BENEFIT BOOKLET FOR PRESCRIPTION BENEFITS

CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community



2013 – 2014

Dear Plan Member:

Welcome to your prescription drug program. California's Valued Trust (CVT) has chosen CVS Caremark as its partner to provide you and your covered family members with a comprehensive pharmacy program.

In this Benefit Booklet you will find the following information regarding:

- Your prescription drug plan
- Summary of benefits and benefit limitations
- Ways to save on prescriptions
- How to fill your prescriptions
- Specialty Pharmacy
- Other plan provisions
- Definitions

Subscribers and covered family members ("members") are referred to in this booklet as "you" and "your".

Please read this Benefit Booklet ("plan") carefully so that you are familiar with and understand all the benefits your plan offers. Keep this plan handy in case you have any questions about your coverage.

TABLE OF CONTENTS

YOUR PRESCRIPTION DRUG PLAN 1

TYPES OF PROVIDERS 1

RETAIL PHARMACY NETWORK 1

For new prescriptions: 1

For refills: 1

PARTICIPATING PHARMACY 1

NON-PARTICIPATING RETAIL PHARMACY 1

MAIL ORDER / MAINTENANCE CHOICE PROGRAM 2

For new prescriptions: 2

For refills: 2

PRESCRIPTION PLAN COPAYS 3

WELLNESS PPO PLAN MEMBERS 4

WHAT IS A THREE-TIER PRESCRIPTION COPAYMENT STRUCTURE? (APPLICABLE FOR PLANS B, C AND D) 4

WHAT IS THE PERFORMANCE DRUG LIST (PDL) AND WHAT IS A PREFERRED DRUG? 4

GENERIC VERSUS BRAND-NAME DRUGS 5

WHAT IS A BRAND NAME DRUG? 5

WHAT IS A GENERIC MEDICATION? 5

MANDATORY GENERICS 6

GENERIC STEP THERAPY 6

DRUG COVERAGE OVERVIEW 6

COVERED MEDICATIONS 6

EXCLUDED MEDICATIONS 6

COVERAGE LIMITATIONS 7

PRIOR AUTHORIZATION 7

QUANTITY LIMITS 7

SPECIALTY PHARMACY SERVICES 8

COORDINATION OF BENEFITS 9

ORDER OF BENEFITS DETERMINATION 9

TERMINATION OF PHARMACY BENEFITS 9

CLAIMS REVIEW 10

RECONSIDERATIONS 10

APPEALS 10

HOW TO INITIATE REQUESTS FOR RECONSIDERATION OR APPEALS 11

REQUESTS MUST BE MADE AS FOLLOWS: 11

REQUESTS MUST INCLUDE THE FOLLOWING: 11

VOLUNTARY SECOND LEVEL APPEALS 11

EXTERNAL REVIEW 11

BINDING ARBITRATION 12

DEFINITIONS 13

YOUR PRESCRIPTION DRUG PLAN

Your prescription drug benefit program is administered by CVS Caremark. You may utilize the CVS Caremark Web site for fast, convenient, helpful information and services such as estimated pricing quotes, drug plan coverage, prescription refills for your mail order prescriptions, and listings of participating pharmacies in your area. CVS Caremark will also send important email notifications and provide helpful health and drug information when applicable so be sure to register on the CVS Caremark Website.

CVT provides a CVS Caremark\health plan combination Identification Card for each subscriber and their eligible dependents enrolled in a CVT PPO (Preferred Provider Organization) Plan. All cards received will be in the subscriber's name only.

TYPES OF PROVIDERS

RETAIL PHARMACY NETWORK

To get a prescription filled, you need only to take your prescription to a participating pharmacy and present your member ID Card. The amount you pay for a covered prescription will be determined by whether the drug is a brand-name or generic medication and, for some plans, whether it is preferred or non-preferred.

For new prescriptions:

- Find a participating retail pharmacy near you.
- At the pharmacy, present your ID card and prescription
- Make sure that the pharmacist has accurate information about you and your covered dependents, including dates of birth and gender.
- The pharmacist will look up your benefit information on the computer to verify coverage and dispense the prescription.
- Pay your portion of the prescription cost. Your pharmacist will tell you the amount you owe depending on your specific prescription benefit plan.
- You may qualify for reimbursement if: (1) you do not have your card, or (2) you use a non-participating retail pharmacy. You will be required to submit a paper claim form. They can be found on www.cvtrust.org

For refills:

- If your doctor has ordered refills, contact your pharmacy when you are ready to order.

PARTICIPATING PHARMACY

To maximize your prescription drug benefit, your prescription should be filled at a CVS Caremark network participating retail pharmacy (for example: CVS, Walgreens, Vons, etc.). This is a nationwide network of participating pharmacies. Using a participating retail pharmacy is generally more convenient and less expensive. Participating pharmacies can easily access information about your prescription benefit program and your applicable copay. You will not need to file any paperwork when you use a CVS Caremark participating retail pharmacy.

NON-PARTICIPATING RETAIL PHARMACY

Non-participating providers are those pharmacies that have not agreed to participate in the CVS Caremark network. In most cases, you will pay more for your prescription if you use a pharmacy outside of the CVS Caremark network than using a participating, in-network pharmacy provider. At a non-participating pharmacy you will be asked to pay **100 percent** of the prescription price at the pharmacy. Then you will need to submit a

paper claim form along with the original receipt(s) to CVS Caremark for reimbursement of covered expenses. If you have prescriptions at a non-participating pharmacy you may be able to save by having your prescription transferred to a participating retail pharmacy. To do this, contact a CVS Caremark participating retail pharmacy, and tell the pharmacist where your prescription is currently on file. If possible, have your prescription bottle with you when you make the call so you can answer any questions. The pharmacist will contact the non-participating pharmacy and make the transfer for you. When you pick up the prescription, bring along your CVS Caremark identification card so that the pharmacist can verify coverage.

MAIL ORDER / MAINTENANCE CHOICE PROGRAM

CVT offers two options for individuals who are on maintenance or long-term drugs or who will be on the same medication for a long period of time. Maintenance or long-term medications are those drugs most commonly used to treat a chronic illness or long term condition, such as asthma, diabetes, high blood pressure, arthritis or cardiovascular disease. Members and their families must choose to receive a 90-day supply of their maintenance medication either by mail through CVS Caremark Mail Service Pharmacy or to pick them up at a CVS Pharmacy near them. This service also follows the same generic vs. brand drug rules as noted in the 'Mandatory Generics' section of this document. The copay remains the same for both services. Mail order prescriptions may be filled with up to a 90-day supply including free standard shipping to your home.

For new prescriptions:

- You may significantly reduce your costs by requesting generic medications. To use this benefit, let your doctor know you would prefer a generic prescription medication, when available and appropriate for your condition.
- Ask for two prescriptions: one for a long-term supply as defined by your Plan (e.g. 90 days) with as many as three refills (if appropriate); the other for immediate use. Have the short-term prescription (e.g. 30 days) filled at a participating retail pharmacy.
- Complete a CVS Caremark Mail Service Order Form. An incomplete form can cause a delay in processing. Mail your order form and original long-term prescription to CVS Caremark; or, for a quick and easy start contact our FastStart Program at 1-866-273-5268. The FastStart representative will contact your physician for your mail order prescriptions, all you need to provide is your ID number, mailing address, drug name, physician name and phone number. Follow these steps to make sure you have a continuous supply.
- You can provide payment information when you place your order or an invoice will be included with the prescription when it is delivered.
- You can expect your medication to arrive approximately 10 to 14 calendar days after CVS Caremark receives your order. Standard shipping is free-of-charge. You will receive a new mail service order form and envelope with each shipment.

For refills:

- You can order refills by internet, phone, or mail. The information included with your last order will show the date you can request a refill and the number of refills you have left.
- Online is the most convenient way to order refills and inquire about the status of your order any time of the day or night. You will need to register and log on to access service. Simply enter your ZIP code, date of birth, prescription number, and credit card information to order.
- By phone. Call the toll-free Customer Care number located on your prescription label for fully automated refill service. Have your ID number and credit card information ready.
- By mail. Attach the refill label provided with your last order to a mail service order form. Enclose your payment with your order.

PLEASE NOTE: By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit. "30-days plus 2 refills" does not equal one prescription written for "90 days". Therefore, be sure your doctor has indicated the extended days supply (e.g. 90-days plus number of 90-day refills) on the prescription form.

PRESCRIPTION PLAN COPAYS

Your copay/coinsurance is the amount you must pay as your share of the cost for receiving a medication covered by your prescription drug plan. Different factors affect your copay/coinsurance, including the selection of a generic, preferred brand-name, or non-preferred brand-name drugs.

You may also be responsible for:

- Entire cost of medications not covered under your prescription drug plan
- Cost of medications purchased at a non-network pharmacy
- Cost of a prescription if you do not present your identification card at the time of service
- Cost for quantities of medication obtained over and above the quantity allowed under your prescription drug plan

	Plan A	**Plan B**	**Plan C**	**Plan D**
Retail (up to 30-day supply)	$5 Generic $22 Brand	$7 Generic $15 Preferred Brand $30 Non-Preferred Brand	$7 Generic $25 Preferred Brand $40 Non-Preferred Brand	$10 Generic 30% Preferred Brand ($25 min; $40 max) 50% Non-Preferred Brand ($40 min; $100 max)
Mail-Order (up to 90-day supply)	$10 Generic $44 Brand	$15 Generic $35 Preferred Brand $70 Non-Preferred Brand	$15 Generic $60 Preferred Brand $90 Non-Preferred Brand	$25 Generic 30% Preferred Brand ($65 min; $125 max) 50% Non-Preferred Brand ($100 min; $250 max)

<table>
<tr><th colspan="4">FOR PLANS WITH BLUE SHIELD OF CALIFORNIA AS THE MEDICAL CARRIER:</th></tr>
<tr><th></th><th>PPO BRONZE PLAN</th><th>PPO HDHP 1 PLAN</th><th>PPO HDHP 2 PLAN</th></tr>
<tr><td>Retail
(up to 30-day supply)</td><td>Deductible:
Individual: $5,000
Family: $10,000
Subject to deductible then:
$25 Copay Generic
$50 Copay Brand
(30-Day Supply)</td><td rowspan="2">Deductible:
Individual: $1,250
Family: $3,000 (no individual limit applies)
Coinsurance: 80/20
Out Of Pocket Max:
Individual: $3,000 per person + deductible
Family: $7,100 + deductible
Family = Employee with one or more covered dependent(s)</td><td rowspan="2">Deductible:
Individual: $2,000
Family: $6,000 (no individual limit applies)
Coinsurance: 80/20
Out-of-Pocket Max:
Individual: $3,250 + deductible
Family: $4,500 + deductible
Family = Employee with one or more covered dependent(s)</td></tr>
<tr><td>Mail-Order
(up to 90-day supply)</td><td>Subject to deductible then:
$50 Copay Generic
$100 Copay Brand
(30-Day Supply)</td></tr>
<tr><td colspan="4">Plan pays 100% of the medication cost once deductible and out of pocket maximum requirements have been met.</td></tr>
</table>

WELLNESS PPO PLAN MEMBERS

Members enrolled in the CVT Wellness PPO Plan may be eligible for reduced pharmacy copayments for certain prescriptions only when enrolled and engaged with a nurse in an approved adult and\or pediatric Alere Health Management Program. You can call Alere at 1-877-864-1327 to enroll or receive more information on this program.

WHAT IS A THREE-TIER PRESCRIPTION COPAYMENT STRUCTURE? (APPLICABLE FOR PLANS B, C AND D)

In addition to generic and brand drug copayments offered under the prescription drug program, a third level copayment is being offered for preferred brand drugs. The three-tier prescription copayment plan provides you with the same access to generic and brand drugs available to you under the plan.

Medications in a 3-tier benefit structure are divided into 3 groups or copayment/coinsurance levels. Generic drugs are in the 1st tier copayment; certain brand-name drugs, including preferred brands, are in the 2nd tier copayment; and non-preferred brands are in the 3rd tier copayment. In most cases there are generic and/or preferred brand alternatives available for non-preferred brands. You should discuss the possibility of being prescribed a preferred brand or generic with your physician, if appropriate. Your doctor always has the final decision on drug selection. If your doctor prescribes a non-preferred brand even after you have explained your preference for a preferred brand or generic, it will still be covered but at the higher copayment. Please note that commonly prescribed 1st and 2nd tier drugs are listed on the preferred drug list for your reference.

WHAT IS THE PERFORMANCE DRUG LIST (PDL) AND WHAT IS A PREFERRED DRUG?

The PDL is a list of commonly prescribed drugs in select drug classes, or grouping of drugs that are used to treat the same condition. There are preferred brand-name drugs as well as generic drugs listed on the PDL. The drugs listed on the PDL are considered preferred drug choices as they provide the greatest economic value in the drug class. It is important to note that preferred medications are not chosen for inclusion on the PDL based on price alone; they are selected based on comparable clinical efficacy to other products in the same drug classes. The PDL

undergoes a rigorous clinical and economic review annually. Medical specialists (physicians and pharmacists) evaluate any proposed changes to ensure they are consistent with the most recent and relevant clinical findings.

The PDL is available online at the CVS Caremark Web site or you may also call CVS Caremark member services at 888-354-6390 to request a copy of the PDL and any updated information. The PDL is not distributed automatically to members when updated; to obtain the most recent copy, visit the CVS Caremark Website or call CVS Caremark member services.

GENERIC VERSUS BRAND-NAME DRUGS

WHAT IS A BRAND NAME DRUG?

A brand name drug is a medicine that is discovered, developed and marketed by a pharmaceutical company. The pharmaceutical company must conduct many tests and research studies before it submits a drug to the Food and Drug Administration (FDA) for approval.

Generally, once a new medication receives FDA approval, the company that developed the medication has a patent and may have 10 more years to market the drug exclusively. In other words, no other company can sell the same medication during this period.

When the patent expires, however, other pharmaceutical companies can apply for approval to market the same medication as a generic.

WHAT IS A GENERIC MEDICATION?

A generic medication is a Food and Drug Administration (FDA) approved copy of a brand name drug. The FDA reviews each generic medication to ensure that it is the same as the brand name drug in safety, effectiveness, quality, and performance (how it works in the body). The generic version is available for the same use (high blood pressure, allergies, etc.) and in the same form (pill, liquid, cream, etc.) as its brand name equivalent.

By law in the United States, a generic medication cannot look exactly like the brand name medication, but it must be equal to the brand name product in safety, effectiveness, quality, and performance.

Your first choice: Ask for generics

Choosing generic medications are one of the easiest ways to save money on your prescriptions.

- Say “yes” if your pharmacist asks whether you would like the generic equivalent of the brand name medication your doctor prescribed.
- If there is no generic equivalent for a brand name medication you are prescribed, ask your doctor if there is a generic alternative available to treat your condition and if it would be right for you. A “generic alternative” is a therapeutic alternative utilizing a generic drug to treat the same condition.

Your second choice: Request drugs from your CVS Caremark Drug List:

If there is no generic equivalent or generic alternative for a brand name medication you are prescribed, ask your doctor if there is a preferred brand medication on your CVS Caremark Drug List* to treat your condition, and if it would be right for you. You may pay a lower co-payment for medications listed on the CVS Caremark Drug List compared to other non-preferred brand name medications. Keep in mind that co-pays for all brand name medications are still usually higher than for generics.

Because it is difficult for doctors to keep track of all of their patients’ different prescription benefit plans, you can assist your doctor by sharing your CVS Caremark Drug List with him or her.

*Your CVS Caremark Drug List can be found on the CVS Caremark website. You will need to register on the website; once logged in click on 'My Drug List' to receive a copy.

MANDATORY GENERICS

Prescriptions will be dispensed with a generic equivalent, if available. If your doctor indicates "Dispense as Written" (DAW) on the prescription you cannot choose a generic without a new prescription. The out-of-pocket amount you will be required to pay will increase if you or your doctor requests a brand when there is a generic equivalent available - you will be responsible for paying the generic copay plus the cost difference between the generic and brand-name drug.

EXAMPLE: Prozac (brand) can cost $185.00 retail compared to fluoxetine (generic) that costs $24.00 retail. Having the fluoxetine filled in place of the Prozac can save $161.00 for that one prescription. If you choose the brand name, you will pay the cost difference between the brand and generic (in this case $161) + the copay of $5 for a total of $166 in this example. If a generic is chosen in this case, you will only pay $5.

GENERIC STEP THERAPY

The Generic Step Therapy program will assist you and your doctors to choose a lower-cost generic medicine as the first step in treating your condition. If you choose a higher cost option, without trying a lower-cost generic, the prescription may not be covered and you may have to pay the full cost. The program provides generous coverage for generic drugs without restriction. Certain brand-name drugs will continue to be covered; however you must try a generic alternative in the same drug class before the brand-name drug will be dispensed. In some instances you may have to try more than one generic alternative.

If you have questions about drug classes associated with this program, please call Customer Care at 1-888-354-6390.

DRUG COVERAGE OVERVIEW

COVERED MEDICATIONS

- Legend drugs (Federal law requires these drugs to be dispensed by prescription only); see exceptions below.
- Multiple ingredient compounded drugs
- Diabetic Care: Insulin, disposable needles and syringes are covered. Lancets and test strips are available through your CVS Caremark prescription plan as well. Glucometers are not a covered item under the CVS Caremark prescription plan; however, CVS Caremark does offer the Diabetic Meter Program. This program offers a new, free meter every two years to eligible members; just call 1-800-588-4456 to receive your free meter.
- Infertility medications up to a lifetime maximum of $7,500 paid by CVT.
- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

EXCLUDED MEDICATIONS

- Anti-wrinkle agents (e.g. Renova)
- Hair growth products (e.g. Rogaine, Propecia)
- Cosmetic hair removal products (e.g. Vaniqua)
- Levonorgestrel (Norplant)
- Medroxyprogesterone acetate (Depo-Provera)

- Pigmenting/Depigmenting agents (e.g. Lustra)
- Medical supplies and durable medical equipment
- Blood and blood plasma
- Cough and Cold products and other over-the-counter items
- Nutritional and dietary supplements
- Over-the-counter medications
- Medical Devices

COVERAGE LIMITATIONS

PRIOR AUTHORIZATION

In order for some prescription drugs to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the drugs' prescribed use meets defined clinical criteria. Through this process, your doctor and CVS Caremark pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition. To initiate a PA evaluation, doctors must call CVS Caremark at 1-888-413-2723.

The drug classes that require PA are as follows:

- Weight Loss Medications / Anti-Obesity
- Acne Medications (topical products and oral Solodyn)
- Allergy / Asthma (Singulair)
- Antibiotic (Vancocin)
- Narcolepsy
- Pain Management

Additional specialty medications will be subject to evaluation, see therapeutic classes listed under the Specialty Pharmacy Services for additional information

Please note that the list of drugs that require Prior Authorization is subject to change.

Please call Customer Care at 1-888-354-6390 or visit the CVS Caremark Web site for details surrounding your specific drug scenario.

QUANTITY LIMITS

Quantity limits are defined as the maximum number of pills or units (i.e. injections or nasal spray bottles) covered by the plan per copayment or coinsurance amount. These allowances are intended to ensure proper prescription utilization by allowing you to receive drugs in clinically appropriate quantities. These allowances are based on clinically approved prescribing guidelines and are routinely reviewed by pharmacists and doctors to ensure clinical appropriateness. The following drug classes are subject to quantity limits:

- Migraine*
- Influenza*
- Pain Management
- Erectile Dysfunction
- Emergency Contraceptives

*Members who exceed the initial quantity allowance may have their physician contact CVS Caremark Prior Authorization (PA) to request additional quantities based on clinical evaluation at 1-888-413-2723
Please call Customer Care at 1-888-354-6390 or visit the CVS Caremark Web site for details surrounding your specific drug coverage scenario.

SPECIALTY PHARMACY SERVICES

Certain rare or complex disease states, such as cancers, rheumatoid arthritis, multiple sclerosis or genetic conditions, require the use of specialty pharmacy products, which may be oral, injected or infused drugs. Medications that may be self-administered are most often covered by the Pharmacy Benefit, while medications that require administration by a health care professional in your doctor's office, a clinic, or infusion suite are typically covered under your insurance plan's Medical Benefit.

For medications covered by the Pharmacy Benefit, CVT partners with CVS Caremark to provide Specialty Pharmacy Services directly to plan participants along with special support, including regular phone calls to answer questions about using the drug.

A specialty pharmacy provides you with your specialty medications, and also provides you with personalized pharmacy care management services. You will have a pharmacist-led CareTeam assigned to you. This group of clinical experts helps you effectively manage your condition, reviews dosing and medication schedules, troubleshoots injection-related issues, discusses side effects, and supplies educational information you may need. In addition, you can call the pharmacists 24 hours a day, 365 days a year, for emergency consultations.

You will also be offered counseling on the disease (emphasizing early intervention), how to best manage it, and the latest developments to get the most from your medication. You can also get answers to your questions on the CVS Caremark Web site or by calling Caremark Connect toll-free at 1-800-237-2767.

All medications are delivered promptly in temperature-controlled, secure packaging. Also included are any required ancillary supplies, including needles, syringes, disposal containers, and alcohol swabs. All medications are shipped discreetly in secure, nondescriptive packaging to your home, office, or other location of your choice.

As part of the Pharmacy Specialty Services, an evaluation will be conducted for specialty medications to determine if the drugs prescribed use meets defined clinical criteria. Through this process, your doctor and CVS Caremark Specialty pharmacists will work together to ensure the appropriateness for your prescribed drug for your condition. CVS Caremark offers Specialty Pharmacy Services for several drug categories including evaluation for:

Acromegaly	Inflammatory Bowel Disease
Alcohol Dependency	Infertility
Alpha-1 Antitrypsin Deficiency	Infectious Disease
Anemia	Iron Overload
Asthma	Lysosomal Storage Disorder
Botulinum Toxins	Movement Disorder
Cardiac Disorder	Multiple Sclerosis
CAPS	Neutropenia
Cystic Fibrosis	Oncology
Gaucher's Disease	Osteoarthritis
Coagulation Disorders	Osteoporosis
Cushing's Syndrome	Pain Management
Electrolyte Disorder	Paroxysmal Nocturnal Hemoglobinuria
Familial hypercholesterolemia	Phenylketonuria
Gout	Pre-term Birth
Growth Hormone Deficiency	Psoriasis
Hematopoietics	Pulmonary Arterial Hypertension
Hemophila and related bleeding disorders	Renal Disorder
Hepatitis B and C	Retinal Disorder
Hereditary Angioedema	Rheumatoid Arthritis

HIV Hormonal Therapies Idiopathic Thrombocytopenic Purpura Immune Disease	RSV Prevention Seizure Disorder Short Bowel Syndrome Systemic Lupus Erythamatosus Transplant Urea Cycle Disorder

Please note that the list of Specialty drugs is subject to change.

To learn more about Specialty Pharmacy Services, please visit the CVS Caremark Web site or call CVS Caremark Connect at 1-800-237-2767.

COORDINATION OF BENEFITS

The following coordination provisions apply separately to each member, per calendar year, and are largely determined by California law. If you are covered by more than one group prescription plan, your benefits under this plan may be coordinated with the benefits of those other plans.

ORDER OF BENEFITS DETERMINATION

- If your spouse or other dependent has prescription drug coverage under his/her own CVT group number or from another carrier, that coverage must be used first for those individuals that have this as the **primary** coverage. Any balances should be submitted to CVS Caremark for consideration of payment.
- If your dependent does not have other prescription drug coverage, CVT requires a letter from the other insurance company or the employer stating that the coverage does not include prescription drugs.
- If your dependent's prescription coverage is canceled for some reason, CVT will again require a letter from the insurance company or the employer indicating the date of cancellation.
- When CVT is the secondary prescription drug coverage carrier, any balances should be submitted to CVS Caremark for consideration. Balances should be accompanied by a pharmacy receipt and statement from the other carrier (EOB) indicating what, if anything, was paid.
- Copays from other carriers can be submitted. Please indicate that these are copays on the form.
- The CVS Caremark computers will show when you are double CVT covered (husband and wife). The copay will automatically be picked up by the computer.
- Balances will be paid up to CVS Caremark allowances, i.e., if the cost of the drug is $26.75 and CVS Caremark allows only $23.00 for that particular drug; balances will be paid up to $23.00.
- All balances should be submitted on a secondary coverage prescription drug claim form and should be mailed directly to CVS Caremark. These forms are available on CVT's website: www.cvtrust.org

TERMINATION OF PHARMACY BENEFITS

Prescriptions Filled for you and/or your dependents After Termination Date:

When your pharmacy coverage has terminated, CVT processes the termination as soon as it is received; however, depending on when CVT receives the termination information, CVS Caremark may not receive the termination date in a timely manner. Until such termination is completed, your coverage may still show eligible at the pharmacy. Even though the pharmacy processed the claim or claims, they did so with incorrect eligibility information.

If you have other insurance at the time, please submit your claim or claims to them for reimbursement or have the pharmacy reverse the claim or claims and bill the proper insurance. If you did not have other insurance, the claim is your responsibility and should be paid back to CVT, in full, immediately. CVT will contact you regarding

reimbursement of the claim or claims. Any reimbursement not received within 45 days from the date of the notification letter, **will be forwarded to a collection agency**.

CLAIMS REVIEW

The benefits of this plan are provided only for those services that are considered medically necessary and satisfy all other terms and conditions of this plan. The fact that a physician prescribes or orders a service does not, in itself, mean that the service is medically necessary or that the service is a covered charge. Consult this benefit booklet or telephone the pharmacy benefit administrator at the number shown on your identification card if you have any questions regarding whether services are covered.

The Plan has designated its pharmacy benefits administrator to make determinations regarding medical necessity. That determination will be made during claims review, unless reviews for medical necessity already were conducted for those services that are subject to the provisions stated under PRIOR AUTHORIZATION.

When the claim is submitted for benefit payment, it is reviewed against guidelines, established by the pharmacy benefit administrator for medical necessity, beginning with preliminary screening against general guidelines designed to identify medically necessary services. If there is a question as to the medical necessity of the services, the claim will be further reviewed against more detailed guidelines. If the medical necessity still cannot be clearly determined, the claim will be reviewed by a physician advisor for a final determination.

Action on a member's claim, including denial and reasons for denial, will be provided to the member in writing.

RECONSIDERATIONS

If you or your physician disagree with an initial claims review determination, or question how it was reached, reconsideration may be requested. The request may be made by you, your physician or someone chosen to represent you.

APPEALS

If the reconsidered decision is not satisfactory, a request for an appeal on the reconsidered decision may be submitted in writing to the pharmacy benefit administrator. The request may be made by you, your physician or someone chosen to represent you. In the event that the appeal decision still is unsatisfactory, the remedy is binding arbitration, which is explained in the next section of this benefit booklet.

a. Review of Benefit Coverage. Caremark shall conduct appeals relating to eligibility and coverage. Such reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, Caremark shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of Caremark shall be final, subject to any External Review, outlined below. Caremark may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, Caremark agrees to be a fiduciary solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. Caremark will review appeals in accordance with the rules and procedures established by Caremark to govern appeals from the denials of claims, as may be amended from time to time.

b. Review of Medical Necessity. Caremark has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of prescription benefits where the Plan beneficiary is entitled to obtain a review of the denial by a physician specialist. Caremark has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process

consistent with the Appeals Program. The decision of the independent vendor shall be final, subject to External Review, outlined below, or available review only for abuse of discretion as established by the Plan and set forth in this Benefit Booklet.

HOW TO INITIATE REQUESTS FOR RECONSIDERATION OR APPEALS

To request an appeal, contact Caremark Member Services at (888) 354-6390 for a Caremark Prescription Claim Appeal Form and Instructions. You may also download the form from the CVT website at cvtrust.org. Mail or fax to the completed form to the pharmacy benefit administrator at:

Prescription Claim Appeals, MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 85072-2084
FAX: (866) 443-1172

REQUESTS MUST BE MADE AS FOLLOWS:

1. In writing, and
2. Within 60 days of receiving the original denial when the request is for reconsideration, or
3. Within 30 days of receiving the reconsidered determination when the request is for an appeal.

REQUESTS MUST INCLUDE THE FOLLOWING:

1. Any medical information that supports the medical necessity of the services for which payment was denied, and any other information you or your physician feels should be considered, and
2. A copy of the original denial.

The pharmacy benefit administrator must respond to the request for reconsideration or appeal within 60 days of receiving the request, except when the pharmacy benefit administrator indicates before the 60th day that additional time is required to review the request. In that event, the claims administrator is permitted a total of 120 days in which to respond to the request.

VOLUNTARY SECOND LEVEL APPEALS

If you are dissatisfied with the first level appeal decision as described above, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

EXTERNAL REVIEW

Caremark has contracted with independent review organizations to provide External Review of benefit determination that are subject to External Review under PPACA. The decision of the independent review organization shall be final and binding subject only to further review as set forth below. If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

A request for an External Review must be in writing. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

All requests for External Review should be submitted by you or your authorized representative to:

Prescription Claim Appeals, MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 85072-2084
FAX: (866) 443-1172

If the decision following the External Review is adverse you have the right to arbitration.

BINDING ARBITRATION

Any dispute, claim or denied appeal, of whatever nature, arising out of, in connection with, or in relation to this plan or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The member and CVT agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The member and CVT agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the member waives any right to pursue, on a class basis, any such controversy or claim against CVT and CVT waives any right to pursue on a class basis any such controversy or claim against the member.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the further review of arbitration proceedings.

The arbitration is begun by the member making written demand on CVT. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and CVT, or by order of the court, if the member and CVT cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and CVT.

DEFINITIONS

Benefit booklet is this written description of the benefits provided under the plan.

CVT is the California's Valued Trust.

Generic equivalent has the same active ingredient of the brand-name product.

Legend Drug is medication that cannot be legally obtained without a doctor's prescription.

Long-Term Medications are a long-term medication taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol.

Medically necessary procedures, equipment, services or supplies are those considered to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your physician or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the subscriber or family member.

Non-participating provider is one of the following providers which does NOT have a CVS Caremark Participating Provider Agreement in effect with the pharmacy benefit administrator at the time services are rendered:

1. A hospital;
2. A physician;
3. An ambulatory surgical center;
4. A home health agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A skilled nursing facility;
8. A clinical laboratory;
9. A home infusion therapy provider; or
10. A hospice.

They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Participating provider is one of the following providers which has a CVS Caremark Participating Provider Agreement in effect with the pharmacy benefit administrator at the time services are rendered:

1. A hospital;
2. A physician;
3. An ambulatory surgical center;
4. A home health agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A skilled nursing facility;
8. A clinical laboratory;
9. A home infusion therapy provider; or
10. A hospice.

Participating providers agree to accept the maximum allowed amount as payment for covered services. A directory of participating providers is available upon request.

Plan is the set of benefits described in this benefit booklet and in the amendments to this benefit booklet, if any. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, an amendment or revised benefit booklet will be issued to each subscriber affected by the change.

Pharmacy benefit administrator refers to CVS Caremark which shall perform all administrative services in connection with the processing of claims under the plan.

Therapeutic generic alternative is substituting a different generic product in the same therapeutic class.

You (your) refers to the subscriber and family members who are enrolled for benefits under this plan.