't use a preferred Specialty Medication, your Prescription may not be covered and you may be required to pay the full cost. The Member has the opportunity to have the Prescriber change the Prescription to the preferred drug or have the Prescriber submit a request for coverage through an exception. Clinical exception requests are reviewed to determine if the non-preferred drug is Medically Necessary for the member.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Plan:

- Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use. *
- 2. Drugs not approved by the U.S. Food and Drug Administration (FDA)
- Off label use of FDA approved drugs**, if determined inappropriate through CVS Caremark's Coverage Management Programs.
- 4. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through CVS Caremark's coverage management programs.
- 5. Drugs or medicines obtainable without a licensed Prescriber's Prescription, often called Over-the-Counter (OTC) Drugs or Behind-the Counter (BTC) Drugs, except insulin, diabetic test strips and lancets, and Plan B.

- 6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by Prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except Prescriptions for single agent vitamin D, vitamin K and folic acid.
- 7. A Prescription Drug that has an over-the-counter alternative.
- 8. Anorexiants and appetite suppressants or any other anti-obesity drugs.
- 9. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses).
- 10. Charges for the purchase of blood or blood plasma.
- Hypodermic needles and syringes, except as required for the administration of a covered drug.
- 12. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
- 13. Drugs labeled "Caution Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any drug or Medication prescribed for experimental indications.
- 14. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
- 15. Any drugs or Medications which are not legally available for sale within the United States.
- 16. Any charges for injectable immunization agents (except when administered at a contracted pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *
- 17. Professional charges for the administration of Prescription Drugs or injectable insulin. *
- 18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility. *
- 19. Drugs and Medications dispensed or administered in an outpatient setting (e.g., injectable Medications), including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *
- 20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or Medication furnished by any other drug or medical services for which no charge is made to the Plan Member.
- 21. Any quantity of dispensed drugs or medicines which exceeds a thirty (30) day supply at any one time, unless obtained through CVS Caremark Mail Service or the Maintenance Choice® program. Prescriptions filled using CVS Caremark Mail Service or the Maintenance Choice® program are limited to a maximum ninety (90) day supply of covered drugs or medicines as prescribed by a licensed Prescriber. Specialty Medications are limited up to a 30 day supply.
- 22. Refills of any Prescription in excess of the number of refills specified by a licensed Prescriber.
- 23. Any drugs or medicines dispensed more than one (1) year following the date of the licensed Prescriber's Prescription order.

- Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the Mail Service pharmacy.
- 25. Compounded Medications if: (1) there is a medically appropriate Formulary alternative, or (2) the compounded Medication contains any ingredient not approved by the FDA. Compounded Medications that do not include at least one Prescription Drug, as defined on page 103, are not covered.
- 26. Replacement of lost, stolen or destroyed Prescription Drugs.

NOTE: While not covered under the Outpatient Prescription Drug Program benefit, items marked by an asterisk (*) may be covered as stated under the Hospital Benefits, Home Health Care, Hospice Care, Home Infusion Therapy and Professional Services provisions of Medical and Hospital Benefits, and Description of Benefits (see your Health Plan's EOC), subject to all terms of this Plan that apply to those benefits.

**Drugs awarded DESI (Drug Efficacy Study Implementation) Status by the FDA were approved between 1938 and 1962 when drugs were reviewed on the basis of safety alone; efficacy (effectiveness) was not evaluated. The FDA allows these products to continue to be marketed until evaluations of their effectiveness have been completed. DESI drugs may continue to be covered under the CalPERS outpatient Prescription Drug benefit until the FDA has ruled on the approval application.

Services Covered By Other Benefits

When the expense incurred for a service or supply is covered under a benefit section of your HMO Plan, it is not a covered expense under this Plan.

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

CVS Caremark manages both the administrative and clinical Prescription drug appeals process for CalPERS. If a Member wishes to request a coverage determination, the Member or the Member's Authorized Representative (Member) may contact CVS Caremark's Customer Care at 1-866-236-1069 (1-855-479-3660 [TTY]). Customer Care will provide the Member with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to CVS Caremark. The written response the Member will receive back is an initial determination. When the Member receives this information, it will tell them how to appeal the initial determination in writing to CVS Caremark if they are not satisfied with the response. A denial of the request is an adverse benefit determination, and may be appealed through an Internal Review process described below. Denials of requests for Partial Copayment Waivers and Member Pay the Difference Exceptions are adverse benefit determinations, and a Member may appeal them through the Internal Review process. If the appeal is denied through the Internal Review process, it becomes a final adverse benefit determination and the Member may pursue an independent External Review or Administrative Review directly with CalPERS. The detailed information for the process is described below.

1. Denial of claims of benefits

Any denial of a claim is considered an adverse benefit determination (ABD) and is eligible for Internal Review as described in section 2 below. Final Adverse Benefit Determinations (FABD) resulting from the Internal Review process may be eligible for External Review in cases involving Medical Judgment, as described in section 3 below.

a. Denial of a Drug Requiring Approval Through Coverage Management Programs

The Member may request an Internal Review for each Medication denied through Coverage Management Programs within one-hundred eighty (180) days from the date of the notice of initial benefit denial sent by CVS Caremark. This review is subject to the Internal Review process as described in section 2 below. Requests for review should be directed to:

CVS Caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

If the Member is dissatisfied with the determination made by CVS Caremark in the Internal Review process, the Member may request an independent External Review as described in section 3 below or CalPERS Administrative Review as described in section 4 below.

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for Prescription drugs are not payable when first submitted to CVS Caremark. If CVS Caremark determines that a claim is not payable in accordance with the terms of the Plan, CVS Caremark will notify the Member in writing explaining the reason(s) for nonpayment.

If the claim has erroneous or missing data that may be needed to properly process the claim, the Member may be asked to resubmit the claim with complete information to CVS Caremark. If after resubmission the claim is determined to be payable in whole or in part, CVS Caremark will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, CVS Caremark will inform the Plan Member in writing of the reason(s) for denial of the claim.

If the Member is dissatisfied with the denial made by CVS Caremark, the Member may request an Internal Review as described in section 2 below.

2. Internal Review

The Member may request a review of an ABD by writing to CVS Caremark within one hundred eighty (180) days of receipt of the ABD. Requests for Internal Review should be directed to:

CVS Caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

Reviews of an ABD involving a Medication to treat a condition that could seriously jeopardize the Member's life, health or ability to regain maximum function; or, in the opinion of the Member's physician, would subject the Member to severe pain that cannot be adequately managed without the Medication, should be submitted as soon as possible from the date of the ABD and be clearly identified as Urgent.

The Member may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the request for Internal Review. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD. The cost of copying and mailing medical records required for CVS Caremark to review its determination is the responsibility of the person or entity requesting the review.

The Member will be provided, upon request and free of charge, a copy of the criteria or guidelines used in making the decision and any other information related to the determination.

For prior authorization of Prescription services (Pre-Service Appeal or Concurrent Appeal), CVS Caremark will provide a determination within 30 days of the initial request for Internal Review and includes the following steps:

- 15 days for a determination regarding claim or benefit; and
- an additional15 days for a determination regarding Medical Judgment.

For review of Prescriptions or services that have been provided (Post-Service Appeal), CVS Caremark will provide a determination within 60 days of the initial request for Internal Review.

For a review of an ABD that is urgent, a determination will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours from the time of the request. If the Member's situation is subject to an urgent review, they can simultaneously request an independent External Review described in section 3 below.

If CVS Caremark upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD the Member may pursue the External Review process described in sections 3 below or the CalPERS Administrative Review process as described in section 4 below.

3. Request for Independent External Review

FABD's that are eligible for independent External Review are those that involve an element of Medical Judgment. An example of Medical Judgment would be where there has been a denial of a prior authorization on the basis that it is not Medically Necessary. If the FABD decision is based on Medical Judgment, the Member will be notified that they may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to the Member. The Member must request an independent External Review, in writing, no later than four (4) months from the date of the FABD. The Prescription in dispute must be a covered benefit. If the Member requests a CalPERS Administrative Review before requesting an independent External Review, the Member will be provided an additional four (4) months to request an independent External Review in the event CalPERS Administrative Review determination upholds CVS Caremark's denial of benefits.

The Member may also request an independent External Review if CVS Caremark fails to render a decision within the timelines specified above for Internal Review or if they think the Internal Review process is not full and fair. Examples of not being full and fair include failure to follow the procedures or not utilizing proper professional experts in determination of the Member's denial. Please note, the process will be deemed full and fair if such errors are minor, not detrimental to the Member's appeal, or attributable to good cause or matters beyond CVS Caremark's control. For a more complete description of these rights, please see 45 Code of Federal Regulations section 147.136.

4. Administrative Review

If the Member or the Member's Authorized Representative (Member) remains dissatisfied after exhausting the Internal Review procedures outlined in pages 15-17, the Member may submit a request for CalPERS Administrative Review. This request must be submitted in writing to CalPERS within thirty (30) days from the date of the Final Adverse Benefit Determination (FABD) or, if applicable, the independent External Review decision in cases involving Medical Judgment.

The request must be mailed to:

CalPERS Health Plan Administration Division Health Appeals Coordinator P.O. Box 1953 Sacramento, CA 95812-1953

Members are encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. The ARHI form will be provided to the Member with the FABD letter from CVS Caremark. If a Member would like to designate an Authorized Representative to represent him or her in the Administrative Review process, Section IV. Election of Authorized Representative of the ARHI form must be completed and signed by the Member. If the Member has additional medical records from Providers that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send copies of documents, not originals, as CalPERS will retain the documents for its files. The Member is responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS will attempt to provide a written determination within 30 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours from the time of the request.

Please note that if the Member requests an independent External Review before, at the same time, or after the Member makes a request for CalPERS Administrative Review, but before a determination has been made, CalPERS will not issue its determination until the independent External Review decision is issued.

CalPERS cannot review claims of medical malpractice, i.e. quality of care.

If the Member requested a CalPERS Administrative Review before requesting an independent External Review, and the CalPERS Administrative Review determination upholds the FABD, the Member will be provided an additional four (4) months from the date of the determination to request an independent External Review. See page 18 for independent External Review procedures.

5. Administrative Hearing

The Member must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

The Member must request an Administrative Hearing within thirty (30) days of the date of the Administrative Review determination, or within thirty (30) days of the independent External

Review decision if the Member elected the External Review process after an Administrative Review determination. See section 1 above. Upon satisfactory showing of good cause, CalPERS may grant additional time to file an appeal, not to exceed thirty (30) days.

The request for an Administrative Hearing must set forth the facts and the law upon which the appeal is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review or External Review.

If CalPERS accepts the request for an Administrative Hearing, it will be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 *et seq.*), An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); the Member may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to the Member within two weeks of the Board's open meeting.

6. Appeal Beyond Administrative Review and Administrative Hearing

If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- Right to records, generally. The Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from CVS Caremark, CalPERS or both, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, the Member may be
 represented by an attorney. If the Member chooses to be represented by an attorney, the
 Member must do so at his or her own expense. Neither CalPERS nor the administrator will
 provide an attorney or reimburse the Member for the cost of an attorney even if the Member
 prevails on appeal.
- Right to experts and consultants. At any stage of the proceedings, the Member may
 present information through the opinion of an expert, such as a physician. If the Member
 chooses to retain an expert to assist in presentation of a claim, it must be at the Member's
 own expense. Neither CalPERS nor CVS Caremark will reimburse the Member for the costs
 of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon the Plan must be served in person at:

CalPERS Legal Office Lincoln Plaza North 400 "Q" Street Sacramento, CA 95814

ADVERSE BENEFIT DETERMINATION (ABD) CHART

Adverse Benefit Determination (ABD)

Appeals Process Member Receives ABD

Standard Process

180 Days to File Appeal

Internal Review –

Final Adverse Benefit Determination (FABD) issued within 30 days for Pre-Service or Concurrent Appeals or 60 days for Post-Service Appeals

Request for External Review (optional*)

Member must request External Review by IRO within **four (4) months** of FABD*

External Review

FABD must be reviewed within **50 days** (**5 days for submittal to IRO**) from date External Review requested for Pre-Service, Concurrent, and Post-Service appeals

Expedited Process

Internal Review -

Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event

Request for External Review (optional*)

Member should submit request for Urgent External Review as soon as possible, but in no event longer than four

External Review

FABD must be reviewed within reasonable timeframes given medical condition but in no event longer than 72

hours

from receipt of request

CalPERS Administrative Review (AR)

Member must file within 30 days of FABD or Independent External Review decision. CalPERS will attempt to notify Member of AR determination within 30 days

CalPERS Administrative Review (AR)

Member should file as soon as possible, but in no event longer than 30 days of FABD or Independent External Review decision. CalPERS will notify Member of AR determination within **72 hours**

*For FABDs that involve
"Medical Judgment,"
the Member may request an External
Review or proceed directly to CalPERS
for AR, under either the Standard
or Expedited Process.

Process continued on following page

Adverse Benefit Determination (ABD)
Appeals Process
Administrative Hearing Process

Standard Process Continued

Expedited Process Continued

Request for Administrative Hearing

Member may request Administrative
Hearing within 30 days of
CalPERS AR determination or
independent External Review
determination, whichever is later.

Administrative Hearing

CalPERS submits statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.

Proposed Decision

After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.

CalPERS Board of Administration

Adopts, rejects, or returns proposed decision for additional evidence.

If adopts, decision becomes final decision.

Member May Request Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Adverse Benefit Determination (ABD) Appeals Process Definitions

The flow chart above and definitions below are included to assist the Member with understanding his or her rights and the provisions of this Plan related to Internal Claims and Appeals, and the independent External Review process available in the event a denial is based on Medical Judgment. The information provided here is general and simplified, consistent with accuracy, but is not intended to be the definitive statement of state or federal law.

Administrative Hearing (AH) – A legal hearing conducted by the Office of Administrative Hearings and governed by the rules established in the California Administrative Procedure Act, (Government Code section 11370). Members may avail themselves of their administrative rights by appealing a FABD or independent External Review decision to CalPERS for Administrative Review. If CalPERS upholds the FABD or independent External Review decision, CalPERS will notify the Member that he or she may formally appeal that decision and request an Administrative Hearing.

Administrative Review (AR) – A review conducted by CalPERS after CVS Caremark's Internal Review process and either before or after the Member elects to participate in the independent External Review process. A Member who wishes to appeal an independent External Review decision must submit his or her appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust his or her administrative rights under California law.

Adverse Benefit Determination (ABD) – Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment based on a determination of a Member's eligibility to participate in a plan, and any denial, reduction or termination of, or failure to provide or make payment 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.

<u>Authorized Representative</u> – A person or entity a Member designates to act on his or her behalf regarding his or her AR or AH.

<u>Concurrent Appeal</u> – An appeal of a claim for approval of medical care, treatment or medication during the time such care, treatment or Medication is being rendered.

<u>Expedited Process</u> – The process to review a claim for medical care, treatment or medication with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or, in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Decisions regarding these claims must be made as soon as possible consistent with the medical exigencies involved, but in no event longer than 72 hours.

<u>External Review</u> – A Member who receives a Final Adverse Benefit Determination (FABD) is eligible to submit the FABD to an independent External Review if the plan's decision involved making a medical judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of health care service or treatment requested. The Member will receive notice of his or her right to request an independent External Review at the time the Plan issues the FABD. The independent External Review is conducted by an Independent Review Organization (IRO), as defined below; the IRO's independent External Review decision is binding on the Health Plan. An independent External Review decision that upholds the FABD, or denial of benefit, may be submitted to CalPERS for Administrative Review. The independent External

Review process is optional and must be elected by the Member within four (4) months of the FABD (defined below).

<u>Final Adverse Benefit Determination (FABD)</u> – An ABD that has been upheld by a plan or issuer at the completion of the Internal Review process.

<u>Independent Review Organization (IRO)</u> – An entity that is accredited by a nationally recognized private accrediting organization that conducts Independent External Reviews of FABDs.

Internal Review - The review conducted by CVS Caremark for an ABD.

<u>Medical Judgment</u> – An ABD or FABD that is based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is Experimental or Investigational, or a rescission of coverage (retroactive cancellation of coverage due to a reduction in time base).

<u>Pre-Service Appeal</u> – An appeal of a claim for approval of medical care, treatment or Medication prior to the time such care, treatment or Medication is rendered.

<u>Post-Service Appeal</u> – An appeal of a claim for approval of medical care, treatment or Medication after the time such care, treatment or Medication has been rendered.

DEFINITIONS

Behind the Counter Drugs (BTC) — a drug product that does not require a Prescription under federal or state law and is available to Members only through facilitation of the pharmacist or pharmacy staff. The Plan does not cover BTC products.

Board — the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Brand–Name Medication(s) (Brand-Name Drug) — a drug which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Calendar Year — a period commencing at 12:01 a.m. on January 1 and terminating at 12 midnight Pacific Standard Time on December 31 of the same year.

CalPERS HMO Basic Plans - For purposes of this Evidence of Coverage, this term means:

- Anthem Blue Cross: Traditional and Select HMO
- Health Net of California: SmartCare and Salud y Mas
- Sharp Performance Plus
- UnitedHealthcare Alliance HMO

Drug(s) — see definition under Prescription Drugs on page

Erectile or Sexual Dysfunction Drugs – drug products used to treat non-life threatening conditions such as erectile dysfunction.

Experimental or Investigational — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Additionally, any services that require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Any services that are not approved or recognized as being in accord with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational. Any issue as to whether a protocol, procedure, practice, medical theory, or treatment is experimental or investigational will be resolved by Anthem Blue Cross, which will have full discretion to make such determination on behalf of the Plan and its participants.

FDA — U.S. Food and Drug Administration.

Generic Medication(s) (Generic Drug(s)) — a Prescription Drug manufactured and distributed after the patent of the original Brand-Name Medication has expired. The Generic Drug must have the same active ingredient, strength and dosage form as its Brand-Name Medication counterpart. A Generic Drug costs less than a Brand-Name Medication.

Home Infusion Therapy — refers to a course of treatment whereby a liquid substance is introduced into the body for therapeutic purposes. The infusion is done in the home at a continuous or intermittent rate.

Home Infusion Therapy Provider — a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Incentive Copayment Structure — refers to any covered Drug with copayment differentials between a Generic Medication, Preferred Brand-Name Medication, and Non-Preferred Brand-Name Medication.

Maintenance Medications — Drugs that do not require frequent dosage adjustments, which are usually prescribed to treat a long-term condition, such as birth control, or a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days.

Medically Necessary – see the Medical Necessity provision on page 3.

Medication(s) - see Prescription Drug.

Member — see definition under Plan Member.

Non-Participating Pharmacy — a pharmacy which has not agreed to CVS Caremark's terms and conditions as a Participating Pharmacy. Members may visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark's Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication — Medications not listed on your printed CVS Caremark Preferred Drug List. If you would like to request a copy of CVS Caremark's Preferred Drug List, please visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). Medications that are recognized as non-preferred and that are covered under your Plan will require the highest (third tier) copayment.

Over-the-Counter Drugs (OTC) — A Drug product that does not require a Prescription under federal or state law.

Participating Pharmacy — a pharmacy which is under an agreement with CVS Caremark to provide Prescription Drug services to Plan Members. Members may visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to locate a Participating Pharmacy.

Pharmacy — a licensed facility for the purpose of dispensing Prescription Medications.

Plan — means CalPERS HMO Outpatient Prescription Drug Benefit Plan, which is a self-funded health plan established by CalPERS and administered by CVS Caremark.

Plan Member – Any individual enrolled in the following CalPERS HMO Basic Plans:

- Anthem Blue Cross: Traditional and Select HMO
- Health Net of California: SmartCare and Salud y Mas
- Sharp Performance Plus
- UnitedHealthcare Alliance HMO

Prescriber — a licensed health care provider with the authority to prescribe Medication.

Prescription — a written order issued by a licensed prescriber for the purpose of dispensing a Drug.

Prescription Drug(s) (Drug(s)) — a Medication or drug that is (1) a prescribed drug approved by the U.S. Food and Drug Administration for general use by the public; (2) all drugs which under federal or state law require the written Prescription of a licensed Prescriber; (3) insulin; (4) hypodermic needles and syringes if prescribed by a licensed Prescriber for use with a covered drug; (5) glucose test strips; and (6) such other drugs and items, if any, not set forth as an exclusion.

Prescription Order — the request for each separate Drug or Medication by a licensed Prescriber and each authorized refill of such request.

Specialty Medications - drugs that have one or more of the following characteristics: (1) therapy of chronic or complex disease; (2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; or (5) potential for significant waste due to the high cost of the drug.

Specialty Pharmacy – a licensed facility for the purpose of dispensing Specialty Medications.