



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

Evidence of Coverage

Effective January 1, 2016

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)



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INTRODUCTION

CalPERS Outpatient Prescription Drug Benefit Plan for selected CalPERS Health Maintenance Organization (HMO) Basic Plans 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
- Anthem EPO Basic
- Health Net of California: SmartCare and Salud y Más
- 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!

MEDICAL NECESSITY

The benefits of this Plan are provided only for those services that are determined to be Medically Necessary; however, even Medically Necessary services are subject to the Benefit Limitations, Exceptions and Exclusions section.

"Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or Drugs (all services) that a qualified Health Professional, 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 service or sequence of services 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 provider may prescribe, order, recommend or approve a service, supply, or hospitalization does not in itself make it Medical Necessary. The Plan reviews services 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 medical and pharmacy policies. A service may be determined not to be Medical Necessary even though it may be considered beneficial to the patient.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Benefit Program is administered by CVS/caremark. This program will pay for Prescription Medications which are: (a) prescribed by a Prescriber 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. All Prescription Medications are subject to clinical utilization review when dispensed and to the exclusions listed in the Outpatient Prescription Drug Exclusions.

Covered outpatient Prescription Medications prescribed by a Prescriber in connection with a covered illness, condition 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 Program is designed to save you and the Plan money without compromising safety and effectiveness standards. You are encouraged to ask your Physician to prescribe Generic Medications or Medications on CVS/caremark's Preferred Drug List whenever possible. Members can still receive any covered Medication, and your Physician still maintains the choice of Medication prescribed but this may increase your financial responsibility.

Although Generic Medications 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. Prescriptions filled with Generic equivalent Medications generally have lower Copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

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 (on CVS/caremark's Preferred Drug List)	\$20	\$40
Non-Preferred Brand (Not on CVS/caremark's Preferred Drug List)	\$50	\$100
Partial Copay Waiver of Non-Preferred Brand (Partial Copay Waiver, see CVS/caremark's appeal process)	\$40	\$70
Member Pays the Difference (MPD)	Member Pays the Difference	Member Pays the Difference
Erectile or Sexual Dysfunction Drugs	50% Coinsurance	50% Coinsurance

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The Maximum Calendar Year Pharmacy Financial Responsibility for each Calendar Year at Retail Pharmacies (not CVS/pharmacies) is \$5,350 per Member and \$10,700 per family.

The Maximum Calendar Year Pharmacy Financial Responsibility per person each Calendar Year for Mail Service/Maintenance Choice® at CVS/pharmacy is \$1,000 (only includes Generic and Preferred Brands).

Erectile or Sexual Dysfunction Drug, and Member Pays the Difference (MPD) Copayments **DO NOT APPLY** to the Maximum Calendar Year Pharmacy Financial Responsibility.

Maintenance Medications* filled at a non-CVS/pharmacy after 2nd fill are limited to a 30-day supply and are charged the higher Copayment.

* 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 Medication 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.

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 1-877-542-0284, 24 hours a day, 7 days a week.

Examples of common long-term Medication or chronic conditions:

Birth control
High blood pressure
High cholesterol
Diabetes

Examples of common short-term or Acute Conditions:

Influenza (the "Flu")
Pneumonia
Urinary tract infection

The Copayment applies to each Prescription Order and to each refill. The Copayment is not reimbursable and cannot be used to satisfy any deductible requirement (Under some circumstances your Prescription may cost less than the actual Copayments, and you will be charged the lesser amount).

All Prescriptions will be filled with a FDA-approved bioequivalent Generic, if one exists, unless your physician specifies otherwise. A maximum \$1,000 per person per Calendar Year Copayment applies to Mail/Maintenance Choice® Prescriptions of only Generic and Preferred Brands.

Maintenance Choice®

Maintenance Medications for long-term or chronic conditions may be obtained at CVS/pharmacy locations, for up to a 90 day supply, through Maintenance Choice®. Maintenance Choice® offers the face-to-face experience and quick service of retail, with the lower Mail Service Copayment structure. Prescriptions for 84 to 90-day supplies of Maintenance Medications can be filled under 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 and follow the procedure described under "Participating Pharmacy."

Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Coinsurance, “Member Pays the Difference” and “Partial Copay Waiver”

- Erectile or Sexual Dysfunction Drugs are subject to a 50% Coinsurance.
- “Member Pays the Difference” program: If a Non-Preferred Brand Name Medication is selected when a Generic equivalent is available, Members will pay the difference in cost between the Brand Name Medication and the Generic equivalent, plus the Generic Copayments. Exceptions to the Member Pays the Difference program will only be considered for Physician requested Brand Name Medication with a Generic equivalent for Medical Necessity.

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

Drug	Brand Plan cost	Generic Plan cost	Difference	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.

- You may apply for a Partial Copay Waiver Exception of a Non-Preferred Brand-Name Copayment or a 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) versus the Preferred product(s) and the available Generic alternative(s). The Partial Copay Waiver Exception and Member Pays the Difference Exception is only available for Non-Preferred Brands and excludes Erectile or Sexual Dysfunction Medications.
- 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.

Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a Participating Pharmacy by using your CVS/caremark ID card.

There are many Participating Pharmacies outside California that will also accept your CVS/caremark ID card. At Participating Pharmacies, simply show your ID card and pay either a \$5.00 Copayment for Generic Medications, a \$20.00 Copayment for Preferred Brand-Name Medications, or a \$50.00 Copayment for Non-Preferred Brand-Name Medications, or no cost for preventive immunizations. Non-Preferred Brand-Name Medications can be purchased for a \$40.00 copayment with an approved partial copay waiver. If the Pharmacy does not accept your ID card and is a Non-Participating Pharmacy, there is an additional cost to you.

If you refill a Maintenance Medication at a non-Maintenance Choice 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, 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]).

OUTPATIENT PRESCRIPTION DRUG PROGRAM

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

Take your Prescription to any Participating Pharmacy*. Present your CVS/caremark 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.

*Limitations may apply.

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 12 months from the date of purchase to be covered. Any claim submitted outside the 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 financial 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 financial 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.

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 Inc. The Non-Participating Pharmacy must still have a valid pharmacy ID (NPI) in order for the Plan to approve the paper claim. This can be obtained from the Pharmacy that you filled the Prescription. 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 and excluded drugs outlined in the Outpatient Prescription Drug Program section and Outpatient Prescription Drug Exclusions section.

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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's Prescription Drug Program if at least one of the active ingredients requires: (a) a Prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Compound Medications are subject to Coverage Management Programs, and Outpatient Prescription Drug Exclusions. 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. 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-Name Copayment. There are three ways to obtain compounded Medications through the Plan's Prescription Drug Program: (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, 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 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 **90-day supply** of Medication for only \$10.00 for each Generic Medication, \$40.00 for each Preferred Brand-Name Medication, \$100.00 for each Non-Preferred Brand-Name Medication, or \$70.00 for each Partial Copay Waiver of Non-Preferred Brand-Name Copayment. In addition to financial 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]).
- **The Maximum Calendar Year Pharmacy Financial Responsibility:** Your maximum Calendar Year Copayment (per person) through the Mail Service Program is \$1,000. This only applies to copayments for Generic and Preferred Brands.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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 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.
2. 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 should be included with your prescription. 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 the combined medical and prescription drug 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.
5. Medications will not be released by CVS/caremark Mail Service without a form of payment on file.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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 www.caremark.com/calpers 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, but are not limited to the High Performance Generic Step Therapy and 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 medications are developed, including generic versions of Brand-Name Medications, or when medications receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those medications or class of medications 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.

High Performance Generic Step Therapy

The High Performance Generic Step Therapy program helps you and your doctor choose a lower-cost, generic medicine as the first step in treating your health condition. Before certain targeted Brand Name Drugs are covered, this program requires that you try a Generic medicine as the first step in treating your health condition. If you cannot or will not make the change, there are the following options:

- If the change is not clinically appropriate, your Prescriber may request a prior authorization.
- If you do not make the change, your targeted brand Drug will not be covered and you will have to pay the full cost of the Drug.

High Performance Generic Step Therapy is available for the following conditions: Depression, Glaucoma, High Blood Pressure, High Cholesterol, Acid Reflux, Acne, Allergy, Headache, Insomnia, Osteoporosis, Pain, Prostate Enlargement and Urinary Incontinence. To obtain a complete list of medications, contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) or visit www.caremark.com/calpers.

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 medication. This process is usually completed within 48 hours. You and your prescriber will receive notification from CVS/caremark of the Prior Authorization outcome. Some medications 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 medication requires prior authorization.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

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 30-day supply.

Specialty Preferred Medications - Specialty Preferred Medication 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 Medication. 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 Medication or have the Prescriber submit a request for coverage through an exception. Clinical exception requests are reviewed to determine if the non-preferred Medication is Medically Necessary for the Member.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. 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).
3. 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 Prescriber's prescription, often called Over-the-Counter Drugs (OTC) or Behind-the-Counter Drugs (BTC), 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. Prescription single agent non-sedating antihistamines.
9. Anorexiant and appetite suppressants or any other anti-obesity drugs.
10. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses) except as required by law.
11. Charges for the purchase of blood or blood plasma.
12. Hypodermic needles and syringes, except as required for the administration of a covered Drug.
13. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
14. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or Medication prescribed for experimental indications.
15. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
16. Any drugs or medications which are not legally available for sale within the United States.
17. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *
18. Professional charges for the administration of Prescription Drugs or injectable insulin. *
19. 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. *
20. 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. *
21. 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.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

22. Any quantity of dispensed drugs or medicines which exceeds a 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 90-day supply of covered drugs or medicines as prescribed by a Prescriber. Specialty Medications are limited up to a 30-day supply.
23. Refills of any Prescription in excess of the number of refills specified by a Prescriber as allowed per federal/state laws.
24. Any drugs or medicines dispensed more than one year following the date of the Prescriber's Prescription Order as allowed per federal/state laws. Note, controlled substances may be less than one year depending on federal/state laws.
25. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a non-Participating Pharmacy, or the CVS/caremark Mail Service program.
26. 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 are not covered.
27. Replacement of lost, stolen or destroyed Prescription Drugs.
28. Drugs or medications used solely for the purpose of diagnosing and/or treating infertility.

NOTE: While not covered under the Outpatient Prescription Drug Program benefit, items marked by an asterisk (*) are 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, 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 pharmacy 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 another benefit section of the Plan, it is not a Covered Expense under the Outpatient Prescription Drug Program benefit.

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

CVS/caremark manages both the administrative and clinical prescription drug appeals process for CalPERS. If you wish to request a coverage determination, you or your Authorized Representative, may contact CVS/caremark's Customer Care at 1-877-542-0284 (1-855-479-3660 [TTY]). Customer Care will provide you 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 from CVS/caremark is an initial determination and will include your appeal rights. A denial of the request is an Adverse Benefit Determination (ABD), and may be appealed through the Internal Review process described below. Denials of requests for Partial Copayment Waivers and Member Pay the Difference Exceptions are ABDs, and you 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 (FABD) and for cases involving Medical Judgment, you may pursue an independent External Review as described below, or for benefit decisions may request a CalPERS Administrative Review.

The cost of copying and mailing medical records required for CVS/caremark to review its determination is the responsibility of you or your Authorized Representative requesting the review.

1. Denial of claims of benefits

Any denial of a claim is considered an ABD and is eligible for Internal Review as described in section 2. below. FABDs resulting from the Internal Review process may be eligible for independent External Review in cases involving Medical Judgment, as described in section 4. below.

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

You may request an Internal Review for each Medication denied through Coverage Management Programs within 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.

CVS/caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-433-1172

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 you 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, you 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 you in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the denial made by CVS/caremark, you may request an Internal Review as described in section 2. below.

2. Internal Review

You may request a review of an ABD by writing to CVS/caremark within 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

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

The request for review must clearly state the issue of the review and include the identification number listed on the CVS/caremark Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale.

You 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.

You 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. To make a request, contact CVS/caremark Customer Care at 1-877-542-0284 or 1-800-863-5488 [TTY].

CVS/caremark will acknowledge receipt of your request within 5 calendar days. For standard reviews of 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 additional 15 days for a determination regarding Medical Judgment.

For standard reviews 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.

If CVS/caremark upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD). Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the independent External Review process described in section 4. below;
- For FABDs involving benefit, you may pursue the CalPERS Administrative Review process as described in section 5. below.

3. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if CVS/caremark determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If CVS/caremark determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you can simultaneously request an independent External Review described below.

4. 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, you will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. You may request an independent External Review, in writing, no later than 4 months from the date of the FABD. The Prescription in dispute must be a covered benefit.

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

For cases involving Medical Judgment, you must exhaust the independent External Review prior to requesting a CalPERS Administrative Review.

You may also request an independent External Review if CVS/caremark fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

5. Request for CalPERS Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions or the independent External Review in cases involving Medical Judgment, you may submit a request for CalPERS Administrative Review. You must exhaust CVS/caremark's Internal Review process and the independent External Review process, when applicable, prior to submitting a request for a CalPERS Administrative Review. See the section entitled "CalPERS Administrative Review and Administrative Hearing".

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

1. Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may submit a request for CalPERS Administrative Review. The California Code of Regulations, Title 2, Section 599.518 requires that you exhaust CVS/caremark's internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

This request must be submitted in writing to CalPERS within 30 days from the date of the FABD for benefit decisions or the independent External Review decision in cases involving Medical Judgment. For objections to claim processing, the request must be submitted within 30 days of CVS/caremark affirming its decision regarding the claim or within 60 days from the date you sent the objection regarding the claim to CVS/Caremark and CVS/caremark failed to respond within 30 days of receipt of the objection.

The request must be mailed to:

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

If you are planning to submit information, CVS/caremark may have regarding your dispute with your request for Administrative Review, please note that CVS/caremark may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after CVS/caremark submits the information it has regarding your dispute, CalPERS may ask you to sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are 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 cannot review claims of medical malpractice, i.e. quality of care.

CalPERS will attempt to provide a written determination within 60 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 3 business days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

You 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.

You and/or your Authorized Representative must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

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

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

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); you and/or your Authorized Representative 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 you and/or your Authorized Representative within two weeks of the Board's open meeting.

3. Appeal Beyond Administrative Review and Administrative Hearing

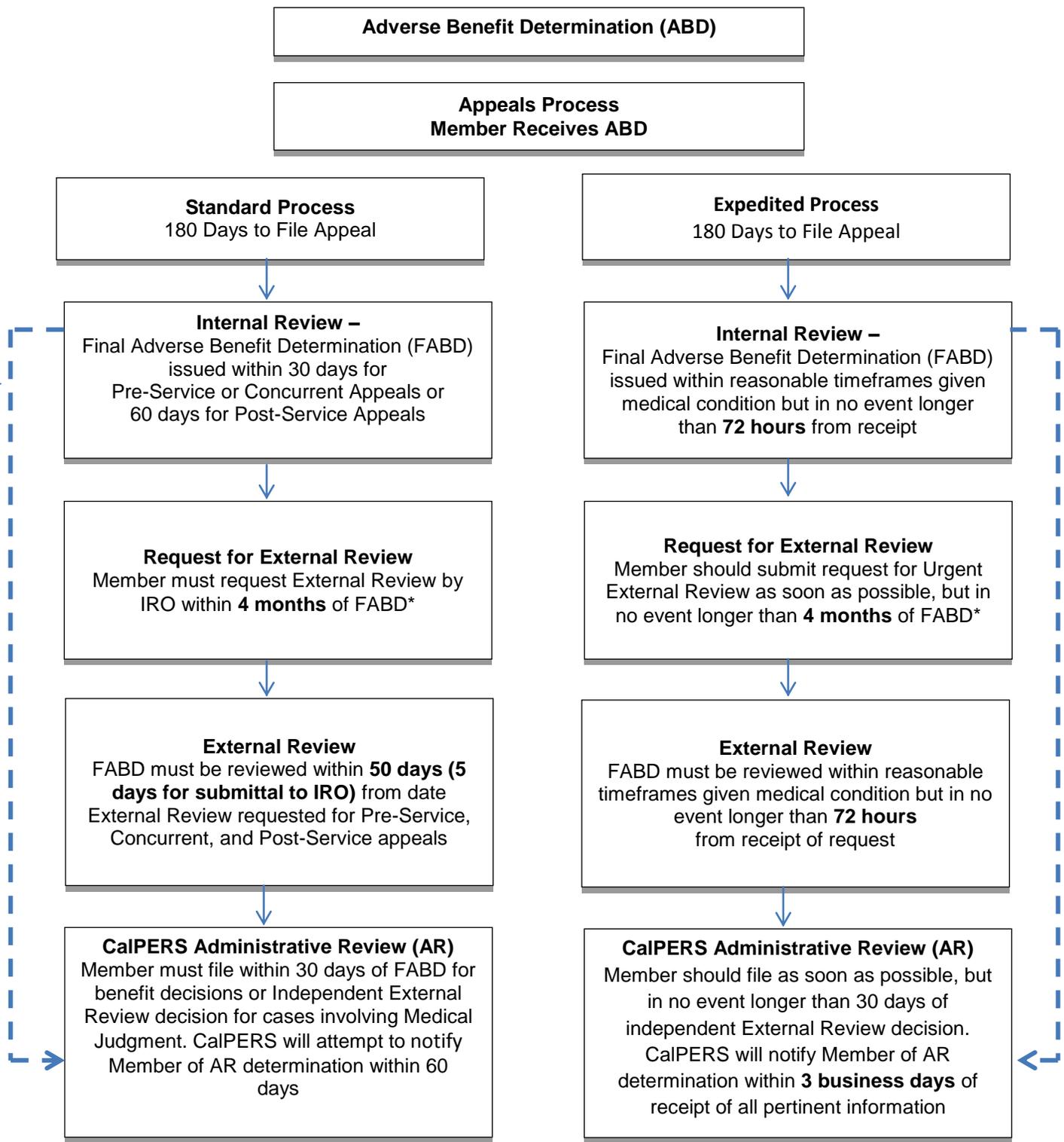
If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You 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.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, 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, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, you may present information through the opinion of an expert, such as a Physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

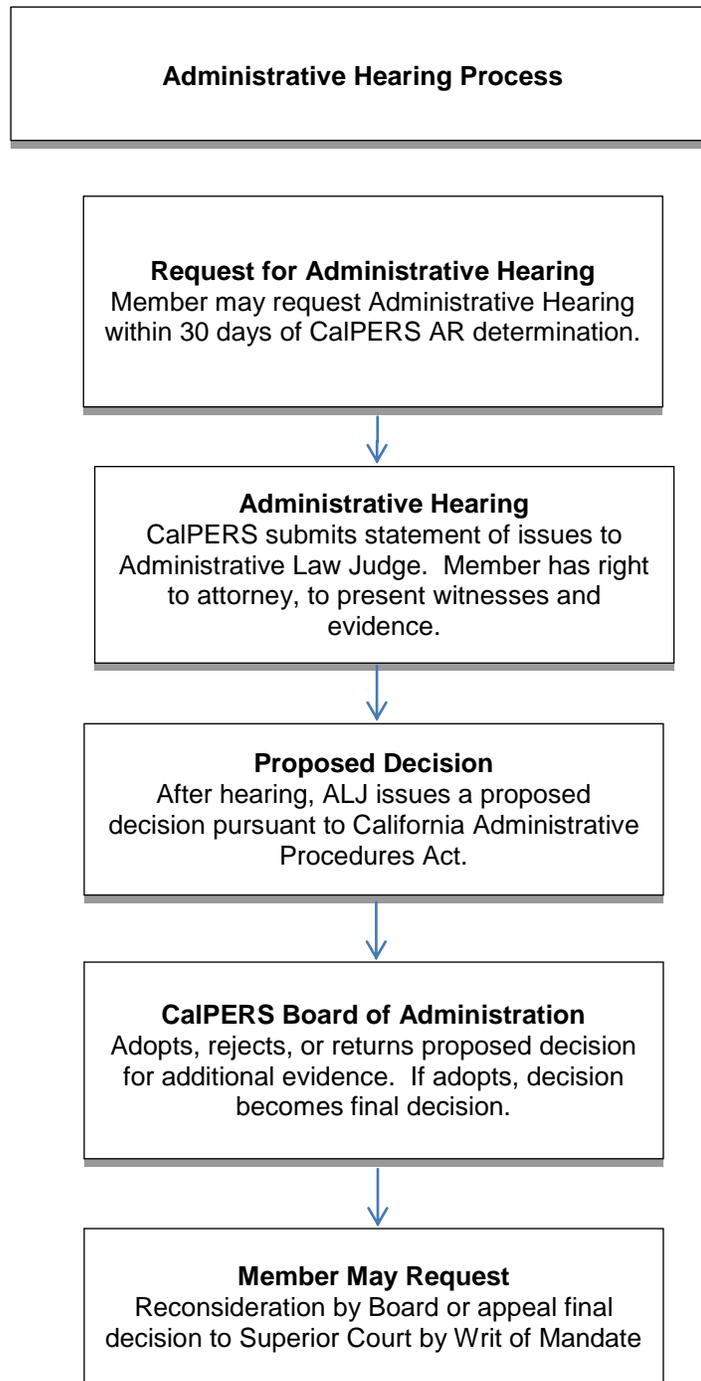
ADVERSE BENEFIT DETERMINATION (ABD) CHART



*For FABDs that involve "Medical Judgment," you must request an independent External Review prior to submitting for a CalPERS Administrative Review

**Process continued
on following page**

ADVERSE BENEFIT DETERMINATION (ABD) CHART



ADVERSE BENEFIT DETERMINATION (ABD) APPEALS PROCESS DEFINITIONS

The flow chart above and definitions below are included to assist you with understanding your 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). You may avail yourself of these 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 you that you may formally appeal that decision and request an Administrative Hearing.

Administrative Review (AR) – A review conducted by CalPERS after Anthem Blue Cross' or CVS/caremark's Internal Review process or after you elect to participate in the independent External Review process. If you wish to appeal an independent External Review decision, you must submit your appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust your 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 your 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 Medical Necessary or appropriate.

Authorized Representative – A person or entity you designate to act on your behalf regarding your appeal or grievance, AR or AH

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

External Review – 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. You will receive notice of your 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 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 4 months of the FABD (defined below).

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

Independent Review Organization (IRO) – 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 Anthem Blue Cross or CVS/caremark for an ABD.

ADVERSE BENEFIT DETERMINATION (ABD) APPEALS PROCESS DEFINITIONS

Medical Judgment – 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).

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

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

Urgent Review – 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 your life or health or your ability of the Member to regain maximum function; or, in the opinion of a Physician with knowledge of your medical condition, would subject you 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 upon receipt of the request by Anthem Blue Cross or CVS/caremark, or 3 business days upon receipt of all pertinent information by CalPERS for the Administrative Review.

DEFINITIONS

When any of the following terms are capitalized in this Evidence of Coverage, they will have the meaning below. This section should be read carefully.

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 Plan: For purposes of this Evidence of Coverage, this term means:

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

Drug(s): See definition under Prescription Drugs

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 CVS/caremark, 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.

DEFINITIONS

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 5.

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 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:

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): 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.

DEFINITIONS

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.