Evidence of coverage

CalPERS Outpatient Prescription Drug Benefit Plan

Effective January 1, 2026

For Selected CalPERS Health Maintenance Organization (HMO) Basic Plans

CVS caremark®

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

CalPERS

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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
- Anthem Blue Cross Select HMO
- Health Net of California: Salud y Más
- Sharp Performance Plus
- UnitedHealthcare SignatureValue Alliance HMO
- UnitedHealthcare SignatureValue Harmony Basic HMO
- Western Health Advantage 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 health care.

Please take the time to familiarize yourself with this Evidence of Coverage (EOC) document. As a 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 document does not serve as an excuse for noncompliance.**

Benefits of the Plan are subject to change. The latest updated addendum and/or document can be obtained through this website at http://www.caremark.com/calpers or you can call CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**).

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 starting on page 12.

“Medically necessary” services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a prescriber (as defined on page 18), 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 medically 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 medically 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 drugs which are: (a) prescribed by a prescriber (defined on page 18) 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 10. All prescription drugs are subject to clinical utilization review when dispensed and to the exclusions listed in the outpatient prescription drug exclusions on page 12. A valid prescription is a written order issued by a licensed prescriber for the purpose of dispensing a drug and shall meet all federal/state regulations as required by law.

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 prescriber to prescribe generic medications or medications on the CVS Caremark preferred drug list whenever possible. Members can still receive any covered medication, and your prescriber still maintains the choice of Medication prescribed but this may increase your financial responsibility. All prescriptions will be filled with an FDA-approved bioequivalent generic, if one exists, unless your physician specifies otherwise.

A medication may be excluded when there is a same or similar drug (one with the same active ingredient or same therapeutic effect) available under the Prescription Drug Benefit and the excluded medication offers no unique therapeutic benefits compared to covered alternatives.

Although generic medications (defined on page 17) 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 17). Prescriptions filled with bioequivalent generic medications generally have lower copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Go to http://www.caremark.com/calpers to check your plan's formulary to see if your medication is covered. You can also search for lower cost alternatives.

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

Classification of medications

The lists of specialty medications (available only through CVS Caremark Specialty Pharmacy), and maintenance medications are subject to change. To find out which Medications are impacted, Members can visit CVS Caremark online at http://www.caremark.com/calpers or call CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**), 24 hours a day, 7 days a week.

Copayment structure

Your copayment will vary depending on whether you use retail versus Home Delivery; whether you select generic, preferred and non-preferred brand name medications; and, for brand-name drugs, whether a bioequivalent generic drug is available.

Medication can be filled for two copayments for up to a 90-day supply at Home Delivery or a participating, in-network pharmacy.

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.

The Plan's copayment structure includes generic, preferred and non-preferred brand-name tier 1, tier 2 and tier 3 medications. The member has an incentive to fill 90-day generic and preferred brand-name drugs. Your copayment will vary depending on day-supply; whether you select generic, preferred or non-preferred brand-name medications-tier 1, tier 2 and tier 3; and, for brand-name drugs, whether a bioequivalent generic drug is available.

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

- Erectile or sexual dysfunction drugs are subject to a 50% coinsurance.
- "Member Pays the Difference": If a brand name medication is selected when a bioequivalent generic drug is available, members will pay the difference in cost between the brand name medication and the bioequivalent generic drug, plus the generic drug copayment. You may apply for a Member Pays the Difference Exception by contacting CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) to request an Exception Form. Your physician must document the medical necessity for the brand product(s) versus the available bioequivalent generic drug(s).
- "Partial Copay Waiver": You may apply for a Partial Copay Waiver Exception only for Non-Preferred Brand Medications by contacting CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) to request an Exception Form. Your physician must document the medical necessity for the non-preferred brand product(s) versus the available generic or preferred brand 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. Erectile or sexual dysfunction medications are excluded.

Maximum calendar year pharmacy financial responsibility

When you receive covered prescription services, your copayments are applied toward the Maximum Calendar Year Pharmacy Financial Responsibility of $8,650 per Plan member, and $17,300 per family. Once you incur expenses equal to those amounts, you will no longer be required to pay an additional copayment for the remainder of that calendar year. Within and as a subset of this maximum, there is a 90-day medication program through CVS Caremark Home Delivery (tier 1 and tier 2). Once you incur expenses equal to $1,000 per Plan member, you will no longer be required to pay any additional Copayment for covered Prescription services received through CVS Caremark Home Delivery for the remainder of that calendar year. You do, however, remain responsible for costs in excess of any specified Plan maximums and for services or supplies which are not covered under this Plan.

Erectile or sexual dysfunction drug coinsurance and Member Pays the Difference Copayments **DO NOT APPLY** to the Maximum Calendar Year Pharmacy Financial Responsibility.

In addition, the following are not included in calculating your maintenance medication program pharmacy limit:

- Tier 3 medication copayments..
- Partial copay waiver of tier 3 copayments.

Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a participating pharmacy by using your member ID card.

There are many participating pharmacies outside California that will also accept your member ID card. At participating pharmacies, simply show your ID card to receive a 30-day supply by paying either:

- Tier 1 medication: $5
- Tier 2 medication: $20
- Tier 3 medication: $50
- Partial Copay Waiver not applicable for retail

Maintenance medications for long-term or chronic conditions may be obtained at CVS Caremark Home Delivery or at participating in-network retail pharmacy locations for two copayments up to a 90-day supply. This allows you to choose an in-person retail experience at the Plan's lower Home Delivery copayment structure.

- Tier 1 medication: $10

- Tier 2 medication: $40
- Tier 3 medication: $100
- Partial Copay Waiver not applicable for retail

To find a participating pharmacy close to you, simply visit the CVS Caremark website at http://www.caremark.com/calpers, or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**).

Home delivery program ("Home Delivery")

Maintenance medications for long-term or chronic conditions may be obtained by mail, for up to a 90-day supply, through the CVS Caremark Home Delivery Program. Home Delivery offers additional savings, specialized clinical care and convenience if you need prescription medication on an ongoing basis. For example, you can receive up to a 90-day supply of Medication for only:

- Tier 1 medication: $10
- Tier 2 medication: $40
- Tier 3 medication: $100

Please note that all prescriptions mailed by the CVS Caremark Home Delivery Program will be subject to the copays above regardless of quantity.

Tier 3 medication can be purchased for $70 copayment with an approved Partial Copay Waiver (page 6).

- 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 member services number: Your questions can be answered by contacting CVS Caremark Member Services at 1-833-291-3649 (TTY users call 711).

How to use CVS Caremark® Home Delivery

If you must take medication on an ongoing basis, CVS Caremark Home Delivery is ideal for you. To get started with home delivery, select from one of the following options:

1. Ask your prescriber 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. Ask your prescriber to send your prescription to CVS Caremark electronically (known as e-prescribing) or to fax the prescription. CVS Caremark can only accept faxed prescriptions from prescribers.
3. Set up an online account at http://www.caremark.com/calpers. Then, log in and select Get Started. Choose which medication you would like to receive through CVS Caremark Home Delivery.
4. Call CVS Caremark at **1-833-291-3649** (TTY users call 711), 24 hours a day, 7 days a week. With your permission, we can contact your doctor's office on your behalf to set up home delivery.
5. Complete and return a New Prescription Order form to CVS Caremark. Forms can be downloaded from http://www.caremark.com/calpers.

    a. Along with your completed form, you must send the following to CVS Caremark:

        1. The original prescription order(s) – **Photocopies are not accepted.**
        2. If you are not paying with a credit card, you must include a check or money order payable to CVS Caremark for an amount that covers your copayment for each prescription.

To order home delivery refills from CVS Caremark, select one of the following options:

1. Log in to your online account. Select the medications you wish to refill.

2. Download the CVS Caremark App for your Apple or Android smart phone. Open the app and under Manage prescriptions click refill prescriptions.
   Choose which medication you want to refill.

3. Call CVS Caremark at **1-833-291-3649** (TTY users call 711) and we can help you refill your medication.

4. By mail: Complete and return the prepopulated refill form that was included in your medication package from your previous order with CVS Caremark. CVS Caremark also includes a return envelope in each order.

New prescriptions that CVS Caremark home delivery pharmacy receives directly from your doctor's office. After the pharmacy receives a prescription from a health care provider, it will be filled. It is important that you respond if you are contacted by the pharmacy to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. You can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our automatic refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of the automatic refill program, which automatically prepares mail-order refills, please contact us by calling CVS Caremark at **1-833-291-3649** (TTY users call **711**).

To confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call CVS Caremark to give us your preferred phone number.

How to use the Retail Pharmacy Program nationwide

Participating pharmacy

Take your prescription to any participating pharmacy*. Present your member ID card to the pharmacist. The pharmacist will fill the prescription for up to a 90-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 online at http://www.caremark.com/calpers and mail it to the address indicated on the form, or submit it on the CVS Caremark app by clicking on the Ask For Reimbursement Link. 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. **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.**

Note that using a non-participating pharmacy or not using your ID card at a participating pharmacy could result in a higher cost for you than if you use your ID card at a participating pharmacy. See example below.

If you had used your ID card at a participating pharmacy, the pharmacy would only charge the Plan $30 for the drug, and your financial cost would only have been the $20 copayment.

Using a non-participating pharmacy or not using your ID card at a participating pharmacy could result 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.

Example of a Direct Reimbursement Claim for a 30-day tier 2 medication*	
Retail pharmacy charge to you	$48
Minus the CVS Caremark negotiated network amount on a preferred brand-name medication	-$30
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
Plus, your copayment for a preferred brand-name medication	$20
Your total financial cost would be	$38

Vacation overrides: Members are generally allowed up to a 30-day supply, two times per medication, per rolling year.

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 an CVS Caremark Prescription Reimbursement Claim Form and mail the form along with your pharmacy receipt to CVS Caremark. Receipts must be submitted in English. For additional claim reimbursement information, visit the CVS Caremark website at http://www.caremark.com/calpers, or call CVS Caremark at **1-833-291-3649** (TTY users call **711**).

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, etc.). Please refer to the Outpatient Prescription Drug Exclusions section on page 12.

Claims must be submitted within 12 months from the date of purchase.

Direct Reimbursement Claim Forms

To obtain an CVS Caremark Prescription Reimbursement Claim Form and information on participating pharmacies, visit the CVS Caremark website at http://www.caremark.com/calpers, or contact CVS Caremark Member Services at

1-833-291-3649 (TTY users call **711**). 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, qualify for coverage if the active ingredients: (a) require a prescription; (b) are FDA approved; and (c) are covered by CalPERS. Compound medications are subject to Coverage Management Programs described on page 10.

Under the Compound Management Program, compound medications can be excluded if: (1) there is an FDA approved alternative available that is as efficacious and safe; (2) contains a bulk chemical that is not FDA approved and is on our bulk exclusion list; or (3) includes a pre-packaged compound kit.

Only products that are FDA-approved and commercially available will be considered preferred for purposes of determining copayment. The copayment for a compound medication is based on the pricing of each individual drug used in the compound. Compound medications that contain more than one ingredient will be subject to the applicable copayment tier of the highest cost ingredient. To verify if a compound medication is covered please call CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) for details. Please note that certain fees charged by the compounding pharmacies may not be covered by your insurance. Compounded prescriptions may undergo a Prior Authorization review.

If a participating pharmacy or a non-participating pharmacy is not able to bill online, you will be required to pay the

full cost of the compound medication at the time of purchase and then submit a direct claim for reimbursement.

To receive reimbursement, complete the CVS Caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. Reimbursement will only be available for covered Drugs in accordance with the Plan provisions. Please see page 8 regarding reimbursement for drugs provided by a non-participating pharmacy.

How to submit a payment to CVS Caremark

You should always submit a payment to CVS Caremark when you order prescriptions through CVS Caremark Home Delivery, just as if you were ordering a prescription from a retail pharmacy. CVS Caremark accepts the following as types of payment methods:

- Check/money order
- Credit card/debit card - Visa®, MasterCard®, Discover®, American Express®, Diners Club®
- ACH payments
- Pay at Retail – Allows members to ship to a CVS Pharmacy (Ship to Retail orders only).

CVS Caremark recommends keeping a credit card on file for copayments. You can securely set up your credit card through your online account or by calling CVS Caremark. Then, each time you refill a prescription, CVS Caremark will bill the copayment amount to the default credit card on file.

Go to http://www.caremark.com/calpers to check your plan's formulary to see if your medication is covered. You can also search for lower cost alternatives.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Coverage management programs

The Plan's Prescription Drug Coverage Management Programs include, but are not limited to, the 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.

Step Therapy

The step therapy program helps you and your prescriber choose a lower-cost medication as the first step in treating your health condition. Before certain targeted brand-name drugs are covered, this program requires that you try a different medication (usually a generic) as the first step in treating your health condition. If you cannot or will not make the change, here are the following options:

- If the change is not clinically appropriate, your prescriber may request a prior authorization to stay on your current medication.
- If you do not make the change, your targeted brand-name drug will not be covered and you will have to pay the full cost of the drug.

To find out if your medication is subject to step therapy contact CVS Caremark Member Services at **1-833-291-3649**
(TTY users call **711**) or visit http://www.caremark.com/calpers.

Prior authorization/point of sale utilization review program

Some prescriptions require a prior authorization to make sure your prescription meets your plan's coverage rules. When you talk with your prescriber, use the pricing tool on the CVS Caremark app to help confirm whether you need a prior authorization for your medication and if there are any alternatives that meet the plan's coverage rules. You can also talk about what you need to do to get your medication. Approvals for prior authorizations can be granted for up to one year; however, the timeframe may be greater or less, depending on the medication. You and your prescriber will receive notification from CVS Caremark of the prior authorization outcome within a few days. Some medications that require prior authorization may be subject to quantity limits.

Please visit the CVS Caremark website at http://www.caremark.com/calpers, use the Drug Pricing tool in the CVS Caremark app or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) to determine if your medication requires prior authorization.

CVS Caremark Specialty Pharmacy services ("Caremark Specialty Pharmacy")

The Caremark Specialty Pharmacy offers convenient access and delivery of specialty medications (as defined in this Evidence of Coverage document), many of which are injectable; as well as personalized service and educational support. A Caremark Specialty Pharmacy patient care representative will be your primary contact for ongoing delivery needs, questions, and support.

To obtain specialty medications, you or your prescriber should call CVS Caremark Specialty Pharmacy at **1-800-237-2767.** CVS Caremark Specialty Pharmacy hours of operation are 8:30 a.m. to 10 p.m. EST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact Caremark 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

Except as otherwise required by law, the following are excluded under the Outpatient Prescription Drug Program:

1. Non-medical devices, including but not limited to: durable medical equipment, digital therapies, support garments, continuous glucose meters, appliances and supplies regardless of their intended use, even if prescribed by a physician. Exceptions: Select insulin, diabetic supplies and agents used to administer or manage specific conditions are covered with a valid prescription.*
2. Off label use of FDA approved drugs**, if determined inappropriate through CVS Caremark coverage management programs.
3. Any quantity of dispensed medications that is determined inappropriate as determined by the FDA or through CVS Caremark coverage management programs.
4. Over-the-counter (OTC), behind-the-counter (BTC) or medicines obtainable without a prescriber's prescription. Exceptions: Select scheduled cough and cold products and select insulin, and select opioid reversal agents, diabetic supplies and agents used to administer or manage specific conditions are covered with a valid prescription.
5. 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., multi-vitamins, and pediatric vitamins), except prescriptions for single agent vitamin D, vitamin K, vitamin B12 injections, and folic acid.
6. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses), except as required by law.
7. Charges for the purchase of blood or blood plasma.
8. Hypodermic needles and syringes, except as required for the administration of a covered drug.
9. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
10. Drugs labeled "Caution – Limited by Federal Law to Investigational Use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications.
11. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
12. Professional charges for the administration of prescription drugs or injectable insulin.*
13. Any charges for immunization agents, except as required by law.*
14. Any charges for desensitization products, allergy, serum or biological sera including the administration thereof.*
15. 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.
16. Reimbursement of charges from a non-outpatient facility for drugs or medicines taken by, or administered to, a Plan member.
17. Refills of any prescription in excess of the number of refills specified by a prescriber as allowed per federal/ state laws.
18. 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.
19. Any participating pharmacy or non-participating pharmacy charges for special handling and/or shipping costs.

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 (see Table of Contents), 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 Members Services at **1-833-291-3649** (TTY users call **711**). Member Services will provide you with instructions and the necessary forms to begin the process. The request for a coverage determination may be made via email, phone, or in writing to CVS Caremark. If your request is denied, 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.

Non-specialty appeals address:
Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax 866-443-1172
Specialty appeals:
CVS Caremark

Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056
Fax 855-230-5548

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:

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax 866-443-1172

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 appeal on an urgent basis, please write "urgent" on your request and provide your rationale. (See definition of "Urgent Review" on next page.)

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 Member Services at **1-833-291-3649** (TTY users call **711**).

CVS Caremark will acknowledge receipt of your request within 5 calendar days for standard Post-Service reviews in writing. If your matter is considered a standard Pre-Service or Concurrent request, CVS will verbally acknowledge your request within 24-hours of receipt. CVS Caremark will provide a determination within 14 days of the initial request for Internal Review.

For standard reviews of prescriptions or services that have been provided (Post-Service Appeal), CVS Caremark will provide a determination within 30 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 appeal is verbally acknowledged within 4-hours of receipt and 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

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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. 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 the CVS Caremark 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 the CVS Caremark 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. 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.

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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.

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 9581

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.

Accidental injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

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 HMO outpatient prescription drug program 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(s)) — 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
- Anthem Blue Cross Select HMO
- Health Net of California: Salud y Más
- Sharp Performance Plus
- UnitedHealthcare SignatureValue Alliance HMO
- UnitedHealthcare SignatureValue Harmony Basic HMO
- Western Health Advantage HMO

Drug(s) — see definition under prescription drugs.

Erectile or dysfunction drugs — Drug products used to treat non-threatening conditions such as erectile dysfunction.

Experimental or investigational — any treatment, therapy, procedure, drug or drug usage for non-FDA approved indications, 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, treatment, or prescription drug is experimental or investigational will be resolved by CVS Caremark, as applicable, which will have discretion to make an initial determination on behalf of the Plan.

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.

Health professional — Physician; dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; acupuncturist; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; Physician assistant; registered nurse; registered dietitian only for the provision of diabetic medical nutrition therapy or nutritional counseling as part of a comprehensive eating disorder program under physician supervision for management of anorexia nervosa and bulimia nervosa; a nurse practitioner and/or registered nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

Homebound — Members are considered to be "homebound" if they have a condition due to an illness or injury that restricts their ability to leave their place of residence.

Home infusion therapy — refers to a course of treatment whereby a liquid substance is introduced into the body

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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 (TJC).

Incentive copayment structure — Members may receive any covered drug with copayment differentials between a generic medication, preferred brand-name medication, and non-preferred brand-name medication.

Maintenance medications — as determined by CalPERS, a drug that does not require frequent dosage adjustments, usually prescribed to treat a long-term (chronic) condition, such as arthritis, diabetes, or high blood pressure.

Medically necessary — see the medical necessity provision on page 4.

Medication(s) — see prescription drug.

Member — see definition under Plan member.

Non-participating pharmacy — a pharmacy which has not agreed to the CVS Caremark terms and conditions as a participating pharmacy. Members may visit the CVS Caremark website at http://www.caremark.com/calpers or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) to locate a participating pharmacy.

Non-preferred brand-name medication(s) (Non-Preferred Brand-Name Drug(s)) — Medications not listed on the CVS Caremark Preferred Drug List. If you would like to request a copy of the CVS Caremark Preferred Drug List, please visit the CVS Caremark website at http://www.caremark.com/calpers or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**). 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. CalPERS HMO Outpatient Prescription Drug Program does not cover OTC products, with the exception of insulin.

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 website at http://www.caremark.com/calpers or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**) 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 employee, annuitant or family member enrolled in the following CalPERS HMO Basic Plans.

Preferred brand-name medication(s) (preferred brand-name drugs(s)) – A medication found on the CVS Caremark Preferred Drug List and evaluated based on the following criteria: safety, side effects, drug-to-drug interactions, and cost effectiveness. If you would like to request a copy of the CVS Caremark Preferred Drug List, please visit the CVS Caremark website at http://www.caremark.com/calpers or contact CVS Caremark Member Services at **1-833-291-3649** (TTY users call **711**).
Preferred Drug List — A list of medications that are cost effective and offer equal or greater therapeutic value than the other medications in the same drug category. CVS Caremark and its Pharmacy and Therapeutics Committee conducts a rigorous clinical analysis to evaluate and select each Preferred Drug List medication for safety, side effects, drug-to-drug interactions and cost effectiveness. The preferred product must (1) meet participant's treatment needs, (2) be clinically safe relative to other drugs with the same indication(s) and therapeutic action(s),
(3) be effective for FDA approved indications, (4) have therapeutic merit compared to other effective drug therapies, and (5) promote appropriate drug use.

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

Prescription(s) — a written order issued by a licensed prescriber for the purpose of dispensing a drug and shall meet all federal/state regulations as required by law.

Prescription drug(s) (medication(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 prescriber; (3) an Rx symbol must be printed on the medicine's label and/or "Caution: Federal law prohibits dispensing without prescription"; (4) insulin; (5) hypodermic needles and syringes if prescribed by a prescriber for use with a covered Drug; (6) glucose test strips; and (7) such other drugs and items, if any, not set forth as an exclusion.

Prescription order(s) — the request for each separate drug or medication by a prescriber and each authorized refill of such request.

Specialty medication(s) – as determined by CalPERS, a drug that has one or more of the following characteristics: (1) therapy for a chronic or complex disease; (2) produced through DNA technology or biological processes; (3) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (4) unique patient compliance and safety monitoring requirements; (5) unique requirements for handling, shipping and storage; or

(6) potential for significant waste due to the high cost of the drug.

Specialty pharmacy – a licensed facility for the purpose of dispensing specialty medications.

Tier 1 – Mostly generic drugs are listed under tier 1 and have the lowest copayments.

Tier 2 – Drugs listed under tier 2 generally include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.

Tier 3 – Drugs listed under tier 3 generally have higher copayments than preferred brand-name drugs and may include some specialty or high-cost drugs.

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