

**PART E: ADDITIONAL RULES AND INFORMATION APPLICABLE TO
PRESCRIPTION DRUG BENEFITS**

**SUMMARY OF PRESCRIPTION DRUG BENEFITS
FOR THE
SEIU HEALTHCARE PENNSYLVANIA
HEALTH AND WELFARE PLAN**

NOTE: This Booklet supplements, and is considered “PART E” of, your “Summary Plan Description” Booklet from the Plan. If you have not received or have lost any other portion of your Summary Plan Description, contact the Plan’s Contract Administrator, MCA Administrators, Inc., at 1-800-877-6490.

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PART E: ADDITIONAL RULES AND INFORMATION APPLICABLE TO PRESCRIPTION DRUG BENEFITS

For each eligible Participant of the SEIU Healthcare Pennsylvania Health and Welfare Plan ("Plan") whose Benefit Class provides for Prescription Drug coverage, such benefits are subject to the rules summarized in this Part E, as well as being subject to all general rules summarized in Part A of this Summary Plan Description Booklet. (To determine your Benefit Class and whether Prescription Drug Benefits are provided for your Benefit Class, you should refer to your collective bargaining agreement and page "i" of this Booklet or call the Contract Administrator, MCA Administrators, Inc. at the phone number on the cover.)

The Plan helps provide for prescription drug needs by paying on a self-insured basis for part of the cost of covered prescription drugs for eligible Covered Employees and dependents. The Prescription Drug Benefit Program is administered by the following private claims payor, which has been hired by the Board of Trustees effective July 1, 2015, in replacement of prior prescription claims payor Express Scripts:

CVS/caremark
9501 E. Shea Boulevard
Scottsdale, AZ 85260
Toll Free: 877-668-8990
Website: www.caremark.com

In order to receive a Prescription Drug Benefit, you must first meet all of the eligibility requirements described in Part A of this Booklet, and you must have submitted an enrollment form to the Plan's Contract Administrator, MCA Administrators, Inc.

SECTION 1 OVERVIEW OF PRESCRIPTION DRUG BENEFITS

The Plan's Outpatient* Prescription Drug Benefits are provided through "CVS/caremark ." The Program uses what is sometimes referred to as a "Three-Tier Open Formulary Co-Pay" approach, which permits you to take advantage of a lower out-of-pocket cost, or "co-pay," if you use a Generic drug or a Brand Name Drug on the Plan's "Preferred" drug list (called the "Formulary") than if you use a Non-Preferred Brand Name Drug. This Formulary list is available at the CVS/caremark website listed above. A hard copy also can be obtained by contacting the Plan's Contract Administrator whose address and telephone number are on the first page of the SPD. The lowest cost to you applies if you use a Generic Drug, and the highest cost to you applies if you use a Non-Preferred, Brand-Name Drug that is not listed on the Formulary. The "Three-Tier Open Formulary Co-Pay" is explained below in more detail in Sections 6 through 8 of this Part E. The Co-Pay amounts are set forth below in the Schedule in Section 2.

When a federal Food and Drug Administration (FDA) approved "Generic" equivalent of a covered drug is available, the Plan allows you to purchase that Brand-Name Drug and still obtain some level of benefits, but you will be responsible to pay for the difference, which is usually substantial, between the cost of the equivalent Generic and the cost of the Brand-Name Drug in addition to the applicable CoPay. This rule applies whether or not the equivalent Brand Name Drug is otherwise listed on the Preferred Drug Formulary List. The rules concerning the use of generics are explained in Section 9.

As is described in more detail below in Section 12 of this Part E, the Plan covers "maintenance drugs" (those medications you take on a regular basis for a long period of time) through either the Plan's Mail

Service program Or at a local CVS/pharmacy, which is known as the “Maintenance Choice Program”. For certain chronic conditions the Plan’s “Step Therapy” rules, described in Section 13, or Specialty Pharmacy rules, described below in Section 14, may apply. This does not apply to medications you are taking on a short term basis (like an antibiotic).

To ensure the lowest cost to you, it also is important that you purchase your non-maintenance prescriptions at a CVS/caremark participating pharmacy (explained in Section 10) or through the Plan's Maintenance Choice Program (explained in Section 12).

As with virtually all prescription drug plans, there are certain exclusions from coverage and limitations, which are explained in Section 5 below. For certain prescriptions, prior approval also may be required, as is explained in Section 11.

**Prescription Drugs that you receive as part of inpatient treatment at a hospital, as well as Prescription Drugs that, due to medical necessity, are administered by a physician or other medical provider, are considered by the Plan to be medical treatment. Benefits, if any, for those Prescription Drugs are determined under the Plan's Medical Benefit Program Rules explained in Part D of this Summary Plan Description. Those benefits are administered through Highmark Blue Cross/Blue Shield for the Plan, and not by CVS/caremark.*

SECTION 2 SCHEDULE OF CO-PAY LEVELS

The co-pay levels applicable to the CVS/caremark Three-Tier Open Formulary Program are:

| | 30 Day Supply at CVS/caremark Participating Pharmacy | 90 Day Supply Through Mail Service or at a CVS/pharmacy | Type of Drug |
|------------------|---|--|--|
| Lowest Co-Pay | \$8 | \$16 | Covered Generic Drugs |
| Middle Co-Pay | \$20 | \$40 | Covered Brand-Name Drugs on the <i>Formulary List</i> (i.e. "Preferred Brand-Name") |
| Highest Co-Pay** | \$35 | \$70 | Covered Brand-Name Drugs not on the <i>Formulary List</i> (i.e. "Non-Preferred Drugs") |

**In addition to this co-pay, if you use a brand-name drug when an FDA-approved generic equivalent is available, you will also pay the difference between the cost of the generic and the cost of the brand-name drug.

SECTION 3 PRESCRIPTION IDENTIFICATION CARDS

When you become eligible for Prescription Drug Benefits under the SEIU Healthcare Pennsylvania Health and Welfare Plan, you should promptly receive a CVS/caremark Prescription Drug Identification Card which you will need to present at the pharmacy when obtaining a new or refill prescription.

SECTION 4 WHAT ARE "COVERED DRUGS" UNDER THE PLAN?

Unless subject to a specific exclusion or limitation, including those explained in Section 5 of this Part E, the Plan's Prescription Drug Benefit Program generally treats medically necessary and appropriate outpatient drugs that require a prescription under either State or Federal law, and that are prescribed by a licensed practitioner, to be "Covered Drugs." (Drugs requiring a prescription under federal law generally bear the legend "Caution: Federal law prohibits dispensing without a prescription," and are therefore sometimes called "Legend Drugs.")

Under appropriate circumstances, the Plan also specifically treats the following items, with a prescription, as "Covered Drugs":

- Disposable needles and syringes for diabetic insulin.
- Insulin
- Oral contraceptive medicines
- "Chemstrips," or other test strips used in glucomonitor machines by diabetics to monitor blood glucose

If an item is considered to be a "Covered Drug," the actual amount of the benefit, if any, a Covered Person will receive depends upon the rules explained throughout this Part E.

SECTION 5 EXCLUSIONS

In addition to the Exclusions set forth in Part A of this Summary Plan Description that are applicable to all types of benefits, there are also some special exclusions, and some special limitations, that apply specifically to Prescription Drug Benefits.

A. COMPLETE EXCLUSION

In addition to the exclusions in Part A of this Summary Plan Description, no Prescription Drug benefits are provided for:

- a. Any substance, except insulin, which may be lawfully obtained without a prescription.
- b. Charges for the administration of any Prescription Drug, insulin, or other substance.
- c. Any Prescription refill in excess of that specified by the physician or other licensed medical provider, or dispensed more than 12 months after it was prescribed.
- d. The amount of any prescription or refill exceeding a 30-day supply, except when using the Mail Service Drug Program or a CVS/pharmacy.
- e. Any prescription directing enteral or parenteral administration of nutrition therapy.
- f. Any drug or item which is investigational or experimental, or any medications labeled to the effect, "Caution: Limited by Federal Law to Investigational Use."
- g. Any drug or item which may not be lawfully dispensed in the United States of America.

- h. Any drug or item to be taken by or administered to a person while he or she is a patient at a hospital, nursing home or similar institution which operates or allows to be operated on its premises a pharmacy or other facility for dispensing drugs. (For potential coverage of such "inpatient" prescriptions, check Part D of this SPD relating to medical benefits through Highmark Blue Cross/Blue Shield.)
- i. Any therapeutic device or appliance, needles and syringes (except needles and syringes for diabetic insulin), support garments, pros-theses and contraceptive devices or materials, regardless of their intended use.
- j. Any immunization agent, biological serum, blood or blood plasma.
- k. Any drug, prescription or otherwise, or items used to eliminate baldness.
- l. Any drug or item used for cosmetic purposes (e.g., Renova for wrinkles, and Retin-A for individuals over 25 years old).
- m. Vitamins (other than Legend Therapeutic vitamins including pre-natal, which are covered).
- n. Infertility medications.

B. PARTIAL LIMITATION APPLICABLE TO " ERECTILE DYSFUNCTION MEDICATIONS "

ERECTILE DYSFUNCTION MEDICATIONS (whether or not at the time listed as a Preferred Medication on the Plan's Formulary List) will be limited to cases of medical necessity as well as being limited to a dosage of four tablets per month.

**SECTION 6
HOW THE PLAN'S OPEN FORMULARY THREE-TIER CO-PAY PROGRAM WORKS**

A. WHAT IS A "FORMULARY" PROGRAM?

A "Formulary" is a list of Preferred Drugs. The specific Formulary List used by the SEIU Healthcare Pennsylvania Health and Welfare Plan is called the "CVS/caremark Preferred Drug List." The Drugs included in that Formulary List are selected by CVS/caremark' Pharmacy and Therapeutics Committee ("P&T Committee"). The P&T Committee is made up of a group of pharmacists and physicians with extensive pharmaceutical expertise.

Medications were selected for inclusion in the CVS/caremark Preferred Drug List by the P&T Committee following a thorough evaluation regarding the effectiveness and therapeutic advantages and disadvantages of the medications reviewed compared to other medications within the same category. If a medication has been determined by the P&T Committee to be safe, appropriate and cost-effective, the Committee considers if the medication offers a unique therapeutic option for the particular disease or condition. If the medication is considered unique, the medication is placed on the Formulary List. If there are similar medications available, the entire drug category is evaluated.

The Formulary List is constantly reviewed and updated by the CVS/caremark P&T Committee to make sure that the List contains medications that meet the most up-to-date criteria for safety and effectiveness. The Formulary List is regularly revised as new medications are approved by the FDA, as new Generic Drugs become available as patents for Brand-Name Drugs expire, and as new scientific information becomes available.

B. "OPEN" FORMULARY VERSUS "CLOSED" FORMULARY

In response to the run-away prescription cost inflation of recent years, many employee prescription benefit plans have implemented "Closed" Formulary Programs. Under those Programs, benefits are only provided for medications that are included in the Formulary List of preferred medications.

Under the "Open" type of Formulary Program used by the SEIU Healthcare Pennsylvania Health and Welfare Plan, however, you are not limited only to Covered Drugs that are listed in the Plan's Formulary List. Instead, this Plan also covers many thousands of Non-Preferred prescriptions in addition to those that are on the Formulary List. As long as a drug is not otherwise subject to an exclusion or limitation of the Plan, you can choose that drug even though it is not on the Formulary List and still receive some coverage. The only difference is that you will have a higher out-of-pocket cost in the form of higher Co-Pays (and any difference between Generic and Brand-Name Drug costs) if you opt to choose a drug not listed in the CVS/caremark Preferred Drug List. Depending on the drug, the cost difference may be substantial. By purchasing Generic Drugs when available and by using Preferred Medications on the Formulary List, both you and the Plan save money.

**SECTION 7
HOW THE THREE-TIER CO-PAY SCHEDULE WORKS**

In addition to the rule concerning the use of Generic Drugs set forth in Section 9 below, it is important for you to understand that there are three levels of Co-Pays that apply under the Plan when you purchase prescriptions at the pharmacy, and three levels of Co-Pays that apply when you purchase prescriptions through the mail-order Program, depending upon whether the drug is Brand-Name or Generic, and, if Brand-Name, whether or not it is in the Formulary List of Preferred medications.

Under the Three-Tier Co-Pay system, you pay the least for prescriptions that are "Generic Drugs." If the drug is a Generic, you do not have to be concerned with whether it is on CVS/caremark Preferred Drug List. The middle-level Co-Pay applies to Covered Drugs that are Brand-Name Drugs included on the CVS/caremark Preferred Drug List. The highest level Co-Pay applies whenever you choose a Covered Drug which is not listed as a Preferred medication on the CVS/caremark Preferred Drug List.

The specific Schedule of Co-Pays is set forth in the Chart in Section 2 of this Part E.

**SECTION 8
30-DAY-PER-FILL LIMIT ON PRESCRIPTIONS FILLED AT LOCAL PHARMACY**

A. GENERAL RULE

Except as set forth in Paragraph (B) of this Section, benefits for prescriptions filled at the local pharmacy (as opposed to those filled by Mail Service) are limited under the Plan to supplies of thirty (30) days at a time, unless at a CVS/pharmacy, where a ninety (90) day supply is allowed.

B. EXCEPTION FOR PRE-PACKAGED, NON-MAINTENANCE DRUGS

For non-maintenance prescription drugs that only come prepackaged in units that exceed a 30-day supply, the Plan's 30-day-per-fill restriction at the local pharmacy does not apply. Instead, you are limited to the smallest number of days' worth of the prescription over 30 days that can be dispensed using the pre-packaged units. Maintenance drugs (*i.e.* long-term prescriptions) always remain subject to the 30-day-per-fill limit at the pharmacy. This is to encourage the purchase of maintenance drugs through the mail-order program, which is explained in Part E, Section 12 of the SPD.

SECTION 9 GENERIC DRUG RULES

A. RULE CONCERNING USE OF GENERIC DRUGS WHEN AVAILABLE

Although the SEIU Healthcare Pennsylvania Health and Welfare Plan -- unlike many other group employee prescription benefit plans -- does not completely exclude all benefits if you choose to use a Brand-Name Drug when an FDA-equivalent Generic Drug is available, in order for you to ensure that you have the lowest out-of-pocket cost, you must use the Generic version of the Drug.

Under the rules of the Plan, when an FDA-approved Generic Drug is available for a specific Brand-Name Drug, the Plan will not pay any more in benefits than what the Plan would have paid for the Generic equivalent. This applies even if the Brand-Name Drug is also listed as a Preferred Drug in the CVS/caremark Preferred Drug List. Consequently, if you choose the more expensive Brand-Name Drug, you will be responsible for paying the difference between the cost of the Brand-Name Drug and the equivalent Generic Drug in addition to paying the applicable Co-Pay.

Be sure to make your physician or other medical provider aware of this rule when you are having a drug prescribed.

B. A WORD ABOUT GENERIC DRUGS

A Generic Drug is a drug that is chemically equivalent to the original Brand Name Drug. Generic Drugs must meet the same FDA standards for purity, strength and safety as the original Brand-Name Drug. Generic Drugs also must produce the same effect in the body and have the same active ingredients, strength and absorption rate as Brand-Name Drugs.

Generic-Drug equivalents for Brand-Name Drugs generally become available as the result of the patent expiring on the Brand-Name Drug, allowing it to be produced as a Generic. The only significant difference between the Generic Drug and the Brand-Name version of the Drug is the cost. The majority of Generic Drugs are actually manufactured by the same companies that produce the Brand-Name Drugs. According to the FDA, Brand-Name manufacturers account for almost 75% of all Generic Drug production. Many manufacturers actually make duplicate versions of their own, as well as other companies', Brand-Name Drugs, but sell them without the Brand Name.

By using Generic Drugs where available, as well following the recommendations in the CVS/caremark Preferred Drug List, you immediately save money directly, and the SEIU Healthcare Pennsylvania Health and Welfare Plan also saves money, which will help to keep the cost of Plan coverage affordable in the long range.

SECTION 10 CVS/CAREMARK PARTICIPATING PHARMACY NETWORK

For outpatient drugs that are not purchased through the Plan's Mail Service Program (described in Section 12 of this Part E), you generally must have your prescriptions filled at a pharmacy that participates in the CVS/caremark Network in order to make sure you have the lowest out-of-pocket costs. Virtually all pharmacies -- including most major national chain stores -- participate in the CVS/caremark Network. The Network includes over 68,000 pharmacies nationwide, and you are able to visit any participating pharmacy in the network and are not restricted to CVS/pharmacy locations.

When purchasing prescriptions at a CVS/caremark Participating Pharmacy, you should identify yourself as a participant of the SEIU Healthcare Pennsylvania Health and Welfare Plan with coverage under CVS/caremark , and you should present your plastic Identification Card to the pharmacist.

For detailed information about the names and locations of pharmacies participating in the CVS/caremark Network, you can either contact CVS/caremark at 1-877-668-8990, or you can search the list of Network Pharmacies by visiting the CVS/caremark website at www.caremark.com.

The extensive CVS/caremark Participating Pharmacy network covers all 50 states and Puerto Rico. The Plan has special rules regarding the handling of Prescriptions obtained by Covered Persons while traveling outside of the country under which Covered Persons are generally reimbursed for the cost of the Covered Drug (which in most other countries is much lower than in the United States) less the appropriate Co-Pay. For more detailed information regarding these special rules, please feel free to contact the CVS/caremark Customer Service department.

If you choose to have a prescription for a Covered Drug filled at a pharmacy that does not participate in the CVS/caremark Network, you may still be entitled to benefits under the Plan by submitting a direct claim for reimbursement in accordance with the procedure explained in Section 15 of this Part E. However, the Plan will not pay benefits which exceed the amount it would have paid to the Participating CVS/caremark Network Pharmacy if the Covered Drug had been purchased there. Consequently, in addition to being responsible for the applicable Co-Pay, you will bear the cost of any excess in the amount of charges by the non-Participating Pharmacy as compared to the amount that would have been charged by the CVS/caremark Participating Pharmacy.

SECTION 11 DRUGS REQUIRING PRIOR AUTHORIZATION

A small number of medications set forth in the CVS/caremark Preferred Drug List require prior approval in order to be covered under the Plan. If a prescription that you are trying to have filled requires preauthorization you will be immediately advised of that by CVS/caremark and of the necessary steps.

Prior Authorization Hotline: The most efficient way to initiate a *prior authorization* review is to ask *your* physician to contact CVS/caremark's *prior authorization* hotline at 800-294-5979. If the request is approved, an override is entered. If the request is not approved, a follow-up letter will be mailed to *you* and *your* physician.

Prior Authorization Form: *Your* physician may also fax a *prior authorization* form to CVS/caremark. *Prior authorization* forms may be obtained from CVS/caremark at 877-668-8990. *Prior authorization* forms may only be completed by *your* physician or *pharmacist*.

To obtain additional information regarding the procedures for prior authorization by CVS/caremark, please call CVS/caremark Customer Service at 1-877-668-8990.

SECTION 12 "MAINTENANCE CHOICE PROGRAM" (MAIL SERVICE PHARMACY BENEFITS)

Benefits for prescriptions filled at a pharmacy other than a CVS/pharmacy are limited under the plan to supplies of 30 days. In other words, for long-term prescriptions (sometimes referred to as "maintenance drugs") in order to receive any benefits under the Plan you must have those prescriptions filled through the CVS/caremark Mail Service pharmacy program or purchased at a local CVS/pharmacy, called the

“Maintenance Choice Program.” You must continue to use the Maintenance Choice Program to purchase maintenance drugs under the Plan for as long you continue to regularly take that prescription.

Advantages of Maintenance Choice Program

By using the CVS/caremark Maintenance Choice program you and the Plan save money. Plus, you will receive the following advantages:

- Free home delivery of your medication if you choose Mail Service.
- Up to a three-month supply of medication with each order both through Mail Service and at a CVS/pharmacy.
- Twenty-four hour access to a pharmacist.

To order your medication through the Mail Service component of this program, just use the Plan's Mail Service Program form, which is available from the Contract Administrator, MCA Administrators, Inc., Suite 400, Gateway Corporate Center, 6345 Flank Drive, P. O. Box 6250, Harrisburg, Pennsylvania 17112, or simply order your prescription online. In order to do so, visit www.caremark.com and follow the directions at that website. After ordering, you should receive your medication in 10 to 14 days. You may ask your physician to write a prescription for a 90-day supply of your maintenance medications (with up to 3 refills) at the same time you receive your 30-day prescription.

The Plan's “Mail Service Program” is designed to allow Covered Persons to receive, in a convenient way and for less money, longer-term quantities of maintenance drugs (e.g. heart medication, blood pressure medication, diabetic medication, etc.). The Mail Service Program is handled through the CVS/caremark licensed mail-order pharmacy exclusive to CVS/caremark.

CVS/caremark also offers the ability to receive up to a 90 day supply of medication at a CVS/pharmacy for the same co-pay as Mail Service via the Maintenance Choice Program. Under this program, you may elect to purchase your 90 day supply of medication at the CVS/pharmacy of your choice. You should identify yourself to the CVS/pharmacy technician as being a member with access to the Maintenance Choice Program or you may contact CVS/caremark customer service with questions. Once the CVS/pharmacy has your prescription for the 90 day supply of medication, you will be able to pick up your 90 day prescription at the CVS/pharmacy of your choice for the same co-pay as Mail Service.

All of the same rules, including all of those concerning the use of Generic Drugs; concerning the CVS/caremark Preferred Drug List; concerning exclusions; and concerning limitations (except for the 30-day supply limitation that applies at the local Pharmacy), apply the same way with respect to prescriptions purchased through the Maintenance Choice Program as prescriptions purchased at the local CVS/caremark Participating Pharmacy.

If you have any questions regarding the Maintenance Choice Program, please call CVS/caremark at 1-877-668-8990.

SECTION 13
THE “STEP THERAPY” PROGRAM FOR CHRONIC (ONGOING CONDITIONS)

A. OVERVIEW

1. ***What is Step Therapy?***

“Step Therapy” is a program especially for people who take prescription drugs regularly to treat an ongoing medical condition, such as, but not limited to, arthritis, asthma or high blood pressure. The program is a new approach to getting you the prescription drugs you need, ***with safety, cost and – most importantly – your health in mind.***

The program makes prescription drugs more affordable for most members and helps our organization control the rising cost of drugs. ***It allows you and your family to receive the affordable treatment you need*** and also helps our organization continue with prescription-drug coverage.

In Step Therapy, the covered drugs you take are organized in a series of “steps,” with your doctor approving and writing your prescriptions.

- The program usually starts with ***generic drugs in the “first step.”*** Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by the Plan have been proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable: Your copayment is usually the lowest with a first-step drug.
- More expensive ***brand-name drugs are usually covered in the “second step,”*** even though the generics covered by the Plan have been proven to be effective in treating many medical conditions.

Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs covered by the Plan. For instance, your doctor must write your new prescription when you change from a second-step drug to a first-step one.

2. ***Who decides what drugs are covered in Step Therapy?***

Step Therapy is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with CVS/caremark they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Then they recommend appropriate prescription drugs for a Step Therapy program, and the Plan’s Board of Trustees chooses the drugs that will be covered after considering their recommendation.

B. WHAT HAPPENS AT THE PHARMACY

1. ***Why couldn’t I fill my prescription at the pharmacy?***

The first time you submit a prescription that is not for a first-step drug, your pharmacist will tell you there is a note on the computer system indicating that the Plan uses Step Therapy. This simply means that if you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug.

To receive a first-step drug:

- **Ask your pharmacist to call your doctor** and request a new prescription,
OR
- **Contact your doctor** to get a new prescription.

Only your doctor can change your current prescription to a first-step drug covered by your program.

2. **How do I know what “first-step” drug my doctor should prescribe?**

You can call CVS/caremark at the number on the back of your prescription card. An agent can give you some examples of possible prescription drugs for you to discuss with your doctor.

3. **I need a prescription filled immediately. What can I do?**

At the pharmacy, you may be informed that your drug is not covered if you have just started taking a prescription drug regularly or if you are a new member of the Plan. If this occurs and you need your medication quickly, you can:

- **Talk with your pharmacist about filing a small supply** of your prescription right away. You may have to pay full price for this drug. Then, ask your doctor to write a new prescription for a first-step drug, so you are sure your medication will be covered by the Plan. Remember: Only your doctor can approve and change your prescription to a first-step drug.

C. TO RECEIVE A SECOND-STEP DRUG

1. **I’ve already tried the first-step drugs on the list. What can I do?**

With Step Therapy, more expensive brand-name drugs are usually covered in a later step in the program if:

- a. You have already tried the generic drugs covered in our Step Therapy program,
- b. You cannot take them (for instance, because of an allergy), or
- c. Your doctor decides you need a brand-name drug, for medical reasons.

If one of these applies to you, your doctor can ask for a “prior authorization” for you to take a second-step prescription drug. Once the prior authorization is approved, you pay the appropriate copayment for this drug. If the prior authorization is not approved, you may need to pay the full price for the drug.

2. **What happens if my doctor’s request for a prior authorization is denied?**

As is explained in Section 5 above, the Plan’s pharmacy benefit guidelines exclude certain drugs from coverage.

- **For as copy of the detailed criteria the Plan uses to decide which drugs will be covered through a prior authorization**, call Patient Services at CVS/caremark. An agent can send you a copy of the criteria. The number to call is on the back of your prescription card.

OR

- ***If you want to file an appeal to have your prescription drug covered, see Section 16 of this Part E of the SPD.***

3. *I filed an appeal and it was denied. What can I do?*

You can talk with your doctor again about prescribing one of the safe, effective first-step drugs covered by the Plan's Step Therapy. Your copayment will usually be the most affordable for one of these drugs. Or you can pay the full price of a drug that is not covered by the pharmacy benefit plan.

**SECTION 14
"CVS/caremark SPECIALTY PHARMACY PROGRAM" FOR DISEASE MANAGEMENT**

The Plan uses the *CVS/caremark Specialty Pharmacy* for specialty drugs used to treat complex conditions. The *CVS/caremark Specialty Pharmacy*, a wholly owned subsidiary of CVS/caremark, is a national provider of specialty *pharmacy services* offering a broad range of healthcare products and *services* for individuals with complex health conditions such as growth hormone deficiencies, hepatitis C, hemophilia, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and many others. *CVS/caremark Specialty Pharmacy* provides comprehensive patient management services including clinical case management programs, counseling, education, and social services. Medications will be ordered specifically for *you* and delivered to *your* home or a location of *your* choice.

CVS/caremark Specialty Pharmacy specializes in specialty medications. *CVS/caremark Specialty Pharmacy* offers many products and *services* that *you* do not get from other pharmacies. Most importantly, *CVS/caremark Specialty Pharmacy* has a complete specialty *pharmacy* inventory with many specialty medications that are not readily available at a local *pharmacy*. *CVS/caremark Specialty Pharmacy*:

- delivers *your* specialty medications directly to *you* or *your* doctor.
- provides *you* with the necessary supplies *you* need to administer *your* medications — at no additional cost.
- offers clinically based care management programs — which include consultation with *your* doctor — to help *you* get the most benefit from the specialty medications that *your* doctor has prescribed for *you*.

CVS/caremark Specialty Pharmacy requires *you* to fill *your* prescriptions at the *CVS/caremark Specialty Pharmacy*. *CVS/caremark Specialty Pharmacy* will manage all of *your* prescriptions and a Patient Care Coordinator will work with *you* to ensure *you* receive the care *you* need. *Your* specialty drugs will be delivered to *your* home within a reasonable time, usually within 24 hours. Included with *your* specialty drugs will be all *your* needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to *you*.

Additional information, including a current listing of the drugs that must be purchased through the *CVS/caremark Specialty Pharmacy* can be obtained by calling 800-237-2767.

**SECTION 15
DIRECT SUBMISSION OF CLAIMS FOR REIMBURSEMENT**

Normally, if you use your Plan CVS/caremark Identification Card to purchase a Covered Drug at a Participating CVS/caremark Pharmacy, everything except for the payment of your Co-Pay is taken care of between the Participating Pharmacy and CVS/caremark. In two instances, however, it may become necessary for you to submit a claim for reimbursement for a Prescription Drug purchased by you. First, prior to the issuance or re-issuance of your Plan CVS/caremark ID Card, it may be necessary for you to pay for the drug purchased at the pharmacy and, in turn, request reimbursement. Since, as discussed above in Section 10, you will only be reimbursed for the amount that would be paid at an CVS/caremark

Participating Pharmacy, it is important that you have your prescription filled at the CVS/caremark Participating Pharmacy, as opposed to a non-Participating Pharmacy, even if you do not yet have your ID card. Since the Plan has no arrangement through CVS/caremark with the non-Participating Pharmacies, you may not be fully reimbursed for your costs (less the appropriate Co-Pay) unless you have your prescription filled at a Participating Pharmacy. The second instance in which it may be necessary for you to submit a claim to CVS/caremark for reimbursement is when you choose to patronize a non-Participating Pharmacy. (A current list of Participating Pharmacies is available online at the CVS/caremark website or may be requested from the Plan's Contract Administrator, MCA Administrators, Inc.)

In either of those instances, the following procedures should be used:

- Secure a claim form from MCA Administrators, Inc.
- Submit a separate claim form for each family member and for each pharmacy patronized.
- Complete the "insured's" portion of the claim form and attach an itemized receipt.

For additional rules that apply to all types of claims under the Plan, please refer to the Plan's general claim and appeal procedure rules summarized in Part A of this Summary Plan Description.

SECTION 16 APPEAL OF ADVERSE BENEFIT DETERMINATION

If you disagree with a claim denial or other determination by CVS/caremark, you have the right to file an appeal with the Board of Trustees. For information concerning the appeal procedure, please refer to Part A of this Summary Plan Description.

SECTION 17 CVS/CAREMARK WEBSITE

For your convenience, CVS/caremark maintains a website that you can utilize. Register today at www.caremark.com to access savings, convenience and service. Use the CVS/caremark website to:

- Get More from your prescription benefit
- See what you will pay for a specific drug
- Discover ways to save
- Order refills and track the status of your order
- Find local participating retail pharmacies near you
- Check your benefit coverage
- Verify coverage for eligible dependents

Privacy and Security: CVS/caremark is committed to protecting the confidentiality of your personal and prescription information. CVS/caremark's complete Privacy Promise is posted on the CVS/caremark website.

SECTION 18 SUSPENSION OF BENEFITS FOR MISUSE OF PRESCRIPTION COVERAGE

To the extent permitted by law, cases of abuse relating to use of the Plan's Prescription Drug Benefits, when determined by the Board, may result in immediate and permanent suspension of the Plan's Prescription Benefits or other Benefits for the Covered Employee and his or her dependents, in addition to subjecting you to other measures available to the Plan under law.